***Huntersville Location*- (Daetwyler Plaza) 13420 Reese Blvd., West, Huntersville, NC 28078**

Professional Disclosure Statement

(Initials) Overview and Description of Services Our counselors/therapists are Marriage & Family Therapists licensed in the state of North Carolina. We see individuals, couples, and families and we partner with clients from an integrative perspective. Being authentic in our approach to therapy, we will work together for you to be empowered to a well and whole self. Our approach to therapy is that of a consultant and fellow journeyman in exploring the challenges, and the emotional unrest of life. Other theoretical perspectives used include:

- ***Positive Psychology*** – focusing on the strengths that enables individuals to thrive and the belief that people want meaningful and fulfilling lives; that they want to cultivate what is best within themselves and enhance their experience of love, work and play.
- ***Humanistic*** – focusing on one's present experience, one's free choice and the idea that self- awareness leads to choices, responsibility and change.
- ***Family systems*** – focusing on the present and playing and paying attention to one's family of origin in a direct and non-confrontational manner to gain self-awareness in current relationships and intergenerational experiences. A genogram (3 generational family history) is constructed, usually within the first two sessions.
- ***Cognitive-Behavioral*** – focusing on the present and interpersonal environments that perpetuate thoughts and behaviors. This modality is directive and actions, negotiations and contracts may be used to help modify cognitive and behavior patterns.

(Initials) Sessions, Fees, Payment Method, Scheduling & Cancellation Policy Initial Diagnostic interview last eighty (80) minutes. Fee: $225.00 Individual Session lasts fifty (50) minutes beginning on the hour and ending ten (10) minutes before the hour unless other arrangements are made. Fee: $150.00 Couples & Family Session lasts (80) minutes beginning on the hours and ending ten (10) minutes before the half hour unless other arrangements are made. Fee: $225.00 Any time overage will be prorated in ten (10) minutes intervals. Clients pay for services after each appointment and are encouraged to schedule on a quarterly basis. Scheduling on a quarterly basis means negotiating and reserving appointment times specifically for the client for a period of 3 months. Professional services are rendered and charged to the clients and not to the insurance company. Clients who wish to submit a statement to their insurance company will receive a statement with appropriate procedure and diagnostic codes. Please note that it is the client's responsibility to determine coverage. Visa, MC, AMEX, check and cash are acceptable forms of payment.

(Initials) Please note: A $50 fee is assessed for each declined credit/debit card or returned check. Also, an advance 24 hr. notice is required for any cancellation or re-schedule. Without 24 hrs. notice, full fee will be charged unless it involves a life-threatening emergency.

(Initials) Confidentiality and Special Concerns Information disclosed in session is confidential and may not be disclosed to anyone without written permission from you, the client. However, North Carolina law requires the following exceptions to confidentiality:

- Where there is suspicion or evidence of child or elderly abuse, where there is reasonable suspicion that the client presents danger to self or others, and Court Order.

Therapeutic notes have diagnosis and become part of the client record. Also, please note that confidentiality cannot be guaranteed in group work. During this process I will always work to help you achieve your goals yet cannot make any outcome guarantees. I will always assume (if possible) both partners love their children and want the best for them. For that reason, please know, I will not testify on behalf or against either party.

(Initials) Telephone Phone sessions are available on request, depending on the therapist you are working with. If you need to contact either therapist between sessions, please leave a message and they will return your call within 24 hours. If an emergency arises, state that clearly in your message and we will respond as soon as possible. An emergency is considered danger to self or other catastrophic loss. In case of a life-threatening emergency, it is in your best interest to contact 911 at once. Please note: Non-emergency calls to my office about issues other than cancelation or scheduling will be considered billable at the standard hourly rate.

(Initials) All Things Social Media It is policy that we, at Inner Peace Counseling Center, do not get involved with any social media with clients to ensure their privacy and helps to protect the client/therapist relationship.

(Initials) Registering Complaints On occasion, clients have concerns and complaints and are urged to bring them to the therapist's or director-Todd Malloy's attention at once. Clients may also register complaints with the NC-MFT Licensure Board.

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LIMITS OF CONFIDENTIALITY, CANCELLATION POLICY and CONSENT TO BILL

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18) Today's Date

Revised 10/18 nnb

Name:

I understand this form is to be used when I do not cancel therapeutic sessions within the cancellation terms of the cancellation policy.

Cancellation Policy Acknowledgement If you should fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for a missed appointments or cancellations with less than 24-hour notice unless it is due to illness or emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. ***Additional Payments Due Policy*** It is your responsibility to know and understand the payment terms with your respected Insurance company. If you do not make payment of your copay, or any other payment which is your responsibility to do as set forth by your insurance company, you understand that we will bill the credit card information below. It is your responsibility to ensure discussion on any payments are done with your therapist respectively. You will receive a bill and later receipt when your card is charged. Thank you for your cooperation in this matter. Please use the following credit/debit card:

Visa Mastercard AmExpress Discover

Card Number:

Expiration Date:

Security Code #: ****Please be sure the above address corresponds with your c-card billing address*****

Client Signature (Client's Parent/Guardian if under 18) Today's Date

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CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and BEFORE your first session.

Name
:

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Address:

City: Zip Code: Tel:

Birth Date: / / Age: **Gender**: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership

□ Married □ Separated

□ Divorced □ Widowed

Please list any child(ren) &
age(s):

E-mail: May we email you? □ Yes □ No **Please note: Email correspondence is not considered to be a confidential medium of communication.*
Referred by (if
any):

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes, previous therapist/practitioner:

Are you currently taking any prescription medication?

No Yes
Please list:

Have you ever been prescribed psychiatric medication? No Yes Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise to you participate

in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression? No Yes If yes, for approximately how long?
6. Are you currently experiencing anxiety, panic attacks, or have any phobias? No Yes If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? No Yes If yes, please describe: _

8. Do you drink alcohol more than once a week?

□ No

□ Yes

9. How often do you engage recreational drug use?

□ Daily

□ Weekly

□ Monthly

□ Infrequently

□ Never

10. Are you currently in a romantic relationship?

□ No

□ Yes If yes, for how long?

11. On a scale of 1-10, how would you rate your

relationship?

12. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY: *In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).*

Please Circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior (OCD) yes/no

Schizophrenia or Paranoia yes/no

Suicide Attempts yes/no

OTHER: (list)

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □

Yes If yes, what is your current employment

situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious?
□ No □ Yes If yes, describe your faith or belief:
3. What do you consider to be some of your strengths?

4. What do you consider to be some things you may need to work on?

5. What would you like to accomplish out of your time in therapy?