Hicks Counseling Services
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PROFESSIONAL DISCLOSURE

I believe the counseling experience is one in which there is a personal relationship based on trust within a safe and confidential environment. This document is part of the standards of practice of the North Carolina Board of Licensed Professional Counselors. Please read this statement prior to our first session.

Education & Experience:

I received a Masters of Education with a degree in counseling from Southern Methodist University in Dallas, TX. I have 25 plus years of counseling experience. My area of special interest and experience is working with couples in marriage counseling and individuals who have been abused or have experienced other traumatic events, as well as, individuals suffering from mood and personality disorders. My experience includes working with individuals, families, couples, addictions, high-risk youth, chemically dependent individuals and their families, the dually diagnosed, as well as, the geriatric population.

I am a Licensed Clinical Mental Health Counselor (LCMHC #2874) with the North Carolina Board of Clinical Mental Health Counselors (NCBLCMHC). In addition, I am a Certified Clinical Supervisor (CCS #176), as well as, a Certified Alcohol Drug Counselor (CADC #1013) with the North Carolina Addiction Specialist Professional Practice Board. I am a Licensed Marriage and Family Therapist (LMFT, TX #3662) with the Texas State Board of Examiners of Marriage and Family Therapist, Licensed Chemical Dependency Counselor (LCDC, TX #3377) with the Texas Health and Human Services Commission, and a Certified Clinical Trauma Professional.

I also hold memberships with the North Carolina Counselors Association, the Licensed Clinical Mental Health Counselors Association of NC(LCMHCA), International Association of Trauma Professionals, Texas Association of Alcohol and Drug Abuse Counselors and the National Association of Alcoholism and Drug Abuse Counselors.

Counseling Philosophy:

The purpose of counseling is to help individuals, couples, and families resolve issues that are interfering with the enjoyment of the process of life. You may want to resolve specific problems or bring a more positive balance to your life. Whether it is individual, couple, family, or group counseling, we will initially determine your goals and assess if we can work together to meet them. As counseling continues, we will regularly evaluate our progress to determine if your goals have been met or if there is a need for additional sessions, termination, or a referral to another practitioner for counseling or assistance.

Counseling sessions will be held within the counseling office only. For your best interests and to protect your personal rights, our relationship must remain professional at all times; this means that even though our relationship may seem very intimate, you must remember that I am only sharing with you as a professional and focusing on the goals you have indicated you desire to reach. This is the primary purpose of our relationship.

Fees and Insurance Reimbursement:

My fees are outlined in a separate Fee Schedule. All payments are due at the time of service. I accept cash, checks or credit/debit cards. If you are unable to come with your child to attend therapy, please send them with the appropriate payment. Clients are responsible for contacting their insurance company to obtain authorization, co-pay, deductible and benefit period information.

PROFESSIONAL DISCLOSURE CONTINUED

Appointment cancellation must be made at least 2 business days in advance to avoid being charged a

missed appointment fee of $75.

Confidentiality:

All information shared will be kept confidential with the following exceptions:

1. If I, as your provider, believe you are a danger to yourself or someone else;
2. In case of abuse to a child or an elderly person confidentiality will be waived;
3. If you give me written permission to disclose information;
4. If the information is court ordered;
5. In case of a medical emergency;
6. If you desire to seek reimbursement from a managed care company, the disclosure of confidential information may be required for reimbursement;
7. If accusations of misconduct are brought.

I, the client, also understand and agree that for the purpose of ensuring the highest quality care, my case may be discussed in conference or supervision with other psychologists or mental health professionals. If I, the client, should default in paying the balance of my account with Hicks Counseling Services, I understand that identifying information and dates of service may be disclosed if litigation or collection action becomes necessary.

Please be aware that any personal information or diagnosis provided to an insurance company can no longer be held to the same standard of confidentiality and may well become part of your permanent insurance record.

Emergencies:

If you have a medical emergency, please call 911. Hicks Counseling Services uses a confidential voice mail system. Even with a good communication system, there may be circumstances under which I cannot immediately respond to your needs. If such an urgent situation arises please contact Holly Hill Hospital Respond program to obtain the support of their counselors. The Holly Hill Respond telephone number is 919-250-7000.

Complaints:

If, at any time, you feel my behavior or my counseling approach is inappropriate or troubling to you, please let me know. If, however, you do not feel your concerns are being addressed appropriately, feel free to contact any or all of the following:

North Carolina Board of Licensed Clinical Mental Health Counselors
PO 77819
Greensboro, NC 27417
Phone: (844) 622-3572 Fax: (336) 217-9450
E-mail: Complaints@ncblpc.org

The North Carolina Addictions Specialist Professional Practice Board
PO Box 10126
Raleigh, NC 27605
(919) 832-0975 Fax: (919) 833-5743

PROFESSIONAL DISCLOSURE CONTINUED

Client Responsibilities:

As a client, you have the responsibility:

- to set and keep appointments. Let me know, as soon as possible, at least within 2 business days, if you cannot keep an appointment.
- to pay your fees in accordance with the schedule you pre-established with the counselor.
- to help plan your treatment goals and follow through with agreed upon goals.
- for your actions when you refuse treatment or do not follow the practitioner's instructions.
- for following the facility's rules and regulations affecting client care and conduct.
- for being considerate of the rights of other clients and facility personnel.
- for holding in strict confidence other client's mental health/substance abuse information which may be obtained during group therapy and socialization.
- to keep your counselor informed of your progress towards meeting your goals and to terminate your counseling relationship before entering into arrangement with another counselor.

Please list any questions you have and bring them with you to your first visit. I will be sure to address all of your questions and concerns.

Consent for Treatment:

By signing below, you indicate that you have read this disclosure, that your questions have been answered, and that you understand the above information. Your signature also indicates that you are consenting to receive counseling services.

Acknowledgement of Notice of Privacy Practices:

My signature indicates that I have received a copy of the HIPAA Notice of Privacy Practice and had an opportunity to ask any questions I may have.

Client Rights, Responsibility and Confidentiality:

My signature attests that I have read, and fully understand my rights and responsiblities as a client. Additionally, I am aware of the limits of confidentiality.

_____ _____
Client Signature Date

_____ _____
2nd Client Signature or Parent/Guardian Signature Date

_____ _____
Witness Signature Date