TAPROOT INTEGRATIVE COUNSELING, PLLC

PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship. This document is apart of the Standards of Practice of the North Carolina Board of Licensed Clinical Mental Health Counselors (LCMHC). The Disclosure Statement is designed to inform you of my professional credentials, types of service offered, fee schedule, and therapeutic orientation and style. You will receive this copy for you records and I will keep the signature pages for my records. Please read this carefully and if you have questions that are not covered here or want further clarification please ask me when we discuss this statement during the session.

Education and Credentials

I received a Masters of Science in Clinical Counseling in 2016 from Bellevue University of Nebraska. I have been providing psychotherapy since that time. I am licensed as a Clinical Mental Health Counselor by the state of North Carolina (License # 12786). My clinical specialties are: trauma, ADHD, mood disorders, and adjustment disorders for children and adults.

Counseling Process and Approach

I use Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Eye Movement Desensitization Reprogramming (EMDR), Dialectical Behavioral Therapy (DBT), Expressive Arts Therapy (creative movement, music, art, journaling, and play therapy as applicable for children and teens), Mindfulness-Based Stress Reduction (MBSR) and holistic practice integrating mindfulness meditation and specific breathing techniques. These theoretical orientations and their accompanying therapeutic modalities are empirically-based. In some cases, certain techniques or modalities may result in some discomfort before relief of symptoms and healing occur.

Services Offered & Length of Session

I provide individual and family psychotherapy. Services will be rendered in a professional manner consistent with ethical standards. It is impossible to guarantee any specific results regarding your counseling goals because the outcome is dependent on your work as well as mine. Sessions are typically 50-60 minutes in duration unless prior arrangements have been made. We will schedule our sessions by mutual agreement via my online practice-management software.

Insurance Reimbursement & Diagnosis

I am credentialed with North Carolina Blue Cross Blue Shield and North Carolina Health Choice. I also work as an out-of-network provider with any other insurance plans that allow out-of-network coverage. Should you wish to use an insurance policy for

counseling services, it is your responsibility to contact your insurance company to inquire about specific coverage for out-of-network benefits for mental health services and the amount of your required co-pay. Please be aware that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. Any diagnosis made will become part of your permanent insurance records. If needed, I can provide a "Super-Bill" for you to mail to your insurance company for possible reimbursement.

Counseling Fee

Payment or insurance co-payment is due at each session. Regardless of insurance, you agree that you are responsible for payment of all fees for services rendered. At this time, all therapy sessions are conducted via Telehealth and payment is securely processed online. Visa, Mastercard, American Express, Discover, or HSP (Health Savings Plan debit card) are acceptable methods of payment. Private pay rates are as follows: $200 for intake and comprehensive clinical assessment, $100 for follow-up therapy sessions, and $150 per couple's sessions (which typically take longer than 60 minutes). I also accept sliding scale fee for therapy services on a case-by-case basis (based on income eligibility and household size). **If you are unable to keep an appointment, please call within 24 hours to cancel or reschedule. Please note cancellation policy below.**

Cancellation Policy

Unless prior arrangements have been made, you will be charged $100 for missed appointments or failing to cancel your appointment within 24 hours. Please understand that your insurance will not reimburse you for any portion of a missed appointment and you are responsible for the full fee.

Emergencies

I do not provide 24-hour on-call emergency services. You are free to call me after hours and leave a message on my voice mail. Should you have a mental health emergency and are unable to reach me, please go to your nearest hospital emergency room or call 911. Residents of Buncombe County, North Carolina may also call the local Mobile Crisis Management Response Team at 888-573-1006. For any psychiatric emergency involving suicidal ideation, please call 1-800-SUICIDE or call your psychiatrist/physician, or a trusted family member, friend, or significant other.

Confidentiality

All information shared in session is confidential, with these few exceptions:

(1) For case consultation purposes, I may consult with other therapists, who are required to keep client information confidential.

(2) The State Law of North Carolina requires that suspected abuse or neglect of a child, elder, dependent adult, or developmentally disabled person be reported.

(3) The State Law of North Carolina also requires that others be informed if a client threatens suicide or harm to herself/himself, or others. If that threat is clear

and imminent danger, the proper individuals and law enforcement must be contacted. The person against whom the threat has been made may also be contacted to prevent harm.

(4) Should I be presented with a court order, I may be required to disclose information in the presence of a judge; however, I will first assert legal privilege in an effort to protect your confidentiality.

(5) Information, which may jeopardize my safety, will not be kept confidential.

(6) In the event of a medical emergency on your part, emergency personnel may have to be provided with some of your information.

(7) If you bring a complaint against me with the North Carolina Board of Licensed Clinical Mental Health Counselors (LCMHC) information will be released.

(8) Children and adolescents must have permission from a parent or legal guardian before receiving services. Confidential information will be shared with a parent or legal guardian only if the child or adolescent is in imminent physical or emotional danger.

(9) If I am made aware that you have a communicable and fatal disease and that you have willfully exposed an identified third party to it.

Complaint Procedures

I adhere to the highest ethical and professional standards. If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, please contact: North Carolina Board of Licensed Clinical Mental Health Counselors at 336-217-6007 or write to PO Box 77819, Greensboro, NC 27417.

Consent and Acknowledgment of Receipt of Professional Disclosure Statement

I _____ (print name) hereby acknowledge

that during the initial contact with Sherry “Share” Friedman, LCMHC, we discussed confidentiality and privacy issues. I was provided a written Notice of Privacy Practices dated November , which outlines how protected health information will be treated in her practice.

By my signature below, I acknowledge that I have read and understand this Professional Disclosure Statement. I consent to therapy with Sherry Friedman, LCMHC, according to the terms described here. I have read the preceding information and understand my rights as a client.

Please initial, sign and date where applicable:

- _____ I have been informed about how my privacy and confidentiality will be maintained by Sherry Friedman, LCMHC

- _____ I have reviewed and received a copy of the Notice of Privacy Practices.

- _____ I have read the Professional Disclosure Statement of Sherry Friedman, LCMHC

- _____ I consent to treatment and voluntarily agree to participate in all treatment and may stop such treatment at anytime.

_____

Signature of Client (or Guardian) and Date

_____

Sherry Ann Friedman, LCMHC and Date