Linda M. Smith, MA, LCMHC, BCC, SEP
1122 Sam Newell Road, Suite 106
Matthews, NC 28105

CLIENT DISCLOSURE STATEMENT
INFORMATION AND CONSENT FORM

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I earned a Master of Arts Degree in Counseling in May, 2000, from the University of North Carolina at Charlotte and have 20 years counseling experience. I am a NC Licensed Clinical Mental Health Counselor (#3855), a Board Certified Counselor (#62625), a member of the American Counseling Association (#06123315), and the North Carolina Counseling Association.

COUNSELING SERVICES AND THEORETICAL APPROACHES

People can make better decisions if they have enough information and understand how something works. Here are some aspects of counseling and therapy as I see and practice it.

Counseling offers a safe environment for self-exploration, personal growth, and self-actualization. I believe in the positive potential of all people and will work towards my client's growth and development in a manner that promotes his/her interest and welfare. The direction of therapy is the responsibility of the client, and we will work together to accomplish mutually agreed upon goals.

Counseling includes your active involvement as well as efforts to change your thoughts, feelings and behaviors. You will need to work both in and out of our counseling sessions in order to facilitate change. I am likely to suggest "homework" assignments and we will decide together the appropriate path to take. Counseling is a process and results occur over time. Periodically, we will evaluate our progress and determine if we need to alter our goals. If I discover I am unable to help you, I will make a referral in your best interest. In addition, it is your right to terminate counseling at any time. However, if you are considering termination, please discuss this with me first.

My basic counseling philosophy is a person-centered approach. This means I believe my clients have the potential to become aware of problems and the means to resolve them. I believe in my client's ability to become self-aware and self-directed. I use a variety of well-researched and effective methods of intervention such as Person-Centered Therapy, Cognitive Behavioral Therapy, Gestalt Therapy, Internal Family Systems Therapy, and Somatic Experiencing.

As with any powerful intervention, there are both benefits and risks involved with counseling. Risks might include experiencing uncomfortable levels of feelings such as sadness, anger, frustration, guilt, anxiety, or having difficulties with other people in order to experience the benefits of emotional healing. For example, counseling will not necessarily keep a relationship together or stop an addiction.

Clients I work with are psychologically and emotionally "healthy" and seek counseling for difficulties due to normal life events. I do not work with clients whom, in my professional opinion, I cannot help using the experience, knowledge, techniques, and skill I have available. I will enter our relationship with optimism and an eagerness to work with you. I have a special interest in working with individuals on issues of trauma, grief and loss, stress, transition, anxiety, depression, Adult ADD, communication/conflict resolution, relationship issues, chemical dependency and recovery issues.

CONFIDENTIALITY

I regard the information you share with me with the greatest respect. The privacy and confidentiality of our conversations and my records is a privilege of yours and is protected by state law and my profession's ethical guidelines except for a few circumstances. I cannot guarantee confidentiality legally and/or ethically (1) when I believe you intend to harm yourself or another person and, (2) when I believe a child or elder person has been or will be abused or neglected. Additionally, in some circumstances, Professional Counselors can be ordered by a judge to release information. I cannot assure confidentiality in the case of insurance reimbursement. Insurance reimbursement dictates the use of the "Medical Model" which means a mental health diagnosis must be made. Many times your diagnosis, symptoms, and treatment plan have to be communicated to the insurance company. At this point, your information is out of my control and is on permanent record with your insurance company. Lastly, in order to provide you with optimal service, there may be an occasion when your case will be

discussed in professional supervision. Your confidentiality is still maintained, but client information may be reviewed.

DUAL RELATIONSHIPS

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you will arrange with me. Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

LENGTH OF SESSIONS AND APPOINTMENTS/CANCELLATIONS

Typically, each session lasts approximately 60 minutes. Your time here is important. If you are unable to keep an appointment, please call to cancel or reschedule at least **24 hours in advance**. If you do not give 24-hours' notice and you miss a scheduled appointment, you will be charged the regular hourly fee for that appointment. Insurance companies **do not** reimburse for missed appointments.

FEES AND METHOD OF PAYMENT

Fees are $165 per session. Payment must be made at the time of service.

Cash, personal checks made payable to Linda Smith, Zelle, and credit cards are acceptable methods of payment. **There is a processing charge on all credit card payments.** Telephone consultations are available and will be billed at the same hourly rate as your regular sessions and must be scheduled in advance. **Please note,** insurance companies do not normally reimburse for telephone sessions or missed appointments. Telephone contact between sessions is limited to five to ten minutes. After that length of time, a fee is charged based on my hourly rate.

BILLING/INSURANCE REIMBURSEMENT

Your insurance policy is a personal and private purchase. Some insurance companies will cover my services and some will not. Please check with your insurance company to determine whether my services are covered by your plan. Please note that you are responsible for all fees incurred in the event your insurance policy does not pay benefits. If you have any questions, please discuss these with me.

If you wish to seek insurance coverage for my services, please inform me and we will discuss filing procedures. Your co-payment will be due at the time of service. If you choose to use your insurance, please be informed that health insurance companies are based on the "Medical Model" and require that I diagnose your mental health condition before they will pay claims benefits. In the event a diagnosis is required, I will be happy to inform you of the diagnosis I plan to use if you request it. Any diagnosis made will become a part of your permanent insurance records.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform me immediately so that we can resolve your concern. I am willing to discuss any dissatisfaction you experience and take appropriate measures. This will make our work together more efficient and effective. If you think you have been treated unfairly or unethically and cannot resolve this problem with me, you can contact the North Carolina Board of Licensed Clinical Mental Health Counselors at P.O. Box 77819, Greensboro, NC, 27417, 336-217-6007, for clarification of clients' rights as I have explained them. I abide by the ACA Code of Ethics.

If you have any questions, feel free to ask me. Please sign and date this form. At your request, I will return a copy to you for your records, and I will retain the original copy for my confidential records.

We agree to these terms and will abide by these guidelines.

Client's Signature_____ Date_____

Counselor's Signature_____ Date_____

Linda M. Smith, MA, LCMHC, BCC, SEP
1122 Sam Newell Road, Suite 106 Telephone: 704.330.9744
Matthews, NC 28105

Addendums Concerning Confidentiality

Confidentiality of E-Mail, Text, Cell Phone and Fax Communication

It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify me if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. I currently avoid the use of email or text communications with my clients because of the confidentiality risk.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorney, nor anyone else acting on your behalf will call on Linda M. Smith to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Insurance

If you choose to file your insurance for your counseling services, your signature on this form grants me permission to contact your insurance carrier to verify benefits and obtain payment for services.

I understand and agree to adhere to the above addendums.

_____	_____	_____
Print Client Name	Date	**Signature**
_____	_____	_____
Therapist Name	Date	**Signature**

LINDA M. SMITH, MA, LCMHC, BCC, SEP
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Matthews, NC 28105
704.330.9744

CLIENT INFORMATION FORM

PLEASE PRINT

Date_____

Client Name_____
(Last) (First) (Middle)
Address_____

City_____State_____Zip_____

Client Date of Birth_____Age_____
Home phone (w/area code) _____
Work phone (w/area code) _____
Cell phone (w/area code)_____

Gender (circle one): Male Female
Ethnic Origin (circle one): Asian African American Caucasian
Hispanic Native American Latino
Other:_____

Marital Status (circle one): Single Separated Widowed
Married Divorced Cohabiting

Client Employed By_____
Business Address_____
City_____State_____Zip_____
Occupation_____Length of Employment_____

Spouse/Partner Name (if any)_____Date of Birth_____Age_____
Employed By_____
Work Phone (w/area code) _____ Home Phone (w/area code) _____

Who is responsible for this account?_____
Address_____City, State, Zip_____
Home phone (w/area code) _____ Work phone (w/area code) _____
Relationship to Client_____

If a Minor- Responsible Party _____
Relationship to Client_____Phone_____
Address (if different from above) _____
City_____State_____Zip_____

Continue on Back

What brings you to counseling?_____
_____

What do you hope to accomplish?_____
_____

Educational History. Highest grade/degree completed_____

Medical History. Name of Primary Care Physician_____
Date of last visit_____ Date of last physical exam_____

Current Medication & Dosage	Reason for Taking	How Long?	Prescribed by?
_____	_____		
_____	_____		
_____	_____		
_____	_____		

What hospitalizations/surgeries have you had?_____
_____

Counseling History. Have you had previous counseling? Yes____ No____ If yes, please note:

____Individual Counseling ____In-patient Treatment ____Support Group, type_____

____Group Counseling ____Out-patient Treatment ____Other (please state) _____

Family History.
Current Household Members and ages:

_____	_____
_____	_____
_____	_____

Number of Children:_____
Number of Siblings:_____ Mother: Living/Deceased Father: Living/Deceased

Other Significant Caregivers:_____

Family history of mental illness or emotional problems? Yes____ No____
Family history of substance abuse? Yes____ No____
Family history of domestic violence? Yes____ No____

Personal History.
Personal history of domestic violence? Yes____ No____
Personal history of sexual abuse? Yes____ No____
Substance use? (i.e., alcohol / other drugs) Yes____ No____
Current or previous history of drug treatment? Yes____ No____
Have you in the past had any thoughts of harming yourself or someone else? Yes____ No____
Have you acted on these thoughts? Yes____ No____
Do you currently have any thoughts of harming yourself or someone else? Yes____ No____
Do you have a plan for acting on these thoughts? Yes____ No____

Legal History.
Have you ever been arrested? Yes____ No____
Have you ever been convicted of a crime? Yes____ No____

How were you referred here?_____

In case of emergency, who should be notified?_____
Relationship to Client_____
Phone Number_____

Thank you for taking the time to fill this out.

Linda M. Smith, MA, LCMHC, BCC, SEP
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Consent to Use and Disclose Information for Treatment, Payment, and Health Care Operations (TPO)

This form is an agreement between you, _____
(Print your name here)
and Linda M. Smith, MA, LCMHC, BCC, SEP. When I use the word "you" below, it will also mean your child, relative, or other person that you have legal guardianship for or power of attorney for, if you have written his or her name here:_____.
(Print name here)
When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information **(PHI)** about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices **(NPP)** explains in more detail your rights and how I can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you.

I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised NPP will be posted in the office. You may ask for a printed copy of the NPP at any time.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment, or health care operations purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my PHI as specified above and in the NPP.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

Date of NPP: 4/14/2003