Name:_____ MC ID #:_____ Record #:_____

amanda K kirby counseling

Professional Disclosure Statement & Consent for Services

Thank you for choosing me as your counselor. I am pleased to have this opportunity to work with you and/or your family. This document contains important information about my professional background, services, and business policies as well as your rights as a client. This form serves as your consent for service and agreement to pay and/or file insurance as well as my professional disclosure statement. It also serves as an acknowledgement that you have received a copy of my privacy practices. **I encourage you to read this document carefully and ask for clarification when needed.**

Education and Experience

I have a MS and Ed.S in Marriage and Family Counseling (2005) from the University of North Carolina at Greensboro. I also have a BA in Psychology (2002) from Baylor University. I have been licensed as a Licensed Professional Counselor (# 5421) in NC since 2006 and have 11 years experience counseling in outpatient settings. In August 2016, I established my private counseling practice.

Professional Services

My services include individual, couples, and family counseling with children, adolescents, and adults. I have special interest and training in treating anxiety and depressive disorders, grief and loss, co-dependency and addiction, relationship/marital dissatisfaction, trauma, and conduct issues. My therapeutic approach is eclectic, often including person-centered, cognitive-behavioral, solution focused, and family systems techniques. It is my goal to offer you a safe, supportive outlet and partner with you to meet your unique and personalized needs. If for any reason I do not believe I have the experience or training necessary to work with you, I will refer you to another mental health professional who is more prepared to address your presenting concerns.

Confidentiality

Protecting your privacy is very important to me. All information related to the provision of counseling services is privileged and confidential. Your case records will not be disclosed to anyone, including another professional or family member, without your express written consent. There are certain exceptions to confidentiality, in which I am ethically and legally obligated to release information about you. These circumstances include:

- Clients either disclose directly or are suspected to pose an imminent danger to the health and safety of themselves or others
- Clients disclose information regarding the abuse of a child or adult
- A court order or subpoena requires the release of my case records or my direct testimony
- Account submitted to the Credit Bureau after non-payment of fees

Please note that children and adolescents are entitled to confidential treatment just as are adults. While it is my goal to partner with parents in the care of their child, I will not discuss the private details of my sessions with minor clients with you. I will, however, inform you immediately if any of the aforementioned exceptions to confidentiality arise.

Explanation of Dual Relationships

Although sessions are psychologically intimate, the therapeutic relationship is professional and not social. It is critical that our professional relationship be based on respect, safety, and trust. Therefore, it is in your best interest that contact with me be limited to counseling sessions or telephone conversations necessary

to your therapy. It is not appropriate to relate to you in any other way outside the professional context of our therapy sessions (e.g., connecting on Facebook or LinkedIn). These limits are designed with your welfare in mind and allow for all efforts to be directed toward your therapeutic concerns only.

Length of Sessions/Missed Appointments and Cancellations

Services will be provided in a professional manner consistent with accepted ethical standards. Sessions are typically a minimum of 45 minutes and can extend as far as 60 minutes in duration and will be scheduled at mutually agreed upon times. If you must cancel your appointment, please do so promptly so that your appointment time may be given to someone else. There is no charge for cancellations at least 24 hours in advance, although I appreciate as much advance notice as possible. **You will be charged $75 for cancellations made within 24 hours of the appointment, unless you have a proven emergency preventing you from keeping your appointment.** Insurance companies do not reimburse for missed appointments. If you call to cancel an appointment, please be sure to leave a message. Attempts at calling without leaving a message will be overlooked and unreturned. A recurring problem with "no shows" and/or late cancellations may result in termination of services.

Fees

Fees for counseling services are due at the time of each session. My out-of-pocket rate for an initial, hour-long diagnostic interview is $150. Standard fee for each subsequent session is $110 per 45-minute session and $130 per 55-60 minute session. If I am summoned to court at your request or by subpoena you are responsible for paying $200/hour, to include time for court preparation, travel, and testimony. I require a deposit of $400 prior to court testimony, which will be applied to your total balance. Fees for additional services, including telephone consultations, letters, and reports are at my discretion, depending on the nature of the service. Cash, personal checks, and credit/debit cards are acceptable forms of payment. I reserve the right to increase my fees at any time and will provide you with a month's notice of such changes.

Insurance

I am in-network with several insurance companies and will file insurance claims on your behalf. I do not file insurance claims to companies with whom I am out of network but am happy to provide you a Superbill to make it easy to do so yourself. **It is your responsibility to understand your policy benefits prior to your first appointment, including the amount of your deductible and/or co-pay/co-insurance, as I do not call insurance companies to check your benefits or acquire pre-authorization.** If you have a deductible, it is my policy to collect at the time of service the entire fee for the session (and any subsequent sessions) until it has been met. If your deductible has been met and you are responsible for a set co-pay or co-insurance, I will only collect that amount on the date services are rendered. Please remember that my professional services are rendered to you, not the insurance company. In accepting my services you also accept the responsibility of paying for these services should your insurance company only pay for a part of the fee or deny the claim altogether. Because I am unaware of other professionals involved in your care (past or present), it is also your responsibility to keep track of the total number of mental health sessions used here and elsewhere and to tell me of any insurance limitations. You should also be aware of the limits of confidentiality when filing insurance for therapy services, as insurance companies necessarily require a diagnostic statement to be placed in your insurance records. Typically, insurance companies require the following information: name, diagnosis, dates of services, and the kind of service you received (i.e., individual, family therapy, etc.). Some companies require additional information. Signing this agreement authorizes the release of information to your insurance company.

Overdue Accounts

All accounts become overdue after 30 days of non-payment or if payment arrangements have not been made. Past due accounts may be turned over to the Credit Bureau for processing if no special

arrangements have been made with me. Please be aware that your identification as a client will be made known to the Credit Bureau in such cases, another limitation of confidentiality as specified above.

Electronic Limitations
There may be at times a need to communicate via electronic means (e.g., cell phone, email, fax, video-chat, Simple Practice client portal). Though I will do my best to take reasonable precautions to protect your confidentiality, please be aware that electronic transmittal, wireless telephone communication, and web-based systems are subject to difficulties beyond my control and that I cannot guarantee the confidentiality of such technology.

Use of Mind-altering Drugs or Alcohol
No smoking is allowed in the building. Please do not appear for a session under the influence of any mind-altering drug, including alcohol. Should the situation occur, the therapy session will not take place and you will be charged the full session fee. Such an occurrence may be considered grounds for termination of therapy.

Emergency Procedures
I am available by phone during normal business hours (9AM – 6PM). I recommend that you seek treatment at a local Emergency Department for after-hours mental health crises; however, I will be available by phone (336-457-0827) after-hours to help triage these situations if needed. Other helpful emergency resources in the community to which you have 24/7 access include:

Moses Cone Behavioral Health
700 Walter Reed Drive, Greensboro
336-832-9700

Sandhills Center
201 N Eugene Street, Greensboro
800-256-2452

You may also call the National Suicide Prevention Lifeline at 800-273-8255.

Complaint Procedure
I adhere to the NBCC Code of Ethics and Standards of Practice as well as the ACA Code of Ethics and Standards of Practice. I encourage you to speak openly and directly with me if you are dissatisfied with the counseling services I provide. However, should the issue not be resolved or if you do not feel comfortable speaking with me directly about your concerns, you may also register a complaint with the North Carolina Board of Licensed Professional Counselors at PO Box 77819, Greensboro, NC 27417 or 844-622-3572.

Attention Medicaid Clients
In the event a medical emergency arises during our scheduled appointment, I will seek emergency care from a hospital or physician.

By signing and dating below you indicate that you have read, understand, and agree to the information presented to you. A copy for your record will be returned to you and one will be kept in your confidential case file.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Amanda Kirby, MS, Ed.S, LPC Date