# Falcon Counseling Disclosure Statement & Agreement For Services

Therapist: Sheryl Boyd MEd
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## INTRODUCTORY DISCLOSURE

You have the right to refuse any treatment you do not want and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You also have the right to terminate your treatment at any time for any reason. The following information is provided to help you determine if what I offer as a licensed mental health counselor meets your needs as a client. This document contains important information about my therapeutic approach, my education, my fees, and your rights as a client, including your rights regarding your private health information. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services.

## Professional Profile and Therapeutic Orientation

I received my Master's Degree in Education, Counseling, from University of Puget Sound in 2006. I have experience in psychotherapy centered around individual counseling with adults and more recently, I have begun to work with children, the youngest having been 9 years old. My experience includes assessment, treatment, and coordination of services. I have focused much of my education, training and experience in trauma; I am currently a Certified Clinical Trauma Professional, Level II. I also have much experience helping individuals with issues of depression, several forms of anxiety, Bipolar, relationships, grief and loss, and also serious mental illnesses to include psychosis and those experiencing a sense of dissociation.

Although I am not able to propose an appropriate course of treatment for you until we have spent some time together, I can ensure you that all treatment begins with an in-depth assessment of issues. We will then develop a treatment plan together with measurable outcomes that will help us determine whether our work is making progress. Supportive therapy is the primary technique utilized in conjunction with cognitive, behavioral, mindfulness, and insight oriented approaches. The latter methods are incorporated based on the needs and capacities of the individual client. Gaining an accurate understanding of the problem (s), identifying areas you would like to change and focusing on ways to accomplish those changes are the work of therapy. Goals and direction may be re-negotiated throughout treatment. You will always be a part of the decision-making process. In the event I do not have the required specialization, or a case exceeds my competency level, I will facilitate an appropriate referral.

## Confidentiality and Client Rights

As a counseling client you have certain rights that are important for you to know about. There are also certain limitations to those rights of which you should be aware. As a client of a Licensed Clinical Professional Counselor, you have confidential and privileged communication under the laws of the State of Idaho. With the exceptions of the situations listed below, you have the absolute right to have information you share with me held in strict confidence. This information includes the fact that you are receiving counseling services and applies to any information disclosed during the course of treatment. Information can only be released with your signed written consent. If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further. For additional information regarding your confidentiality rights, please carefully review the Notice of Privacy Practices.

The following are exceptions to your right of confidentiality:

1. If you state directly, or I believe from your statements, that you are likely to do serious harm to yourself or to another person, I must take steps to protect you and/or other persons _____ (initials)
2. If I receive first hand information about the physical abuse, sexual abuse or neglect of a minor child or vulnerable adult, I am required by law to report this to the appropriate governmental agency and/or the police _____ (initials)

3. If you are seeing me in family or couples therapy, and you or a family member should see me in an individual session as part of the therapy, information shared with me in that meeting may be shared in the joint session if I feel it to be in the best interest of the work we are doing together. In all situations, I will first have a conversation with the person disclosing the information regarding why I believe it is relevant to share the information _____ (initials)

4. As a patient, your are authorizing this office to leave appointment reminders and/or provide session provide session dates and times to facilitate the scheduling or rescheduling of appointments _____ (initials)

## Family, Couples, and Group Counseling

If you are seeking group, family, couples, or marriage counseling, it is important you understand that I will adhere to the ethical and legal requirements of confidentiality as stated above, however, I cannot ensure that you or the other participants in group, family, couples, or marriage counseling will maintain confidentiality about your therapeutic experience, including content discussed within the counseling session. In addition, in the case of group, family, couple, or marriage counseling, the entire treatment record will be available to any and all participants in the group, family, couples, or marriage counseling and all participants must consent to any authorized third party disclosure.

## Complaints

If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the issue can be clarified and resolved. If, after our discussion, you still feel the issue is not resolved, complaints can be made to:

Division of Occupational and Professional Licenses
11351 W Chinden Blvd Bldg #6
Boise, ID. 83714
Phone: 208-334-3233
Email: COU@dopl.idaho.gov

## Crisis Information

If you are experiencing an emergency or crisis, please call 911 or Western Idaho Community Crisis Center, on 524 Cleveland Blvd, Set 160, Caldwell, ID, 83605, phone # 208-402-1044. In such situations you may also need to go to the nearest hospital Emergency Room. Also, the Suicide Prevention Lifeline is 1-800-273-TALK.

## Insurances

Insurance companies and other third-party payers may require that I provide them with information regarding the services I provide to you. This information may included the type of service provided, the dates and times of service, your diagnosis, treatment plan, a description of impairment, progress of therapy, and case notes and summaries. If you do not want me to provide your confidential information to your insurance company, let me know so that we can discuss alternatives.

## Financial Agreement and Fee Policy

Appointments are scheduled with a frequency we agree will be helpful. The session lasts for 45 to 50 minutes unless we arrange in advance to meet for a longer period of time. Longer sessions will incur an extra charge based upon the amount of time.

The time of your session is set-aside just for you. If you miss a session without canceling, or if you cancel with less than 24-hour notice, you will be charged $50.00. Insurers will not compensate you under such circumstances. _____ (initial)

If you are late for a session, you will be seen for the time remaining in your session and charged the full rate.

Please remember that **you** are responsible for payment, not the insurance company. My standard fee for a 45 to 50 minute session is $130.00 and the fee for the initial assessment session is $160.00. This fee is regardless of the number of people attending the session. I cannot take medical coupons or barter.

**I expect that you will pay the full fee or your co-pay based upon your insurance coverage at the beginning of each meeting.** Bills over due more than one month will incur a $7.50 re-billing charge unless we have made other arrangements in advance about you incurring a debt. Any bill outstanding longer than 90 days will incur legal and/or collections actions. _____ (initial)

## Anticipation of Litigation

I offer professional services for the primary purpose of counseling and psychotherapy, not for the primary purpose of preparing for litigation. If you are seeking services for preparation of litigation or other legal action, I can help you find a referral to a forensic expert. I do not normally serve as an expert witness, however, for those cases I do choose to participate in, I will bill you on an hourly basis for all the time I spend on your case, including meeting with your attorney, writing reports, travel and preparation time. My fee for any activity outside the courtroom is $120.00 and hour. My fee for time spent in depositions or testifying is $200.00 per hour.

## Client Consent for Treatment

I have read Ms.Boyd's Office Policy Statement and Client Agreement and understand its contents. I have asked any questions that I had about this statement, and about statements regarding fees, payment and collection policies.

I consent to the use of a diagnosis and billing to my insurance company, and to the release of this Protected Health Information (PHI). I hereby authorize my insurance benefits to be paid directly to Falcon Counseling LLC and I am financially responsible for any services not covered by my insurance carrier. I understand PHI is used to decide on the treatment approach, and may be used to coordinate treatment planning and care, including the sharing of information with other health care providers. By signing this form I agree to let my PHI be disclosed as related to my treatment, and with authorization to be disclosed to others. )The Notice of Privacy Practices explains in more detail your rights and how I can share your PHI. Please read this before signing the Consent Form).

I consent to therapy under the terms described above with Ms. Boyd, and understand that I have the right to terminate therapy at any time. My signature on this document attests that I have read the above information, that I consent to treatment, that I agree to the terms in this document, and that I have received a copy of this agreement. Furthermore, I understand after I have signed this consent, I can still revoke it (in writing) at anytime. This request will be honored from the time received, however, PHI already disclosed will not be affected.

Client Signature (if client is between ages of 14-18 both client and parent / guardian must sign) Date

Print Name

Responsible Party Parent/Legal Guardian Date

Print Name

Sheryl Boyd LCPC / Falcon Counseling Date