Choices for Change Counseling, PC

CONSENT TO TREAT

I acknowledge that I have received and understand the disclosure statement and/or other information about the counseling I am considering, and I have had an opportunity to have all my questions answered fully.

I do hereby seek and consent to take part in the counseling by this therapist-Ronnie McCarrell. I acknowledge that I am exercising my Freedom of Choice by consenting to take part in counseling with Ronnie McCarrell. I agree that no solicitation or promises has been made to me by this therapist. I understand that developing a treatment plan and regularly reviewing my progress on my treatment goals are in my best interest. I agree to play an active role in this process.

I am aware that I may stop my counseling with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (For example, if my counseling has been court-ordered, I will have to answer to the court).

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged $25.00 for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnosis(es) and providers of any services I receive. I understand that if payment for the services I receive is not made, the therapist may stop my counseling.

PROFESSIONAL DISCLOSURE STATEMENT AND CODE OF ETHICS

Much of this document is mandated by both South Carolina State law and Public Law 104-191; it is provided for your protection. Choices for Change Counseling, PC has tried to anticipate any risks you may face because of being in counseling. If you have Choices for Change Counseling, PC any questions regarding the documents you have received, please feel free to discuss them with me.

Contact Information:

Office location and mailing address is: 25 Sweetbriar Road, Suite A6, Greenville, SC 29615. Office: 864-214-4887; Fax: 877-744-5147; Email address is ronnie@choicesforchangecounseling.org

Office Hours:

**Clients are seen by appointment only. Wednesday through Friday-11am to 5pm. Office hours are subject to change.

Qualifications:

- South Carolina Licensed Professional Counselor #5217
- South Carolina Licensed Professional Counselor Supervisor #7092
- South Carolina Licensed Addiction Counselor #458
- South Carolina Licensed Independent Practitioner #PC1108

Membership Associations:

- South Carolina Counseling Association
- South Carolina Clinical Mental Health Counselors Association
- National Perpetrator Network Association
    - Certified Trainer for Prevention, Intervention and Counseling of Children/Juveniles
    - with Sexual Behavioral Problems
- National Association of Drug Court Professionals

Educational Background:

- Bachelor's Degree (BS) from USC-Upstate in 1999
- Master's Degree (MA) from Webster University in 2007

Counseling Philosophy:

It is my belief that individuals who are experiencing emotional and/or behavioral issues can restore themselves to a higher level of functioning with a supportive, solution focused and nonjudgemental therapeutic approach. Choices for Change Counseling, PC's goal is to assist individuals in acquiring healthy skills to address stressful life issues.

Counseling Modality:

1) Cognitive-Behavioral Counseling (CBT) is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations, and events. The benefit of this fact is that we can change the way we think to feel to act better even if the situation does not change.

2) Solution-Focused Brief Counseling (SFBT) that emphasizes identifying untapped resources for coping and change.

3) TF-Cognitive-Behavioral Counseling (TF-CBT) is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

Services and Fees:

Diagnostic Comprehensive Assessment	$155.00 for an hour session
Individual Counseling	$115.00 for an hour session
Family Counseling	$115.00 for an hour session
Group Counseling (when offered)	$40.00 for an hour session
Court Appearances	$200 per hour; $1000 for the day

Services I DO NOT Provide, in which case a referral will be made:

Divorce and Child Custody Services; Disability Services; Serious Mental Health Services; Personality Disorder Services, that can be better served through the Department of Mental Health.

Code of Ethics:

The South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists: Article 7; 36-17 Code of Ethics for Professional Counselors. A copy of the Code of Ethics can be found at http://www.llr.sc.gov. The Licensure of Professional Counselors, Marriage and Family Choices for Change Counseling, PC Therapists, and Psycho-educational Specialists Board is in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803- 896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered “protected health information” by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in my Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information does not require your consent or authorization:

1. Uses and disclosures required by law-like files court-ordered by a Judge.

2. Uses and disclosures about victims of abuse, neglect, or domestic violence-like the Duties to Warn.

3. Uses and disclosures for health and oversight activities-like correcting records or correcting records already disclosed.

4. Uses and disclosures for judicial and administrative proceedings-like a case where you are claiming malpractice or breech of ethics Choices for Change Counseling, PC.

5. Uses and disclosures for law enforcement purposes-like if you intend to harm someone else or someone has harmed you.

6. Uses and disclosures for research purposes-like using client information in research; always maintaining client confidentiality.

7. Uses and disclosures to avert a serious threat to health or safety-like calling Probate Court for a commitment hearing; behaviors engaging in risk of harm or arrests.

8. Uses and disclosures for disability eligibility-like the basic information obtained in counseling as a result of your disability eligibility.

Client Rights:

As a client of Choices for Change Counseling, PC; you have the right to prompt service, respect, and confidentiality.

Prompt Service: My goal is to see clients within two weeks of their initial contact with my office. At your initial appointment you will be asked questions about the nature of your concerns, issues and your personal history. At the end of this first meeting, you and I will discuss the type of counseling that would be most helpful and the frequency of our contact. If it is determined that your needs are beyond the scope of services I provide, I will refer you to someone who may best meet those needs. My goal is to provide you with the best counseling experience.

Respect: I am committed to treating all clients with respect, regardless of race, age, gender, sexual orientation, or religion. I will demonstrate this respect by keeping appointments, by making every effort to notify you if a change in time is necessary, and by giving you my complete attention and avoiding interruptions during sessions. Your input is valuable; therefore, I will ask for your feedback on our sessions to make sure I am meeting your need.

Confidentiality: Counseling involves the disclosure of sensitive personal and private information and therefore trust is very important. To facilitate that trust, I will maintain a policy of strict confidentiality as required by our professional ethics and state and federal law.

Essentially this means that all clinical contacts between you and I are privileged and confidential. No acknowledgment that you have been seen receiving counseling with me will be made, nor will information about your actual counseling be released to anyone, including spouses, parents, attorneys, solicitors, probation officers, caseworkers or outside therapists, etc. without your written permission.

There are several rare circumstances where I may need to breach your confidentiality to protect you or another person. These include situations where I believe that your life or safety might be in danger, or the life and safety or another person might be in danger, there is a current issue of child or elder neglect/abuse, or a court orders the release of counseling records. In these instances, I will only divulge as much information as is necessary or called for, as well as notifying you of the report. Reports are made to the Department of Social Services and/or the Local Sheriff Department.

Confidentiality cannot be maintained when:

You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform the appropriate person(s) what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform the appropriate person(s), and I must inform the person(s) how you intend to harm others.

You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional/clinical judgment to decide whether a duty to warn applies.

You tell me you, as a child, are being abused-physically, sexually or emotionally-or that you have been abused in the past. Note: there are no statutes of limitations regarding sexual abuse so if you, as an adult, inform me that you were sexually abused as a minor and you can identify the abuser, then by law I must report that incident to the Law Enforcement office in the jurisdiction the offense occurred. In this situation, I am required by law to report the abuse to the South Carolina Department of Social Services or to the local Law Enforcement office, depending on the nature of the disclosure.

You are involved in a court case and a request is made for information about your therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening. Note: a subpoena is not a court order, therefore, I will need written consent to release any documents from you or

when a minor is involved, the custodial parent/legal guardian. If there is a joint custody agreement, then I will need both parents' signature.

For Children/Adolescents: Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, to help them know how to be more helpful to you.

For Children/Adolescents: Communicating with Other Adults:

I will not share any information with your school, your doctor, your attorney nor your referring agency's case manager unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone to find out how things are going for you, to provide progress updates and to provide recommendations that you would benefit from.

For Children/Adolescents: Parent/Guardian:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. Although I know I have the legal right to request written records/session notes since my child is a minor (15 years old and under), I agree NOT to request these records to respect the confidentiality of my child's treatment. I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with the parent.

For Non-English-Speaking Clients: All effort will be made to provide translation services to clients who do not speak fluent English by:

1) Arranging translation services from an outside source.

2) Referring to a provider who speaks your native language fluently.

Client Responsibilities:

To make progress in counseling, your active participation in the counseling process is essential. Fulfilling the responsibilities listed below are important.

Promptness:

Counseling sessions are generally 50-60 minutes long. Arriving promptly for your sessions will allow you to make the most of the available time. If you know that you will be late for an appointment, please notify me.

Attendance:

It is your responsibility to keep scheduled appointments. If you need to cancel an appointment, please call me as soon as possible, leave a message if you are unable to talk with me. If you decide to discontinue counseling, please inform me of your decision.

No-Show Policy:

If you miss a regular appointment, you need to contact me within two working days if you wish to schedule another appointment. If I do not hear from you within this time, I am unable to guarantee your regular appointment time and I may need to close your case. It is my policy to close your case if you were to have two no shows or a pattern of rescheduling.

Effects of Counseling:

Most clients can expect to benefit from counseling, making positive change in their thoughts, feelings, and/or behaviors. However, some clients may not find counseling to be beneficial, and a very few may have a negative counseling experience. Even the most successful counseling may at times be uncomfortable, as you deal with emotionally difficult issues. As you make personal changes, changes may also occur in your relationships with others.

If you have any questions or concerns about your rights and responsibilities, the possible effects of counseling, or any services you are receiving, you are encouraged to discuss them with me.

Graduate Counselor Site:

Choices for Change Counseling, PC is a counseling site for graduate level counseling students, who are pursuing a master's degree in counseling services. During your services, you may be assigned to work with a graduate level counseling student, who will be under the supervision of Ronnie McCarrell, MA, LPC, LPCS, LAC.

Choices for Change Counseling, PC

Client's Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS

I acknowledge that I have read, understand and have received the Choices for Change Counseling, PC the following documents for counseling:

Please initial below stating that you have received the following information:

_____ Consent to Treat

_____ Professional Disclosure Statement and Code of Ethics

_____ HIPAA

_____ Client Rights and Responsibilities

_____ No Surprise Act: Good Faith Estimate

I acknowledge that I have been given the opportunity to ask questions about my counseling experience and expectations. I am aware that I reserve the right to ask questions or to address any concerns at any time during my counseling experience.

Signatures:

For Adult Clients:

Client's Signature: _____Date _____

For Minor Clients:

Minor's Signature: _____Date _____

Parent/Legal Guardian's Signature: _____Date _____

Print Name/Relationship to Minor: _____

Therapist's Signature: _____Date _____

Choices for Change Counseling, PC

AUTHORIZATION TO REQUEST/RELEASE PROTECTED HEALTH INFORMATION

Completion of this form will serve as written permission for Ronnie McCarrell, MA, LPC, LPCS, LAC to communicate with the individuals you have listed below for the purposes you identify. This authorization will be considered valid throughout the course of counseling unless otherwise requested by the client and/or parent/legal guardians.

Client's Name (Print): _____

___I authorize Ronnie McCarrell, MA, LPC, LPCS, LAC to Release Information to the following person or agency: _____

___I authorize the Release of Information to Ronnie McCarrell, MA, LPC, LIP from the following person or agency: _____

For the purposes of (check all that apply):

_____Coordinating Continuity of Services _____Counseling Plan/Progress

_____Other: _____

Shared information may include (check all that apply):

_____No restrictions, all information relevant/pertinent to coordinating patient treatment

_____Session notes only _____Assessment information only

_____Progress updates only

_____Other: _____

Communication to/from these individuals or agencies may occur in a variety of ways (in person, phone conversations, email, fax transmittals, etc.) and may include information from your record. Please know you have the right to restrict how this information is shared. Indicate any restrictions you wish to request regarding how this information is shared.

___ I wish to apply the following restrictions (i.e. phone calls only, no emails, etc.)

Please state_____

___ I wish to apply no restrictions:

Signed: _____ Date: _____

Printed Name/Relationship to Client: _____

Witness Signature: _____ Date: _____

Authorization Expiration Date: (1 year from date) _____