



Professional Disclosure Statement and Counseling Agreement

Anna Clower, M.A.

We are pleased that you have selected the Christian Counselor Cooperative and me, **Anna Clower**, as your therapist. Read on below for important information to know at or first appointment together.

NATURE OF COUNSELING

My goal at the CCC is to help you identify your childhood wounds, faulty thinking, and unhealthy behavioral and relational patterns and to walk beside you in the healing process. Unfortunately there are no "quick fixes" in counseling only hard work in the form of sessions, homework assignments, writing, reading, learning tools and techniques, and attending workshops when appropriate. As a Christian counseling practice we are committed to help your spiritual life develop and enable you to understand Biblical truth and apply it to your life.

CONFIDENTIALITY

We at CCC respect the information you share with us and how difficult it can be to open up. During my licensure process, I will be under the direct supervision of Steve McIlvaine, M.A., LMFT, LPC-MHSP. I am required to discuss all my client's cases with him and will be updating him during my time working with you. All personally identifying details will be withheld from the supervision process and your confidentiality will be preserved. The purpose of this is to ensure that you are receiving the best care possible. Our conversations and our written/taped records will be kept confidential and are protected by state law, with a few exceptions, which are for your own protection: (1) when we believe that you intend to harm yourself or another person (2) when we believe a child or elderly person has been - or will be - abused or neglected and (3) when there is domestic violence in the home. In rare circumstances, Professional Counselors can be ordered by a judge to release information. Otherwise, we will not tell anyone else about your treatment, diagnosis, history, or even that you are a client without your full knowledge, and usually with a signed Release of Information Form. A copy of the HIPAA (Health Insurance Portability and Accountability Act) Patient Notification of Privacy Rights will be made available to you. Signing at the end of this disclosure will indicate that you have had an opportunity to review and understand this (HIPAA) document.

COUNSELING RELATIONSHIP

During the time of your treatment we will meet regularly for 50-minute sessions. Ours is a professional relationship and must be respected by both sides. There may be opportunity for us to run into each other in a social context i.e. church, the grocery store or school, etc. Let's both keep our professional relationship in mind at this time. To protect you, I'll tend to avoid initiating with you in public. However, you always have the freedom to initiate with me. Please feel free to discuss this with me at any time when this happens. My goal is to make you comfortable with our professional relationship and best meet your needs as a client.

SCHEDULING AND LENGTH OF SESSIONS

A counseling session 50 minutes. I will schedule our sessions per mutual agreement, as time is available. If you call the main CCC phone number, you will usually have to leave a message, but my desire is to call you back as soon as possible. Because, I operate on an appointment basis only, I may not be able to handle urgent emergencies that may arise with clients. If your situation is out of control can not wait on an appointment, it is important that you contact 911 or your local emergency services. If you are unable to keep an appointment, please call at any point on the day before the appointment. You may leave me a message if you need to. Same day cancellations will result in you being responsible for paying the full cost of the session that you missed. Of course, this policy does not apply to emergencies.

FEES/METHODS OF PAYMENT

My standard fee is \$100.00 for the first session. This rate may slide to a lower amount based on the combined gross monthly income of the client and number of dependents. I ask for payment at the

time of service, and do not engage in billing for clients. In return for a fee of \$___ per session, I agree to provide counseling services for you. Cash, check, or credit/debit cards are all acceptable forms of payment. For credit/debit cards, there will be a \$3 convenience fee each individual session the card is used. I will provide you with a receipt upon request, for fees paid if you desire. There will be a \$25 fee for returned checks. I am also willing to help you seek financial support from your local church and your family to help with the cost of counseling. If you are involved in litigation and I am required to be involved in your case (travel time, preparation, attendance at court, letters) I will charge you a fee of \$200/hour (pre-paid).

BILLING/INSURANCE REIMBURSEMENT

Until I complete all of my requirements for licensure in Tennessee, I will be unable to bill any insurance company.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform me or Greg Seymour, owner of CCC, immediately. This will make our work together more efficient and effective. If a problem arises requiring a legal remedy to solve, the client agrees to solve all problems through the means above or independent mediation and not pursue formal litigation. Complaints should also be registered with the Tennessee Department of Health Attn: Office of Investigations - 665 Mainstream Dr., 2nd Floor, Suite 201 - Nashville, TN 37243.

APPROPRIATE REFERRALS

I am qualified to meet the needs of the vast majority of the people who come to see me. If I cannot help you, I will try to refer you to another appropriate professional in the community to meet your needs.

If you have any questions, please feel free to ask me. Once you have read and understood this statement, please sign and date. Thank you for choosing this practice to meet your needs.

Counselor Signature: _____ Date: _____

Client Signature: _____

Date: _____

Client Signature: _____

Date: _____

Parent – or - Legal Charge, if Client is a Minor: _____

Date: _____