Professional Disclosure Statement

Please initial next to each paragraph acknowledging your understanding. If you have questions, please discuss with your therapist.

_____ **Qualifications:** I am a fully licensed therapist in the State of Nevada. My formal education and life experiences have prepared me to provide therapeutic services for adults, teens, adolescents, children, families, couples, and groups.

_____ **Nature of Therapy:** I believe that all individuals strive to be the best they can be and that they seek growth. We will discuss my therapeutic approach and your goals in our initial visits. Using techniques in combination with evidence based methods such as unconditional positive regard, empathy, reflection, and goal setting, clients begin to view and experience themselves differently.

Informed Consent

_____ **Therapeutic Relationship & Contact:** We will meet by appointment for approximately 50-minute sessions. Our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. During business hours please contact the office line at 775-507-7222. I will make every effort to return your call within 1-3 business days, with the exception of weekends, holidays, and scheduled vacation. If you are experiencing a psychiatric emergency after 6pm or on the weekends, you must dial 911 or go to the nearest emergency room. You can contact me on my cell phone for emergencies, please refer to my business card for that number. You can also contact the Crisis Call Center (800-273-8255) to speak to a trained volunteer. Do not send crisis information via email, social media, or any other messaging systems.

_____ **Effects of Therapy:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, or discontinuing therapy. While benefits are expected from therapy, specific results are not guaranteed. Therapy is a personal exploration and may lead to major changes in your life perspective and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of theses changes cannot be predicted. Together we will work to achieve the best possible results for you.

_____ **Client Rights:** Some clients achieve their goals in only a few therapy sessions; others may benefit from months or even years of therapy. As a client, you are in control, and may end your therapy relationship at any time, although I do ask that you participate in a termination session. You will have the right to refuse or discuss modification of any of my therapeutic techniques or suggestions that you believe might be harmful. I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time, for any reason, you are dissatisfied with my services, please let me know. You acknowledge that a copy of the Client Rights and Notice of Privacy Practices have been made available to you.

_____ **Fees and Cancellation:** If you do not call to cancel 24 hours prior to your appointment time (not including weekends or holidays) and/or do not attend a scheduled session you will be expected to pay $100. I will charge the credit card you have on file and you are agreeing that I may do that. If you have a standing appointment and need to cancel, please do so within 24 hours of the appointment time. If you are absent to two appointments, I will assume that you are no longer interested in therapeutic services. Likewise, if you intend to discontinue therapy, please inform me immediately.

_____ **Records and Confidentiality:** Most of our communication is confidential, but the following limitations and exceptions do exist and I may disclose necessary information in these situations a) if I determine that you are a danger to yourself or someone else; b) I may seek consultation with colleagues in order to provide proper services; c) if you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person, past or present; e) if I am ordered by a judge to disclose information; f) if you direct me to release your records g) if we engage in text or non-encrypted email; i) for the use of treatment, payment, and operations of the practice and healthcare companies that reimburse Mind Body Counseling Associates for services provided. If I see you in public I will protect your confidentiality by acknowledging you only if you approach me first.

_____ **Group Therapy:** If you attended group therapy sessions please be advised that confidentiality is not guaranteed. The purpose of group therapy is to process your life experiences with others in a way that engages relationship and provides feedback and learning.

By signing below, you are indicating that you have read and understood this statement, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications. This notice may change from time to time and revised consent forms can be found on the Forms page of the website.

_____ _____

Client's Name Therapist's Name

_____ _____

Client's Signature Therapist's Signature

_____

Date

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[1] Rev 01/19