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Healing Hearts Counseling
13238 Executive Park Terrace
Germantown, MD 20874

PROFESSIONAL DISCLOSURE AGREEMENT

Welcome to my counseling practice. Thank you for choosing Healing Hearts Counseling to help you explore your potential for change. It is important that we work together so that our work can be effective. I look forward to witnessing positive change and growth occur in your life.

ABOUT THE COUNSELOR

I. **Credentials:** I have a Master's degree in Community and School Counseling from Regent University, which is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). I also have a Bachelor's degree in Business Administration from the University of Maryland at College Park.

II. **Licensing Regulations:** I am a Licensed Clinical Professional Counselor (License#: LC5014) in the state of Maryland which is governed by the Maryland Board of Professional Counselors and Therapists located at 4201 Patterson Avenue, Baltimore, MD 21215-2299; phone: (410) 764-4732; fax (410) 358-1610; http://dhmh.maryland.gov/bopc/SitePages/Home.aspx
I am also a Registered Play Therapist (T2468) with the Association for Play Therapy

III. **Ethical Guidelines:** I follow the ethical guidelines set forth by the American Counseling Association. A copy of these guidelines can be acquired at: American Counseling Association, 5999 Stevenson Ave., Alexandria, VA 22304; (800) 347-6647; http://www.counseling.org

ABOUT THE COUNSELING PROCESS

I. **Counseling Approach/Theory:** My main theoretical approach is Cognitive Behavioral Therapy (CBT). This type of therapy focuses on the importance of how an individual's thoughts affect the individual's emotions and behaviors. However from time to time I reserve the right to utilize techniques from other theories that have shown success with particular issues.

II. **Voluntary Participation:** Participation in therapy is voluntary unless mandated by the state court system.

III. **Benefits and Risks Associated with Counseling:** With any therapy treatment there are potentials for risks as well as benefits. For example, there may be a risk that clients will experience an increase of negative emotions such as anger, sadness, anxiety, loneliness,

frustration, helpless and other emotions due to recalling unpleasant memories. In addition, client problems may get worse before they get better and relationships with others may become imbalanced for a period of time.

However, clients can experience many benefits from the therapy process. There can be an improvement in communication and interpersonal skills as well as an increased self-awareness and empowerment. Clients overall may grow in many directions, in their personal, work and spiritual lives.

Although growth and change can happen, there is no guarantee as the results of counseling depends on many various factors that can be unpredictable.

IV. **Length of Therapy and Termination:** The length of therapy will be mutually agreed upon between the client and counselor unless limited by third party payment. Initially the counseling process starts with once a week sessions until it is agreed upon to decrease the frequency of appointments. The process of stopping therapy, called termination, can be a valuable part of therapy. Therefore it is best to not end things casually but to discuss termination when the time arises. The client or myself can initiate this.

V. **Interruptions in Therapy by Therapist:** At times, emergencies will arise that require me to reschedule appointments with the client. In emergency cases, please indict below how I am to contact you.

Phone number: _____

Is it okay to leave a message at the above number? Y/N _____ **Initial**

VI. **Counselor Involvement:** As a counselor, I will provide a framework and treatment plan to assist clients in meeting the mutually agreed upon goal(s) of therapy. The initial intake and evaluation session will be up to an hour in length. Thereafter, each session will be 45-55 minutes in length. If the client is 15 minutes late to the session, the session will be considered cancelled. If the client arrives prior to the 15 minutes, the remainder of the 45-55 minutes is what will be allocated to the client and not the full 45-55 minutes.

VII. **Client Involvement:** I expect my clients to be full participants of the counseling process. The client plays an active role during each session and completes any assigned homework assignment between sessions.

VIII. **Minor Clients:** In cases where my clients are under 18 years of age, I require parental consent before beginning treatment. In order for there to be trust in the relationship with the minor client, I consider our conversations confidential. Therefore, by signing this Disclosure Agreement, it gives me authority to determine what information will be shared with parents/legal guardians. If there is anything that needs to be addressed with the parents of the minor child, all parties (parent, minor client and counselor) will meet and discuss these issues. I will also periodically meet with parents to review any changes as well as give a general overview of the minor client's progress in therapy. _____ **Initial**

- If you and your spouse have a custody dispute, or a court custody hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
- In cases where the minor client's parents have a custody agreement or legal guardianship is to a non-parent, I may require a copy of the agreement.

RIGHTS AND RESPONSIBILITIES OF THE CLIENT

I. **Confidentiality and Privilege:** The client has the right to confidentiality in regards to information shared during therapy sessions. With the exceptions noted in the next section, the client has the right to know that information discussed during counseling sessions will not be revealed without client consent. The client also has the right to privileged communication. Privilege communication means that a judge cannot order information that has been recognized by law as privileged to be revealed in court. Confidentiality and privilege belongs to the client and therefore the client has the right to assert privilege in legal proceedings if the counselor is asked to disclose privileged information.

II. **Exceptions of Confidentiality and Privilege:** The exceptions to confidentiality and privileged information are:

- When the client poses a danger to self or others
- In cases of abuse of children or others with limited abilities to care for self
- When the client is a minor child or a legally incompetent adult
- In cases of group, marriage or family counseling
- When clients claim lawsuits claiming emotional damage by the counselor
- In cases where the counselor is ordered to do so by a court of law (subpoena)
- For purposes of involuntary hospitalization
- When the counselor has knowledge that the client is contemplating commission of a crime
- When the client has a fatal commutable disease and is putting others at risk of contracting the disease
- When clients waive their privilege or confidentiality
- In emergencies where therapist is incapacitated or otherwise unavailable and therapist's designee will need to notify the client and/or client's representative.

III. **Use of Technology in General:** There are inherent risks when using technology such as cell phones, cordless phones, faxes, emails, video chat and computers so that confidentiality cannot be guaranteed when communicating with these devices. Theses risks are as follows but not limited to:

- Use of emails may result in various servers creating permanent records of these transactions. In addition, email communication is not encrypted.
- Confidentially may be breached at any point when using electronic communication through use of unauthorized monitoring/interception of transmission from your computer and my computer. Therefore it is possible that third parties may access your records/communication
- Many employers and government agencies review email archives on a regular basis, record letters typed on a keyboard and/or engage in data mining programs to identify transmissions containing specific content.
- Your insurance company may consider our electronic communication to be part of the medical record and request them

By understanding these risks, you can make an informed consent about when, how and where you use those devices. Now that you have knowledge of these ricks, if you use any of these methods of communication with me, you are giving me permission to do the same with you.

IV. **Release of Information:** Clients have the right to request copies of their records to be released to other health care providers. However, the client must sign a release form. The client also has the right to his or her own records. If the client requests records for their own purpose, I reserve the right to discuss the request with the client if there is evidence to suggest that viewing these records would harm the client. There is a preparation fee of $15 for medical records with a charge of $.50 for each page of the medical record. In addition, a fee to cover postage and handling. _____ **Initial**

V. **Divorce/Custody Disputes:** If a client ever becomes involved in a divorce or custody dispute, I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons:

- My statements will be seen as biased in your favor because we have a therapy relationship; and
- The testimony might affect our therapy relationship, and I must put this relationship first. By signing this document, you are acknowledging your full understanding of and agreement to my position on this matter

VI. **Cancellation Policy:** The client is responsible for giving twenty-four (24) hours notice for any session cancellations. When you must cancel an appointment, please notify me by telephone as I do not check my email on a daily basis. Since cancelled or missed sessions cannot be billed to the client's insurance company, it will be the responsibility of the client to pay the full amount prior to the next scheduled session. The only exceptions would be for true emergencies such as hospitalizations, inclement weather conditions, or other unpredictable situations. The fee will be the full session fee of $50. The client is responsible for paying this fee. _____ **Initial**

VII. **Fees and Charges:** The client is responsible for paying prior to each session. The initial intake and evaluation session can be up to an hour in length at the cost of $200. Thereafter, each session will be 45-55 minutes in length at the cost of $150 per every 45 minutes and $200 per every 55 minutes session. At times, there will be appointments that require 90 minute sessions. In these cases, the cost per session will be $250. I will let you know if and when it is necessary for sessions to be 90 minutes. The fee is subject to increase annually and the counselor will notify the client a month in advance of the fee increase. If the client is late for any sessions, the session will still end at the scheduled time and the full amount will be paid for the session. Requested written reports will be done at a fee of $150. Fees for court/deposition appearances will be $2400 per day (certified check or money order) due 10 days prior to court (this includes travel, preparation time and missed work hours). If court is cancelled with a 5-day notice, $600 will be refunded. The client, minor client's parent or requesting party is responsible for payment. _____ **Initial**

VIII. **Insurance Reimbursement:** The client is responsible for providing insurance information for billing purposes. The counselor will submit claims to the insurance company using a third party provider. The client is responsible for any co-payment and for charges that the insurance does not cover/pay that is considered member responsibility. _____ **Initial**

IX. **Responsibility for Payment:** The client is responsible for payment for counseling sessions. After two months of non-payment, accounts will be considered delinquent. Delinquent accounts are subject to a 5% interest charge per month. Two sessions or two months after accounts are considered delinquent; the counseling relationship will be terminated and sent to debt collections. _____ **Initial**

X. **Counseling and Financial Records:** Counseling records are store in a locked cabinet in a locked room. Only authorized personnel will have access to files. These files will be kept for 5 years after the last date of counseling/report and for minor children, the age of majority plus 3 years or for 5 years after the record or report is made, whichever is later. After that time, the files will be shredded. All access to computers is password protected and secured in a location where unauthorized personnel cannot access.

XI. **Disputes and Complaints:** If the client is unhappy with the counseling that is occurring, it is my hope that the client will bring this up in session. I will take the compliant seriously and address any necessary changes. If the client does not want to bring up complaints in session or believes that I have behaved unethically, the client can address those complaints to the Maryland Board of Counselors and Therapist at:

Maryland Board of Professional Counselors and Therapists
4201 Patterson Avenue
Baltimore, MD 21215-2299
(410) 764-4732 or http://dhmh.maryland.gov/bopc/SitePages/Home.aspx

RESPONSIBILITIES OF THE COUNSELOR

I. **Affiliation Relationship:** I am a full time psychotherapist of Healing Hearts Counseling (a Limited Liability Company). This practice is independent and not associated with any other practice that may be located at the same address.

II. **Colleague Consultation:** In order to provide quality care, I may find it necessary to consult with other professionals. During these consultations, I will ensure that every effort is made to protect the identity of the client.

III. **Tape Recording or Videotaping of Sessions:** As a counselor, I support teaching and training of counselors-in-training as well as continual education for myself. As part of this process, permission is sometimes requested of clients to audiotape and/or videotape the interviews. Audiotaping and video recording the sessions can be a significant component of counselor training. However, no recording is ever done unless the client and parents/legal guardians of minor clients have given permission to do so.

IV. **Dual Relationships:** It is my responsibility to protect the nature of the counseling relationship with the client. Therefore, if I see/meet the client outside the counseling session, I will not acknowledge the client or give any indication of knowing the client. That choice will be left up to the client to approach the counselor. In addition, it is my policy not to accept gifts or socialize with clients outside the counseling relationship.

V. **Communications:** I will try to return communications within 24 hours however in the case of an emergency, please call 911 or the Montgomery County Crisis Center at (240) 777-4000.

VI. **Vacation Coverage:** I will have a colleague available to intervene if the client has an emergency or would like to continue with sessions during the time I am unavailable. A name and number will be made available at that time.

VII. **Closing Statement:**

I, _____, have read or have had read to me, and fully understand my rights and responsibilities detailed in this document. It is my understanding that any of the points mentioned above can be discussed and may be open to change. If at any time in the counseling process I have questions about these subjects, I can bring it up with the therapist and she will do her best to answer them. "I understand my rights and responsibilities as a client/parent of client, and I understand my counselor's responsibilities to me. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my counselor." I give consent to the terms of this document and agree to enter into a counseling relationship and/or give consent to have my child enter into a counseling relationship with Judy Wang, LCPC, RPT and Healing Hearts Counseling. I understand no promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

Client's Signature _____ Date _____
(If client is 16 or older)

Parent/Guardian's Signature _____ Date _____
(If client is 15 or younger)

Parent/Guardian's Signature _____ Date _____
(If client is 15 or younger)

I have discussed and explained the above information with the client

Counselor's Signature _____ Date_____