**Professional Disclosure Statement**

# Therapy with families, individuals and children

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. Please read this form carefully and sign in the appropriate places. You will receive a copy of the signed form for your own records. Feel free to ask questions or discuss this information with me at any time.

**Philosophy and Approach to Therapy:**

My philosophy of therapy is holistic, meaning that I believe that people are made up of many parts — body, soul (mind, emotions, will) and spirit. I believe that brokenness can occur if when any part is out of balance, causing pain, which signals the need for help, forgiveness and healing.

My main focus is on the importance of emotional balance and well-being. I believe that everyone experiences difficulties in their lives and see therapy as a space for clients to explore express feelings, receive validation and support. I believe that people have all of the components for a happy and healthy life but sometimes need help processing their feelings through the various stages of life and learning effective ways to cope.

My specialization is in grief and loss - specifically with traumatic loss and/or complicated grief. I also specialize in the LGBTQ community and related factors that can arise from self-esteem, social supports, depression, trauma, gender and relationship issues. I also specialize in anxiety related issues that can lead to maladaptive ways of coping.

**Code of Ethics & Supervision:**

As a licensed professional counselor, I am bound to the American Counseling Association Code of Ethics and the laws of the state of Michigan. My license number is 6401010604. I have completed my Master’s Degree in Counseling at Oakland University in 2007.

**Formal Education and Training:**

Master's Degree in Counseling

Licensed Professional Counseling

**Specializations:**

Specialization in grief and loss with experience from

* Beaumont Hospice – Bereavement Counselor
* Yatooma’s Foundation for the Kids – Contract Therapist
* Ele’s Place (a nonprofit grief support group for children 3-18 and their caregivers)
  + Support group facilitator for grieving parents
  + Family Services & Volunteer Coordinator
* Schoolcraft College Students of AMF Faculty Advisor

Specialize in emerging adulthood/college issues, academic barriers, and career counseling

**Professional Boundaries:**

I will not acknowledge the existence of the relationship outside of the therapy session unless initiated by the client. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at any time. Such a relationship, in my view, would be detrimental to our purposes of therapy.

**Your rights as a client:**

1. You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy. If you desire, I will explain mu usual approach as well as qualifications.
2. You have the right to decide not to receive therapeutic assistance from me or to seek a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. In a professional relationship, such as ours, sexual intimacy between therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the American Counseling Association and the State of Michigan.
5. You have the right to expect confidentiality within the limits described under #7 below.
6. If you request in writing, any records can be released to any person or agency you designate (note that consent from all clients in the treatment unit is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.
7. There are certain situations in which I am required by law to reveal information obtained during therapy without your permission. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if a court of law issues a legitimate court order (signed by a judge); (c) if you reveal information relative to physical abuse, sexual abuse, or neglect of a child or the elderly (in the past as well as the present); (d) if you are in therapy by order of a court of law; or, (e) if you are involved in a criminal or delinquency proceeding.

**Consent to Treatment:**

**I affirm that prior to becoming a client of Anna Arciero, MA, LPC, NCC at Only Human Counseling Services LLC, she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits of therapy, and the nature of confidentiality. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. My signature below affirms my informed and voluntary consent to receive therapy. With the understanding of the above information and conditions, I agree to participate in therapy.**

**Signature Date**

**Signature Date**

**Therapist’s Signature Date Appointment Issues:**

In order to serve you in the best way possible and meet your needs for therapy services, the following is my policy on missed and canceled appointments.

1. A 24-hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a $35 cancellation fee. I understand that this will be my responsibility, not that of the third-party payer. If an emergency occurs, **please call** and you will not be charged for the appointment.
2. If you are late for a session, the time of your session may be shortened, but you will be required to pay for a full session for cash paying clients. I will report actual time of therapeutic services rendered for any third party payer involvement.
3. For individuals who haven’t called and are late to an appointment, I will wait for up to 15 minutes, then assume you are not coming. The $35 cancellation fee will be applied for the time I reserved for you. If an emergency occurs that causes this, we can discuss the exception.

**Financial Considerations:**

1. My standard fee for therapy is **$\_\_\_\_\_ for a 55 minute session**. If we agree to longer or shorter sessions, you will be charged accordingly. Payment in full is expected at the end of each session.
2. There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances (in the case of children’s cases only), phone calls lasting over 10 minutes, and missed appointments.
3. Therapists have the right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.
4. When diagnostic testing is appropriate and recommended, the costs for testing are in addition to the usual therapy fee. The cost for testing varies depending on the test. Some psychological assessment needs may be referred to another mental health professional who will determine his or her own fee.

**Health Insurance Claims:**

I give my authorization to release medical records to assist in the processing of my insurance claims to Health Care Connect, LLC. I also authorize payments of my Claims to be mailed directly to Anna Arciero, MA, LPC, NCC for providing my services. I understand that I am completely responsible for any charges incurred and that billing my insurance does not guarantee payment of the claim(s). If the provider of service does not receive payment in a timely fashion, I understand that I may receive a bill for services rendered. I also understand HIPAA policies and practices

**I have read the above and both understand the financial considerations and agree to the appointment policy. The agreed upon fee for a standard therapy session is $\_\_\_\_\_ (for cash paying clients). I understand my insurance policy, that my co-pay is \_\_\_\_\_\_\_\_\_, my deductible is \_\_\_\_\_\_\_\_\_\_, and that I can pay by cash, check or charge any balance I may have at the end of every session.**

**Signature Date**

**Signature Date**

**Therapist’s Signature Date**