

North Alabama Christian Counseling Statements of Understanding

The Counseling/Consultation Process

People come to counseling because they want something to be different in their lives. They may want to change their personal or family situation, solve a particular problem, or simply bring a healthier balance to their lives. The counseling process can be very challenging, difficult and even painful. However, the goal will always be to bring about some positive change.

Counseling is conducted in various ways depending on the therapist. As a client of North Alabama Christian Counseling (NACC), you have the right to know your therapist's qualifications, methods, and mutual expectations of our professional relationship. Please feel free to discuss any questions or concerns you may have before we begin our session.

At our initial meeting, we will assess your current needs and concerns, and decide if we can work together to address them. We will evaluate the results of our work together, and determine the need for additional sessions, termination, or outside referral for further counseling or assistance.

Throughout our work together, we will make every reasonable effort to professionally facilitate the resolution of your needs and concerns. Ultimately, you must decide to use what you gain from the counseling process.

Credentials and Experience

Dr. Bill Clark is a Licensed Professional Counselor (#510) in the State of Alabama. He holds a Ph.D. degree in psychology, a D.Min. in Christian counseling, Masters degree in Christian counseling, and a Masters degree in psychology. He specializes in marriage and family issues.

Dr. Clark is also experienced in the areas of personal relationships, pre-marital counseling, anxiety, depression, grief and loss, stress/anger management, identity issues, spiritual direction, isolation loneliness, trauma recovery, sexual issues, and sex addiction.

Your Rights and Responsibilities

You have the right to ask your therapist to explain his/her reasons for making certain recommendations or for using certain procedures. You also have the right to refuse to follow these recommendations, and/or to terminate the counseling process at any time and for any reason. As your therapist, I have the right and ethical responsibility to terminate counseling and offer a referral to another therapist if you choose not to follow my recommendations. Either of us may request a final session to discuss the reasons for termination and to decide on an appropriate referral if desired. Please inform your therapist if you are seeing another mental health professional during the course of our work together so that he/she may provide consistent treatment for you.

Therapists at NACC are bound by a Code of Ethics set forth by the Alabama Board of Examiners in Counseling. You may request a copy of the ethics code at any time.

_____ 1. Limitations of Service

- a. Only scheduled services are provided by therapists of NACC.
- b. Access to 24 hour-a-day care is not available.

- c. The client may ask for referrals or for information about *potential providers* of medical services such as: psychiatrist or educational information about the nature of prescriptions for psychotropic medications, however, such information or referrals do not constitute medical advice or the endorsement of the service provider.
- d. I understand that, counseling or advice *between sessions* will *not* be given by phone or by email or in any other form. *Information about counseling services or informational articles, suggested reading, etc.* may be provided by phone or email but will not be in the form of counseling services. Likewise, *no part of any counseling session is to be recorded or transmitted* by the client or counselor in any form for the benefit of any party without express written consent of the client and the counselor. The services provided are intended for the scheduled participant only.
- e. Further limitations of services are due to the availability of our counselors. NACC therapists *are only available during regularly scheduled office hours*. Office hours are Monday through Thursday from 9 a.m. to 6 p.m. unless special arrangements are made with your therapist. NACC will close for holidays, inclement weather, and when your therapist is on vacation.

Since NACC therapists do not provide services outside the stated business hours, in the event of an emergency, mental health services should be obtained by calling 911 or going to the nearest hospital emergency room.

_____ **2. Confidentiality:** I understand that my personal health information (PHI) is held in strict confidence unless I sign a release of information form designating the person(s) to whom my information is to be released. I also understand that *there are exceptions by law to the privilege of confidentiality such as:*

- a. If I say I am going to harm myself or another person, my therapist will report this to the appropriate agency or person(s).
- b. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the therapist, he/she is obligated to report this to a state agency for follow-up.
- c. If a judge subpoenas my clinical records, your therapist must comply.

_____ **3.** For your convenience, a copy of the HIPAA Notice of Privacy Practices will be emailed to you. If you have any additional questions concerning our privacy practices please contact our Executive Director, Bill Clark, Ph.D., LPC, at 256-239-5510.

By law, NACC is required to obtain your signature indicating you have read or received the document. *Your signature on this form does not surrender any rights or confidentiality.*

I _____, acknowledge I have been notified how to receive a copy of the privacy policies of NACC and am aware of the contents of the HIPAA notification. I understand these disclosures. I have received or been offered a copy of this Disclosure Statement and Notice of Privacy Rights.

_____ **3.** If my child or ward will be receiving services, I give consent for his/her treatment.

_____ **4.** I understand that cancellations must be made at least 24-hours in advance of my scheduled appointment. If I fail to do so, I will be charged a \$25.00 non-refundable fee. We understand that legitimate situations unexpectedly arise that make it necessary to cancel appointments (i.e., roads closed due to inclement weather, family emergencies, sickness, etc.). We will attempt to work with you. The "failure to cancel" fee must be paid or arrangements made with my therapist before or at the next scheduled session.

_____ 5. I understand that if I no-show a scheduled appointment, I will be charged a non-refundable fee of \$25.00. The “no-show fee” must be paid or arrangements made with my therapist before or at the next scheduled session.

_____ 6. I understand that if I refuse payment for the services that I receive, no further counseling will be authorized.

_____ 7. I understand that a \$25.00 service charge will be charged for all checks returned by a bank for insufficient funds. If outstanding balances are not paid in a timely manner, my therapist may elect to not continue providing services.

_____ 8. I understand that my therapist may be required (court subpoena) to become involved in legal proceedings concerning my counseling. In that case, I agree to pay for my counselor’s time (\$135.00 per hour) in preparing for such legal action, including, but not limited to, traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my counselor may incur as part of my involvement in such legal action.

_____ 9. I understand that my therapist may be asked/required to complete forms/questionnaires and/or submit letters on my behalf. I agree to pay for my counselor’s time (\$135.00) in preparing these documents.

Date Signed

Signature of Client or Person Authorized to Sign for Client

Date Witnessed

Signature of Witness