



PROFESSIONAL DISCLOSURE  
STATEMENT

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**Welcome**

Practical Choices and Healthy Change Therapy, LLC welcomes you as a potential client. Please carefully read the following information because it will help you utilize my services most effectively. I realize that starting counseling is a major decision and you may have many questions. I believe it is important for you to be informed about the nature of counseling/psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for my services, and your rights and responsibilities as a client. If you have any inquiries or concerns, please feel free to ask and I will try my best to provide you with all the information needed to make a sound decision.

**Professional Credentials**

I earned my Bachelors of Arts in Psychology from University of Alabama in Tuscaloosa and my Masters of Science in Clinical and Counseling Psychology from Capella of University. I am an Associated Licensed Counselor for the state of Alabama (#C2673A) and have been authorized to engage in private practice of counseling under the supervision of Cheryl Lynn Holmes.

**Services Offered and Theoretical Approach**

Therapy begins with an intake process designed to evaluate your needs and difficulties and to help you and I decide about engaging in therapy. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. This process usually takes approximately 2 hours to complete. The therapy process itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Each therapy session lasts 60 minutes, and therapeutic treatment is guided by a treatment plan that you and I both agree to pursue. I believe counseling is a collaborative effort in which you and I work together to help you change the thoughts, feelings, and behaviors that are interfering with you being able to live a fulfilling life.

I utilize an integrative-psychotherapeutic approach which uses information taken during your intake interview as well as a continual assessment of your current stage of change, coping style, reactance level, and treatment preferences to decide techniques effective in addressing the presenting problem. As such, my role as counselor will change to match your needs; whether it is advisor, supporter, consultant, etc. I will not attempt to impose my values on you. If becoming a client here does not seem feasible, I can always provide you with a suitable referral. Alternative forms of treatment may include referrals to psychiatry, substance abuse services, inpatient hospitalization, and group therapy.

**Counseling Relationship and Its Effects**

Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling session that you arrange with me and necessary phone contact. Please do not offer me gifts or ask me to engage in social activities with you. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. Although I expect you to benefit from counseling, I cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Risks may include experiencing uncomfortable feelings, such as sadness, guilt,

anxiety, anger, frustration, loneliness and helplessness, because the process of counseling often requires discussing the unpleasant aspects of your life. You may feel distressed, usually only temporary, by some of the things you learn about yourself or some of the changes you make. However, counseling has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Counseling requires a very active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve best possible results for you. If you are dissatisfied with any aspect of our work, please talk with me about it.

**Confidentiality**

The information you share with me is confidential. Also, all records and documentation are stored in a locked file, or a HIPAA approved online storing. This means that information about you will not be revealed to other persons or agencies without your written permission or consent. Exceptions or limitation to his policy include:

- Mandated reporting of suspected child or elderly abuse (This does not apply to adults working on abuse/neglect that occurred in their childhood)
- Duty to warn any serious threat of physical violence or death against a reasonably identifiable victim or victims to the law enforcement agency and victim or victims
- Revealing confidential information obtained during therapy if you file civil or criminal charges against me in legal proceedings or if you file an ethics complaint with the licensure board. In these instances, I am permitted to use treatment records to defend against these charges or complaints
- Your records being reviewed by Cheryl Lynn Holmes for purpose of clinical supervision and quality control as it is standard professional practice
- If your therapy is court ordered, the results of treatment must be revealed to the court. If you do not give consent for disclosure or if you want to fight the court ordered disclosures, you must provide the funds for an attorney to fight this for you without cost to me (your therapist)

Other clients have the same rights of confidentiality that you do. If you see other clients as they come and go from my office, you have the right to expect that they will not divulge your client status to anyone, and they have the right to expect that you will protect their confidential status. It is also important to note that cell phones and emails are used on some occasions, and all electronic communication compromises your confidentiality.

**Appointments**

I will schedule all appointments. If you are unable to keep a scheduled appointment, please notify me 24 hours in advance that you would like to reschedule or cancel a session via phone or email. **If you miss a session without canceling, or cancel with less than 24-hour notice, the policy is to collect a \$30 cancellation fee.** No charge is applied if appointments are cancelled more than 24 hours in advance. Unforeseen emergency situations will be taken into consideration. In additions, you are responsible for coming to your sessions on time; if you are late, your appointment will still need to end on time.

**Fees and Payment**

The standard fees are as follows:

<b>Intake Fee.....</b>	<b>\$100</b>
<b>Individual Sessions Fee.....</b>	<b>\$50</b>
<b>Cancellation without 24 Hour Notice Fee.....</b>	<b>\$50</b>
<b>Copy of Records Fee.....</b>	<b>\$0.10 per page</b>

You are responsible for payment at the beginning of each session. Payment may be made by VISA, American Express, Discover, MasterCard, and Cash. **Fees for additional copies of records are \$0.10 per page.** Cost of living increases may

occur on an annual basis. Practical Choices and Healthy Change Therapy, LLC ask all clients to complete a credit card authorization sheet at the time of intake. In the unlikely event that you have a balance owed for more than 60 days, I will charge the overdue amount to your account and notify you of this charge by mail. If you fail to pay a delinquent account after 90 days, you automatically waive your right to confidentiality regarding financial information and are subject to all fees associated with payment recovery. Recovery of delinquent payments may involve a collection agency or attorneys and you will be responsible for all cost of collection. I will provide a receipt for payment for personal tax purposes.

**Termination of Therapeutic Services**

Optimally, therapy ends by a mutual agreement, or you may choose to end therapy at any time. I reserve the right to discontinue therapy due to non-compliance of treatment recommendation, failure to attend therapy, referral of the client elsewhere for therapy, or if I determine that therapy is no longer effective. I request that you have at least one face-to-face termination session with me to discuss reasons for termination rather than you terminating by phone, mail, or not showing up. This final session allows time to finish the therapeutic process or provide you with a suitable referral if the connection between you and me is unsatisfactory.

If you have not attended an appointment with 3 months of your last completed appointment, your failure to participate in therapy is considered an intention to end the therapeutic relationship. Your status as an active client will be terminated. If you would like for your therapy to continue elsewhere, I will refer you to another qualified provider. Although you may end therapy at this time, it is preferred that you have at least one face-to-face concluding appointment with me rather than terminating by telephone, mail, or by not showing up. Although your therapeutic relationship may have ended, your billing account will not be formally closed until your balance is paid in full.

**Informed Consent**

My signature indicates I have read or have had read to me the Professional Disclosure Statement, and have raised any questions I might have about it with my therapist. I have received full and satisfactory responses to my inquires, and I understand and accept the policies contained therein. Having read and explained the information fully, I hereby agree to assessment and treatment freely and without reservations. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent for treatment at any time.

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Client name (please print)

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Signature of therapist

\_\_\_\_\_  
Date signed