1601 Jones Franklin Road, Suite 104, Raleigh, NC 27606 TEL (919) 851-1527 Fax (919) 851-3555

April Miller, MACC, LCMHC
Professional Disclosure Statement

Credentials

B.A., Miami University, 1992
MACC, Gordon-Conwell Theological Seminary, 2006
LCMHC, N.C. Board of Licensed Clinical Mental Health Counselors, License No. 7067

Professional Experience and Services

Inpatient and outpatient therapy with adults, adolescents, and families since 2006, including therapy to individuals, couples, and families.
Provide individual and/or family therapy using family systems, developmental, and/or psychodynamic approaches. Techniques may include cognitive-behavioral, structures communication training or reframing.

CONFIDENTIALITY

The confidentiality of your personal health information is very important to me. At LifeCare we have a team approach and confidential information may be shared with other providers on our team as necessary to insure the best quality of care. Your personal information is confidential within the practice. I may use and disclose your personal information without authorization for the following purposes: abuse, neglect, domestic violence, or court order. As required or permitted by law, I may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence, or court order. If such a report is optional, I will use my professional judgment in deciding if to make such a report. If feasible, I will inform you promptly that I have made such a disclosure.

Minors and Disabled Adults

When working with clients who are minors or adults who are legally incapable of giving consent, I will obtain consent from a parent or legally authorized representative. For children who are clients, it will be determined the extent that he or she has an understanding of privacy based on chronological age and cognitive ability. If the child has no concept of privacy, then I am free to share information with parents without informing the child first.

Pre-adolescents and adolescents will be seen on an" informed forced consent" in that information will be handled as confidential, but it is up to the therapist to decide what information is pertinent to share with the parents. Sometimes it is in the best interest of the minor client not to disclose all information to the parents that the child shares with the therapist so as to strengthen the therapeutic alliance and work through issues with the minor. Parents of the minor will be given updates of progress of goals and treatment plans on a scheduled basis. When it is determined that information should be shared for therapeutic reasons or as part of family counseling, the client will be informed and consulted and/or included in sharing the information to the parents or guardians. This of course, is superseded by any of the exceptions of confidentiality (danger to self or others, abuse, or court order) as stated in the above paragraph.

When working with two or more persons who have a relationship such as in a group, family or marriage, I will clarify at the outset who is the primary client as an individual or family unit. I will not share confidences by one family or group member to others outside the family without permission or prior agreement of all members except described in legal exceptions of threat of serious harm to self or others as described above in paragraph one.

Marriage Counseling

With couples specifically, my counseling work will focus on both your relationship and each of you as individuals. In order to maintain fidelity to both of you and your relationship, it is important that we agree on these policies:

1) I may share any information conveyed to me by either of you with the other member of the couple. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in therapy. This includes all verbal, written and phone conversations and messages.

2) If I meet with one or both of you in an individual session, I will likely share the contents of that meeting with the partner in a couples' session in the near future.

3) The continued participation by each person is voluntary. Either participant may suspend or terminate the therapy at his or her individual request. At that time, client confidentiality remains solely with the client who is continuing therapy.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that I can address your concerns. If I cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Office Manager. If after doing so you are still dissatisfied, you may contact the NCBLCMHC at P.O. Box 77819, Greensboro, NC 27417 or by phone at 844-622-3572.

Please see "Notice of Privacy Practices" for more detailed information about confidentiality of service and records.

Consent For Professional Services for LifeCare Counseling and Coaching

Main: 1601 Jones Franklin Road, Suite 104, Raleigh, N.C. 27606 (919) 851-1527 Fax (919) 851-3555
West: 1709 Legion Road, Suite 222, Chapel Hill, NC, 27517
Brier Creek: 8801 Fast Park Drive, Suite 107, Raleigh, NC 27617

Name: _____ DOB: _____ Date: _____

Scope of this Consent For Professional Services applies to **all providers** at LifeCare Counseling and Coaching.

Please INITIAL beside the following:

_____ I have read the attached Professional Disclosure statement for my provider who is an employee of LifeCare Counseling and Coaching and I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable, then a treatment plan will be agreed upon at the end of the evaluation.

_____ (Optional) I am willing to allow an intern to sit in on our sessions in that I understand that a mission of LifeCare is to train and license future counselors.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said client or patient at this office, unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of $40.00 for any checks that are returned unpaid. I understand if the client or patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent.

For when the card on file does **not** belong to the client or patient: I, the financially responsible one, _____ _____
(Print Name) (Signature)
give complete permission that the costs incurred by _____ and any outstanding balances now and going forward may be collected by LifeCare using my credit card number. (Client or Patient Name)

Fee Schedule for our Therapists (by degree)

Doctoral Level

Psychotherapy 55-60 min	$150 (only this may be covered by insurance)
Family/Couple Session 55-60 min	$150
Assessment w/written report	Priced individually

Masters Level

Psychotherapy 55-60 min	$140-$145 (only this may be covered by insurance)
Family/Couple Session 55-60 min	$140-$145 (only this may be covered by insurance)
Supervised Intern	**Sliding Fee**

ALL Therapists

No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation	Based on time required
Reports and Letters	Based on time required
Photocopying	Based on number of pages
Court Preparation/Appearances	$200 an hour

Fee Schedule for our Psychiatric Providers

Complete Diagnostic Interview 45-60 minutes (90792)	$215
Complete Diagnostic Interview 75-90 minutes.	$265
Medication Management 10-15 minutes (99XXX).	$95
Psychotherapy with evaluation and medication management 20-30 min (99XXX)	$140
Psychotherapy with evaluation and medication management 45-50 min (99XXX)	$180
No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation ≤ 5 minutes.	No charge
Telephone Consultation > 5 minutes.	Based on time required
Reports and Letters	Appointment required
Photocopying	Based on number of pages
Court Preparation/Appearances	$300 per hour

Payment, Insurance Reimbursement, and Problem Resolution

It is our policy to receive payment for services at the time they are provided. Cash, personal checks, credit and debit cards are acceptable forms of payment. As a convenience to you, we will file your claim with your insurance company. If you are unable to keep an appointment, please call to cancel the business day prior 24 hours before your appointment. Less than that will be considered a late- cancellation. No call or not coming to your appointment will result in a No-show fee. No-show and late-cancellation fees are listed above.

Therapy. In surveying other practices in the area, our fee of $130 per session is in line or below the prevailing rates for professional licensed psychotherapy services. At LifeCare, we are committed to provide you with excellence in Christian counseling. Our counselors are well-trained, board certified, and experienced in dealing with a wide variety of needs. We sincerely appreciate the opportunity to help you with your current concerns.

We are in-network providers with Blue Cross Blue Shield of North Carolina, except for Blue Local plans. Some of our providers are also in-network with United Healthcare and Cigna, but not all. Please check with your therapist or psychiatric provider regarding whether they are in-network for your plan. Please be aware that some insurance companies contract mental health benefits out to a different insurer who may be out-of-network. Your insurance company can confirm your benefits.

We are out-of-network providers for all other insurance plans. As a convenience to you we will make every effort to file a claim on your behalf. If we are not able to file the claim we will provide you with the appropriate forms so you may file the claim yourself. We ask for the full fee at the time of service, then file the claim and assign payment of any benefits to come directly to you personally. We are not accepted providers for Medicaid or Medicare.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require the participation of a LifeCare provider, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, therapists charge $200 per hour for preparation (psychiatrists charge $300) and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if we are compelled to testify by another party. An agreed upon amount will be rendered *in advance* and held in escrow. Any left-over amounts will be returned to you upon resolution of the legal matter.)

Insurance/Third Party Payment

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

____ If I have third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

____ I certify the following information to be accurate: (Check **one** below)

___ 1) **No Insurance**

___ 2) **Using Insurance, but Out of Network.** I have insurance/third party coverage with _____

___ 3)**Contract with Insurance/In-network.** I have insurance with _____

____ I authorize use of this form on all my insurance submissions.

____ I authorize release of information to all my insurance carriers.

____ I understand that I am responsible for my bill.

____ I authorize LifeCare to act as my agent in helping me obtain payment from my insurance carriers.

____ I authorize payment directly to my LifeCare provider, and hereby assign my right to reimbursement for services rendered to LifeCare Counseling and Coaching, P.C.

____ I permit a copy of this authorization to be used in place of the original.

_____ _____

Client or Patient Date

_____ _____

Legally Responsible Person Date