

**Jeremy D. Hudson, Intern Counselor
Professional Disclosure Statement**

Credentials

MA in Clinical Mental Health Counseling from Liberty University (anticipated Dec 2021)
BA in Chemistry / Environmental Studies, UNC-Wilmington in 1995.

Professional Experience and Services

I am currently working to obtain a Master of Arts in Clinical Mental Health Counseling from Liberty University. My approach to counseling is integrative with a focus on tailoring the therapeutic journey to your individual characteristics, preferences, needs, abilities, and spiritual beliefs. I enjoy working with clients of all ages and I especially enjoy working with those ranging from adolescents to mature adulthood. As a therapist, I greatly value you, the client, as an individual and view counseling as a means of helping you achieve your personal goals for growth. I believe in treating the client as a whole, addressing physical, emotional, psychological, and spiritual components to problems and growth. Risks involved in counseling might include experiencing uncomfortable levels of emotions or tension in relationships.

Fee Schedule

Psychotherapy 45-50 min (90834)	\$40 a session = total household income a year is over \$50K
.....	\$30 a session = total household income a year is between \$20K and \$50K
.....	\$20 a session = total household income a year is from unemployed to \$20K
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

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. 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. Any exception to this policy requires agreement from your therapist and a written note of authorization be placed in your file. We greatly appreciate your understanding and cooperation with this request.

I will not be filing your sessions with any insurance company.

It is standard practice to give a diagnosis after the beginning of the first session.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that we can address your concerns. If we cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Office Manager.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require my participation, it is expected that you would pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, I charge \$200 per hour for preparation and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if I am 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.)

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 ensure 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, we 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.

For educational purposes, I will record our sessions. The only person with access to these recordings besides me is my supervisor.

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
Holly Springs: 190 Rosewood Centre Drive, Suite 100, Holly Springs, NC 27540
West: 1709 Legion Road, Suite 224, Chapel Hill, NC, 27517
Brier Creek: 8801 Fast Park Drive, Suite 107, Raleigh, NC 27617

TEL (919) 851-1527 Fax (919) 851-3555

Name: _____ DOB: _____ Date: _____

Provider: Jeremy D. Hudson, Intern

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 Jeremy D. Hudson, an intern 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.

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)

____ I certify the following information to be accurate:

____ **No Third-Party Payer.** I have no insurance or understand that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

____ **Contract with church or Third Party.** I have third party coverage with:

_____. I understand there is a contract between this payor and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by this third party.

Client

Date

Legally Responsible Person

Date

Provider

Date

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I consent to allow the video or audio recording of my sessions with my counselor,

_____ for the purpose of clinical supervision.

(name of counselor)

I understand that these recordings will be shared with his or her supervisor,

_____, and are subject to the same confidentiality

(name of clinical supervisor)

agreements as my other health information.

Client

Date

Legally Responsible Person

Date

Counselor

Date