1768 Heritage Center Dr., Ste 201, Wake Forest, NC 27587 TEL (919) 851-1527 Fax (919) 851-3555

Catherine Doster, Intern Counselor
Professional Disclosure Statement

Credentials

MA in Clinical Mental Health Counseling, Richmont Graduate University – Online Expected 2024
- *Trauma Certification* Expected 2024

MA in Theology, Gordon-Conwell Theological Seminary - South Hamilton, MA 2016
B.A. in Liberal Arts, St. John's College, Annapolis, MD, 2012

Professional Experience and Services

Includes therapy with adults, adolescents, and families, including individuals, couples, and families. Provide individual and/or family therapy using psychodynamic, family systems, and narrative approaches. Counsel for anxiety, depression, adjustment disorders, women's issues, identity, trauma recovery & processing, relationship issues, parenting, grief & loss, attachment, family-of-origin, and forgiveness & reconciliation.

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.

Intern 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 104 & 111, Chapel Hill, NC, 27517
Brier Creek: 8801 Fast Park Drive, Suite 107, Raleigh, NC 27617
Holly Springs: 190 Rosewood Centre Dr., Ste 100, Holly Springs, NC 27540
Triad: 14 West Main Street, Suite 317, Thomasville, NC 27360
Wake Forest: 1768 Heritage Center Dr., Ste 201, Wake Forest, NC 27587
Wilmington: 5020 Randall Parkway, Ste 4, Wilmington, NC 28403

Name: _____ DOB: _____ Date: _____

Provider: Catherine Doster, 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 Catherine Doster, 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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Consent for Video Recording

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