8801 Fast Park Dr., Ste 107, Raleigh, NC 27617 TEL (919) 851-1527 Fax (919) 851-3555
1768 Heritage Center Dr., Ste 201, Wake Forest, NC 27587

Steven A. Price, M.A., LCMHC
Professional Disclosure Statement

Credentials

B.S. in Management, Clemson University, 1992
M.A. in Professional Counseling, Liberty University, 2017
LCMHC, N.C. Board of Licensed Clinical Mental Health Counselors, License No. 13473

Professional Experience and Services

Outpatient therapy with adults, adolescents, and families since 2017, including therapy to individuals, couples, and families.
Provide individual, pre-marital, marital, and/or family therapy using an eclectic psychodynamic and/or family systems approach. Techniques may include cognitive-behavioral, EMDR, motivational interviewing, dialectical behavior therapy, or narrative.

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. For those who have the NC State Health Plan as their health insurance, as required by law, your demographic information will be disclosed to a state agency called NC HealthConnex.

****Recording of sessions without your provider's knowledge is forbidden.**

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 we cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Practice Administrator. If after doing so you are still dissatisfied, you may contact the North Carolina Board of Licensed Clinical Mental Health Counselors 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.

Rates for LifeCare Counseling and Coaching

Main: 1601 Jones Franklin Road, Suite 104, Raleigh, N.C. 27606 (919) 851-1527 Fax (919) 851-3555
Brier Creek: 8801 Fast Park Drive, Suite 107, Raleigh, NC 27617
Chapel Hill: 1709 Legion Road, Suite 104 & 111, Chapel Hill, NC, 27517
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

Fee Schedule for ALL our Therapists

Psychotherapy 55-60 min (Initial session) (90791)	$200 (only this may be covered by insurance)
Psychotherapy 55-60 min (Ongoing session) (90837)	$170 (only this may be covered by insurance)
Family/Couple Session 55-60 min.	$170 (only this may be covered by insurance)
Psychotherapy 55-60 min Cash rate (No insurance)	Call the office
Supervised Intern	Sliding Fee
No-Show	$150
Late-Cancellation	$75
Telephone Consultation	Based on time required
Reports and Letters	Based on time required
Photocopying	Based on number of pages
Assessment w/written report	Priced individually
Court Preparation/Appearances	$300 an hour

Fee Schedule for our Psychiatric Providers

Complete Diagnostic Interview 75-90 minutes (90792)	$300
Initial Medical Evaluation with high complexity (99205)	$280
Complete Diagnostic Interview 45-60 minutes (90792)	$235
Initial Medical Evaluation with moderate complexity (99204)	$220
Medication Management low complexity 10-15 minutes (99213)	$135
Medication Management moderate complexity or higher 20-30 minutes (99214).	$190
Psychotherapy with evaluation and medication management 20-30 minutes (90833)	$105
Psychotherapy with evaluation and medication management 45-50 minutes. (90836).	$130
Cash rate (No insurance)	Call the office
No-Show	$120
Late-Cancellation	$60
Telephone Consultation $\leq$ 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	$500 per hour

Rates are subject to change.

Consent For Professional Services for LifeCare Counseling and Coaching

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Name: _____ DOB: _____ Date: _____

Scope of this Consent For Professional Services applies to **all providers** at LifeCare Counseling and Coaching. This means if any client or patient ends up seeing more than one provider at LifeCare, then those LifeCare providers can share information between each other on an as-needed basis.

Please INITIAL beside the following:

_____ I understand and agree that the recording of sessions without my provider's knowledge is **forbidden.**

_____ 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)

Payment, Insurance Reimbursement, Cancelation Policy, Rates 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. The No-show fee is the full cash rate fee of the appointment and the Late Cancellation fee is half the cash rate fee of the appointment.

Rates. In surveying other practices in the area, our fee per session is in line with or below the prevailing rates for professional licensed psychotherapy services and psychiatric services. Rates are subject to change. 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 Aetna and Blue Cross Blue Shield of North Carolina, except for Blue Local plans. Some of our providers are also in-network with United Healthcare/Optum and Cigna/Evernorth, 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. Please inform us when you get a new insurance. Your insurance company can request your records, but this rarely happens.

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 receipt to submit to your insurance plan. 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 $300 per hour for preparation (psychiatrists charge $500) 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