Journey Within Marriage and Family Therapy PLLC
Angela Wilkers LMFT

PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship.
The Disclosure Statement is designed to inform you of my professional credentials, types of service offered, fee schedule, and therapeutic orientation and style. You will receive this copy for you records and I will keep the signature pages for my records. Please read this carefully and if you have questions that are not covered here or want further clarification please ask me when we discuss this statement during the session.

Education and Credentials

I received a Masters of Marriage and Family Therapy from East Carolina University in 2007. I have been providing psychotherapy since that time. I am licensed by the state of North Carolina LMFT #1271. I am Rostered as a Trauma Focused Cognitive Behavioral Therapist in North Carolina and I am an approved Clinical Supervisor for LPCA's and a Supervisor in training (Candidate) with the AAMFT for LMFTA's. I work with clients struggling with a wide range of challenges and disorders.

Services Offered & Length of Session

I provide individual, family and couples psychotherapy. Services will be rendered in a professional manner consistent with ethical standards. It is impossible to guarantee any specific results regarding your counseling goals because the outcome is dependent on your work as well as mine. Sessions are 53 minutes in duration. We will schedule our sessions by mutual agreement. If you are unable to keep an appointment, please call at least 24 hours prior to cancel or reschedule. See cancellation policy below.

Counseling Process and Approach

I use Family Systems, Solution Oriented and Experiential theories as a foundation for my practice and beliefs around change and growth. I also utilize strategies from other therapy approaches including CBT, art therapy and play therapy as it fits with my individual clients needs. These theoretical orientations and their accompanying techniques are empirically-based and may sometimes cause some discomfort before relief.

Insurance Reimbursement & Diagnosis

Should you wish to use an insurance policy for counseling services, it is your responsibility to contact your insurance company to inquire about specific coverage for mental health services. Please note that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. I am a provider for Blue Cross Blue Shield. In addition, I work as an out-of-network provider with any other insurance plans that provide out of network coverage. I can only accept HSA cards with a Visa/Master Card logo at this time. Any diagnosis made will become part of your permanent insurance records. Counseling Fee Payment or co-payment is due at the beginning of each session. Regardless of insurance, you agree that you are responsible for payment of all fees for services rendered. Cash, personal checks, Visa, Mastercard, American Express, and Discover are acceptable methods of payment and I will provide a receipt for all fees paid. Private pay rates are as follows: $120 for intake sessions, $100 for family/couple and $90 for individual sessions.

Cancellation Policy

You will be charged $120 for missed appointments or failing to cancel your appointment with 24 hours notice. Please understand that your insurance will not reimburse you for any portion of a missed appointment and you are responsible for the full fee.

Emergencies

I do not provide 24-hour on-call emergency services. You are free to call me after hours and leave a message on my voice mail. *Should you have a mental health emergency and are unable to reach me, please go to your nearest hospital emergency room, call 911, call the Mobile Response Team at 1-800-573-1006, call 1-800-SUICIDE, call your psychiatrist/physician, or a family member/friend.*

Confidentiality

All information shared in session is confidential, with these few exceptions:

(1) For case consultation purposes, I may consult with other therapists, who are required to keep client information confidential.

(2) The State Law of North Carolina requires that suspected abuse or neglect of a child, elder, dependent adult, or developmentally disabled person be reported.

(3) The State Law of North Carolina also requires that others be informed if a client threatens suicide or harm to herself/himself, or others. If that threat is clear and imminent danger, the proper individuals and law enforcement must be contacted.

The person against whom the threat has been made may also be contacted to prevent harm.

(4) Should I be presented with a court order, I may be required to disclose information in the presence of a judge; however, I will first assert legal privilege in an effort to protect your confidentiality.

(5) Information, which may jeopardize my safety, will not be kept confidential.

(6) In the event of a medical emergency on your part, emergency personnel may have to be provided with some of your information.

(7) If you bring a complaint against me with the North Carolina Board of Licensed Marriage and Family Therapists, information will be released.

(8) Children and adolescents must have permission from a parent or legal guardian before receiving services. Confidential information will be shared with a parent or legal guardian only if the child or adolescent is in imminent physical or emotional danger.
(9) If I am made aware that you have a communicable and fatal disease and that you have willfully exposed an identified third party to it.

Complaint Procedures

I adhere to the highest ethical and professional standards. If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, please contact the North Carolina Board of Marriage and Family Therapists for further assistance

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Consent and Acknowledgment of Receipt of Professional Disclosure Statement

I _____ (print name) hereby acknowledge that during the initial contact with Angela Wilkers MS LMFT, we discussed confidentiality and privacy issues. I was provided a written Notice of Privacy Practices dated April 14, 2003, which outlines how protected health information will be treated in her practice. By my signature, I acknowledge that I have read and understand this Professional Disclosure Statement. I consent to therapy with Angela Wilkers MS LMFT, according to the terms described here. I have read the preceding information and understand my rights as a client.

Please initial where applicable:

□ ___ ___ I have been informed about how my privacy and confidentiality will be maintained by Angela Wilkers MS LMFT.

□ ___ ___ I have reviewed and received a copy of the Notice of Privacy Practices.

□ ___ ___ I have read the Professional Disclosure Statement of Angela Wilkers MS LMFT and I have been provided a copy.

□ ___ ___ I consent to treatment and voluntarily agree to participate in all treatment and may stop such treatment at anytime.

□ ___ ___ I intend to use insurance and I do want my therapist to file my insurance claims and have payments sent directly to her. (Please attach insurance card for me to copy.)

□ ___ ___ I do not intend to use insurance and will pay for my sessions out of pocket.

□ ___ ___ I consent to treatment for my child.

_____ _____

Signature of Client Date

_____

Signature of Partner/Spouse Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Angela Wilkers MS LMFT Date