Counseling with Jess

Jess Albright, LCPC, ACS
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Professional Disclosure Statement
And Consent for Mental Health Counseling Services

Licensed Clinical Professional Counselor in Maryland – License No. LC5406
Approved Licensed Professional Counselor Supervisor – No 1268
National Certified Counselor – Certificate No. 254112

I invite you to read this prior to selecting me as your mental health therapist. This information is required by the Board of Professional Counselors and Therapists, which regulates all licensed and certified counselors and therapists. The Board of Professional Counselors and Therapists, 4201 Patterson Ave. Suite 316, Baltimore, MD 21215. 410-764-4732. (2008, ch. 505, § 2.)

Training
B.A. in Art, Art Education, & Deaf Studies, McDaniel College – 2005
M.A. in School Counseling, Gallaudet University – 2008

Areas of Expertise

Anxiety
Depression
Self Injury/Harm
Disordered Eating
Body Dysmorphia (BDD)
Conceptualization of Self/Self-Esteem
Stress Management
Peer/School Difficulties
Separation/Divorce/Other Family Changes
Life Transitions

Professional Organizations of Which I Am a Member
American Counseling Association
Licensed Clinical Professional Counselors of Maryland
National Board for Certified Counselors
Registry of Interpreters for the Deaf

Psychotherapy Philosophy
I believe that for therapy to be effective, both you and I must be actively involved in developing therapeutic goals and assessing progress. In order for the therapy to be most successful, you will have to work on things both during our sessions and at home. Some changes will occur quickly and easily, but more often change requires slow, deliberate, and repeated efforts. You should be aware that while therapeutic interventions offer potential benefits, they also present possible risks. Such risks might include uncomfortable feelings of sadness, guilt, anxiety, anger, or frustration. It is important to weigh the potential risks against the benefits, which might include such assets as gaining insight into your problems, developing coping skills and resources, and changing yourself so that participating in life's daily activities generally becomes a more positive experience. If you have any concerns about your progress or the results of your therapy experience, please talk with me at any time during our work together.

Billing/Fee Schedule

Fees for Service:

Individual session (45-50 min)	$140
Family therapy w/ 3 or more members	$160
Paperwork (first 45 min)	$140
($45 per addition 15 min increments)	

Initial _____

Cancellation Policy

If you fail to cancel a scheduled appointment, I cannot use this time for another client, and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. Thank you for your consideration regarding this important matter.

Initial _____

Payment/Insurance Filing

Payment of fees is expected at the time of each appointment. No exceptions. If for some reason you are unable to pay at the time of service, you have **48 hours** to bring your payment. For your convenience, I do accept major credit cards. Payment must be received by 5:00 p.m. within 48 hours (2 business days). If payment is not received at that time, a $25 late fee will be assessed to your account. You are responsible for paying this fee along with your original payment. Each week your payment is not received, an additional $25 will be assessed to your account.

I do not file insurance claims on your behalf. You may be entitled to reimbursement from your insurance company if you have counseling/mental health benefits. I can provide you with a receipt which will include a procedural code and diagnostic code if necessary, in addition to the date of the counseling session you attended. Once this information is released to you for filing your insurance claims I assume no responsibility for the continuation of confidentiality.

Initial _____

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Initial _____

Confidentiality

In general, the privacy of all communications between us is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. There are some situations in which I am legally obligated to take action to protect you or others from harm. I would inform you of any time when I think I will have to put these into effect. They are as follows: a) If I have good reason to believe that there is abuse of children, elderly, I am obligated to contact Child Protective Services. b) If you are in imminent danger of harming yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection. c) If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim. d) If your records are subpoenaed by court order, I may be required to disclose confidential information.

I take part in regular consultation and support meetings with colleagues. The goal is to gain feedback and suggestions regarding your treatment. In these meetings, I do not use your last name or reveal other identifying information about you. All discussions of this type are subject to the same provisions of confidentiality discussed above.

In the event that I happen to see you in public, for reasons of maintaining your confidentiality I will not greet you unless you greet me first. You are free to greet me or not, but please be aware that my ability to maintain your confidentiality becomes more difficult if either one of us is with another person at that time.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting.

Initial _____

In Case of Emergency
If you have an urgent situation that you feel needs immediate support and I am not available in my office or by phone, please contact one of the following: your primary care physician, call the Frederick County Hotline: 211, go to the nearest hospital emergency room, or call 911.

Thank you for your strength in seeking therapy for your specific needs. I look forward to assisting you in this journey. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____

Signature of Client/ Parent/ Guardian Date

_____

Jess Albright, LCPC, ACS Date

I _____ authorize Jess Albright, LCPC, ACS, to keep my credit card information on file. I understand that my card will be charged a full session's fee for the following reasons: 1) If I do not show for my scheduled appointment or 2) If I do not give Jess Albright, LCPC, ACS, 24 hours notice to cancel my appointment.

Jess Albright, LCPC, ACS, will not use your credit card information for anything other than payment for the services listed above. Jess Albright, LCPC, ACS, will not release the Credit Card information to anyone aside from the service providers allowing for the transaction to be completed. Your information will be kept in a secure location.

Type of Credit Card: Circle

Visa MasterCard Discover American Express

Credit Card Number: _____

Expiration Date: _____

Security Code (Last 3 Digits on the back of card): _____

Address: _____

_____

Signature: _____ **Date:** _____

Printed Name: _____

Clinician's Signature: _____ **Date:** _____