



**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

### **Psychotherapy Philosophy**

Psychotherapy is not a cut and dry process. It varies depending on the personalities of the therapist and the client, as well as the particular issues you wish to explore. It calls for a very active effort on your part. Some changes will occur quickly and easily, but more often change requires slow, deliberate, and repeated efforts. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anxiety, anger, or frustration. On the other hand, therapy often leads to solutions to specific problems, significant reduction of distressful feelings, and improved relationships with yourself and others.

### **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**

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.

Initial \_\_\_\_\_

**Insurance Reimbursement**

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 dates of the therapy sessions 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. 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 by phone, or it is outside of normal business hours, 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.

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Signature of Client/ Parent/ Guardian

Date

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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:** \_\_\_\_\_