Name: _____ DOB: _____

Professional Disclosure and Consent for Services

Professional Disclosure ____ Initial

Please ask your particular therapist about his or her style and theoretical orientation to counseling. Generally speaking, however, our backgrounds, experience, and education lean towards cognitive- behavioral therapy, family therapy, behavior modification, group work, and others. Again, please feel free to ask any questions you may have of your therapist directly or, you may download their resume (if listed) through our website at: www.one-eighty-behavioral.com

Confidentiality _____ Initial

Be assured that what you discuss in therapy will remain confidential. We cannot release information about you without a written, signed consent to release such information. There are, however, some limitations to confidentiality. In cases where there is reason to believe that someone may harm themselves or someone else, we are legally and ethically obligated to release your identifying information to the appropriate persons or agencies to ensure your safety and the safety of others. In cases where there is suspicion of child or elder abuse and/or neglect, we are legally and ethically obligated to report this to the appropriate Department of Social Services. In case of medical emergency, we may contact emergency services on your behalf. Lastly, in some instances, mental health and/or substance abuse information may be subpoenaed by a Court of Law.

Termination of Services _____ Initial

While we will make every effort to resolve any issue you may have, there are a few situations which may result in a termination of your services with us. The following is a list of these situations:

1. Repeated no-shows for appointments
2. Non-payment for services rendered

3. Threatening or dangerous behaviors

4. Your therapist deems that you require a higher level of service than we can provide in private practice

5. Slander or libel involving your therapist and/or 180 Behavioral Health.

***Please note that in any of the aforementioned situations, we will be happy to refer you to another therapist if you like. If you have signed a release of information to the person or agency to whom we will be referring, we will gladly forward your treatment records as well.

180 Clinical Service Providers

Joseph W. Dickson, MA, LPC

Director

LPC-NC Board of Licensed Professional Counselors #4632

Areas of Practice

Adult, Child, Adolescent, and Family
Oppositional and Defiant Behavior
Conduct Disorders
Mood Disorders
Anxiety Disorders
Violence Risk Evaluation Family Dynamics
Substance Abuse
Parenting Issues
Assessment and Diagnosis ADHD
Care Coordination Medical/Behavioral Integration Problems of Adolescence

Grievance Resolution _____ Initial

If, at any time, you feel our behavior or counseling approach is inappropriate, please let us know as we may not be aware of your concerns. We are confident that we can work through most any issue. If, however, you do not feel your concerns are being addressed appropriately, feel free to contact the following:

***Continued on next page…**

North Carolina Board of Licensed Professional Counselors

P.O. Box 77819
Greensboro, NC 27417
Tel. (844) 622-3572 or (336) 217-6007 Fax: (336) 217-9450

Fees and Payment _____ Initial

General Guidelines:

As of April 1st, 2015, 180 Behavioral Health will no longer process insurance information for reimbursement. All services will be charged on a fee-for-service basis according to the fee schedule listed on the next page. You may still submit charges to your insurance company yourself, if you so choose. Please contact your insurance company to inquire about submitting claims prior to obtaining services through 180 Behavioral Health. Please note that you are solely responsible for any charges for services obtained through 180 Behavioral Health, even if you are unable to obtain reimbursement through your insurance provider.

Initial Diagnostic Assessment/Intake

1hr 30 minutes $125.00

Individual Therapy

20-30 minutes $37.50

60 minutes $75.00

> 60 minutes $100.00

Family Therapy w/ Patient Present

20-30 minutes $47.50

60 minutes $95.00

>60 minutes $115.00

Family Therapy w/o Patient Present

20-30 minutes $40.00

60 minutes $80.00

> 60 minutes $90.00

Crisis Intervention Face to Face (as determined by therapist) not occurring at regular appt.

$50.00 per each 30 minutes needed to resolve crisis

Crisis Consultation by phone

$25.00 per each 30 minutes needed to resolve crisis

Patient focused meeting attendance (school, case coordination, etc)

$30.00 up to :30 minutes

$60.00 > :30 but less than or up to 1:00

$120.00 > 1:00 up to 1:30 and $30.00 per each :30 thereafter

Case Consultation by phone (w/ physicians, other providers, etc)

$15.00 for every :30 minutes or portion thereof

No -Show Fee (non- attendance to previously scheduled session)

$25.00

We cannot schedule any appointments for persons with delinquent (over 30 days) accounts. All delinquent accounts over 60 days will be sent to collections.

Returned Checks: There is a fee for any returned check. 180 Behavioral Health will assess a $35.00 returned check charge for any returned check. You will receive notification of this by email or standard mail. The original amount will be charged back to your account and the returned check fee will be added.

No-show Policy: If you are unable to attend a scheduled appointment, please call at least 24 hours prior to your appointment to cancel. It is fine to leave a voicemail with us for this purpose. Please be aware, however, that if the appointment is not cancelled within 24 hours of the appointment time, there is a $25.00 No-show/Late Cancellation Fee that will be billed to your account.

HIPAA _____ Initial

By initialing here, I am stating that I have received a copy of my rights under HIPAA (included in this packet). I have had an opportunity to ask questions and to have those questions answered regarding HIPAA. Your HIPAA information is located at the back of this packet.

Emergencies _____ Initial

If you or your family member has a crisis (angry outbursts, suicidal thinking, threats to harm others, running away, etc) you may call us at 828-263-4480. If, for some reason (poor cell reception, etc) we do not return your call within 15 minutes, and the situation is extremely urgent, please call 911 or your local medical facility. **If, however, there has been a suicide attempt, suicidal threats, homicidal threats, an attempt to seriously harm or assault others, a medical emergency, or any event where the immediate safety and well being of someone is in jeopardy, DO NOT CALL YOUR THERAPIST, PLEASE IMMEDIATELY CALL 911 INSTEAD.**

Please list your child's emergency contact and phone:

Name: _____ Relationship: _____ Phone: _____

Email Correspondence _____ Initial

Email correspondence has become an integral part of everyday life. As such, it is very useful for us to be able to email you (or for you to email us) regarding your care. As a part of our ongoing efforts to maintain technology which assists in creating less of an environmental impact, we use email regularly. Thus, unless you specifically request that we do not email you, you will receive emails containing information about appointments, therapeutic care and coordination, clinical recommendations, and billing. ALL BILLING STATEMENTS ARE SENT BY EMAIL UNLESS OTHERWISE INDICATED. In the space below, please provide your email address so that we may contact you with the information detailed above. PLEASE DO NOT PROVIDE AN EMAIL ADDRESS TO WHICH YOUR CHILD(REN) OR ANYONE ELSE MAY HAVE ACCESS AS THIS MAY RESULT IN A VIOLATION OF YOUR OR YOUR CHILD'S CONFIDENTIALITY. If at any time you believe your email may have been compromised, please let us know and provide any new email address you may have acquired.

Email Address: _____

Mutual Understanding and Agreement

I, _____, have read this document in its entirety. I have had an opportunity to ask questions and to have these questions answered. I hereby state that I understand the policies and procedures contained in this document and agree to abide by these policies. My initials beside each section indicate that I have read, understand, and agree with these sections. By signing below, I agree to the terms as listed in this disclosure statement in its entirety and hereby state that I consent to be seen or to have my family member seen for evaluation, testing, therapy sessions, and/or other treatments my therapist may recommend. I also understand that additional treatment recommendations will be fully discussed with me prior to implementation.

_____

Signature of Client (if 18 or older) Date

_____

Signature of Parent/Guardian Date

_____

Signature of Parent/Guardian Date

_____

Witness Date

_____ _____

**Not valid without 6 pages, the last being the signature page. 2017