

PROFESSIONAL DISCLOSURE STATEMENT

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Professional Qualifications: Master's degree in Counseling, University of New Orleans, LA, 2003, Doctoral coursework in Counseling, University of New Orleans and Georgia State University; Licensed Professional Counselor (#005453). My formal education has prepared me to counsel individuals, groups, families, parents, and children.

Experience: During my master's level internship at the New Orleans Center for Science and Mathematics High School and my doctoral internship at the University of New Orleans Counseling Center, I was trained and supervised in a variety of theoretical orientations. For the past 6 years, I have worked as a counselor in various school settings and at a psychiatric hospital in Tallahassee, FL, New Orleans, LA, and Atlanta, GA.

Competency: In addition to providing individual and couples' counseling, my focus is family play therapy, an intervention that respectfully includes and guides parents in the process of helping their children solve problems. I also provide workshops regarding parenting and developmental concerns.

Informed Consent

During the time we work together, we will meet weekly, or as scheduled, in sessions lasting approximately 50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions you arrange with me except when you may page me. Please do not invite me to social gatherings, offer me gifts, and ask me to write references for you, or ask me to relate to you in any way other than in the professional context of the counseling sessions. You will be best served if our sessions concentrate exclusively on your goals and concerns.

Effects of Counseling

At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed; counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights

Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, although I do ask that you participate in a termination session. You also have the right to refuse or discuss modifications of any of my counseling techniques or suggestions that you believe might not be helpful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the:

Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists
237 Coliseum Drive
Macon, GA 31217-3858
(478) 207-2440

Postponement and Termination

I reserve the right to postpone and/or terminate counseling of clients who come to their session under the influence of alcohol or drugs. I also reserve the right to discontinue counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Cancellation

Your session is reserved for you. In the events that you will be unable to keep an appointment, please notify my office at least 24 hours in advance, so that someone else may utilize this time. In the absence of your notification, you will be billed for the missed session. Also, if you are absent for two consecutive sessions, I may ask to terminate our counseling relationship, and provide you with appropriate referrals.

Referrals

I realize that I am not able to provide appropriate treatment for all of the conditions that clients may have. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide you with some alternatives including programs and/or people who may be able to assist you. A verbal exploration of alternatives to counseling will also be made available to you at your request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Confidentiality

All of our communication becomes part of the clinical record. Records are my property, but you have a right to the information within your record. Adult client records are disposed of seven years after termination of the counseling relationship. Records of minor clients are disposed of seven years after the client's 18th birthday. Most of our communications are confidential, but the following limitations and exceptions exist: (a) you provide me with your consent to release information; (b) I have reasonable suspicion that you are a danger to yourself or someone else; (c) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; (d) you disclose sexual contact with another mental health professional; (e) I am ordered by a court to disclose information; (f) you involve me in a lawsuit; (g) I need to release specific information in order to receive compensation for services rendered; or (h) I am otherwise required by law to release information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Marriage or Family Counseling

I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge any secret to be detrimental to the therapeutic process.

By your signature below, you are indicating that you read and understood this statement, and any questions you had about this statement were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Printed name of Client or Child

Date

Signature of Client or Legal Guardian

Signature of Counselor

Signature of Client or Legal Guardian