Name: _____ DOB: _____Date: _____

Provider: Don Wiggins

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure statement for Don Wiggins, an intern of LifeCare Counseling and Coaching.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable, then a treatment plan will be agreed upon at the end of the evaluation.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said client at this office, unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of $40.00 for any checks that are returned unpaid. I understand if the client balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent.

For when the card on file does **not** belong to the client: I, the financially responsible one, _____ _____
(Print Name) (Signature)
give complete permission that the costs incurred by _____ and any outstanding balances now and going forward may be collected by LifeCare using my credit card number. (Client Name)

____ I certify the following information to be accurate:

___ **No Third Party Payer.** I have no insurance, or understand that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

___ **Contract with church or Third Party.** I have third party coverage with:

_____. I understand there is a contract between this payor and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by this third party.

_____ _____
Client Date

_____ _____
Legally Responsible Person Date

_____ _____
Provider Date

1601 Jones Franklin Road, Suite 104, Raleigh, NC 27606 TEL (919) 851-1527 Fax (919) 851-3555

Don Wiggins, Intern Counselor
Professional Disclosure Statement

Credentials

BS in Landscape Architecture, University of Wisconsin, 1976
MA in Landscape Architecture, Cornell University, 1981
MA in Christian Counseling, Gordon-Conwell Theological Seminary, Charlotte, NC expected May 2018

Professional Experience and Services

This internship is part of my transition in becoming a professional counselor, away from my existing career as a Landscape Architect. I developed my enthusiasm to come alongside people in need and working toward bringing about the hope and positive change in clients that can occur through counseling as a result of my adulthood life experiences. My divorce and subsequent 25 years as a single parent who successfully raised two sons to young adulthood has allowed me to develop an authentic caring for others and create the empathetic environment needed for clients to feel safe in the sharing of their stories and feeling accepted as they participate in their therapeutic process. This personal experience has allowed me to develop a passion to help those struggling with the distress, conflict, and anger occurring during life's adjustment periods; in marriage, relationships, separation/divorce, single parenting, empty-nesting as well as other life changes. I have lead divorce recovery, single parenting, and Bible study groups for over 20 years in several churches within the Triangle area. I counsel adults struggling with depression, anxiety and anger and practice person-centered, cognitive-behavioral, dialectical behavior therapy (DBT) and emotionally focused therapy, as would be needed by the individuals or couples seeking counseling.

Payment Policy

The issue of payment is always a question and we want to explain why we request *payment at the time of service*.

Sometimes clients ask if they can bring the check to us once it is received. This has proven problematic for us in the past. In order to keep our costs competitive, we do not provide administrative oversight for billing services. This requires us to handle payment at the time services are rendered. Any exception to this policy requires agreement from your therapist and a written note of authorization be placed in your file. We greatly appreciate your understanding and cooperation with this request.

Fee Schedule

Psychotherapy 45-50 min (90834)	$40 a session = total household income a year is over $50K
.....	$30 a session = total household income a year is between $20K and $50K
.....	$20 a session = total household income a year is from unemployed to $20K

No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation	Based on time required
Reports and Letters	Based on time required
Photocopying	Based on number of pages
Court Preparation/Appearances	$200

Payment, Insurance Reimbursement, and Problem Resolution

Payment is due at the time services are received. Cash, personal checks or credit cards (Master Card or Visa) are acceptable for payment. If you are unable to keep an appointment, please call to cancel by 12 noon the business day prior to your office visit. Otherwise, you will be charged a fee for the missed visit. No-show and late-cancellation fees are listed above. I will not be filing your sessions with any insurance company.

It is standard practice to give a diagnosis after the beginning of the first session.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that we can address your concerns. If we cannot come to a satisfactory resolution, you may speak further with me or with Maria Lyons, Office Manager.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require my participation, it is expected that you would pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, I charge $200 per hour for preparation and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if I am compelled to testify by another party. An agreed upon amount will be rendered *in advance* and held in escrow. Any left-over amounts will be returned to you upon resolution of the legal matter.)

CONFIDENTIALITY

The confidentiality of your personal health information is very important to us. We may use and disclose your personal information without authorization for the following purposes: abuse, neglect, domestic violence, or court order.
As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence, or court order. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Minors and Disabled Adults

When working with clients who are minors or adults who are legally incapable of giving consent, I will obtain consent from a parent or legally authorized representative. For children who are clients, it will be determined the extent that he or she has an understanding of privacy based on chronological age and cognitive ability. If the child has no concept of privacy, then I am free to share information with parents without informing the child first.

Pre-adolescents and adolescents will be seen on an" informed forced consent" in that information will be handled as confidential, but it is up to the therapist to decide what information is pertinent to share with the parents. Sometimes it is in the best interest of the minor client not to disclose all information to the parents that the child shares with the therapist so as to strengthen the therapeutic alliance and work through issues with the minor. Parents of the minor will be given updates of progress of goals and treatment plans on a scheduled basis. When it is determined that information should be shared for therapeutic reasons or as part of family counseling, the client will be informed and consulted and/or included in sharing the information to the parents or guardians. This of course, is superseded by any of the exceptions of confidentiality (danger to self or others, abuse, or court order) as stated in the above paragraph.

When working with two or more persons who have a relationship such as in a group, family or marriage, I will clarify at the outset who is the primary client as an individual or family unit. I will not share confidences by one family or group member to others outside the family without permission or prior agreement of all members except described in legal exceptions of threat of serious harm to self or others as described above in paragraph one.

Marriage Counseling

With couples specifically, my counseling work will focus on both your relationship and each of you as individuals. In order to maintain fidelity to both of you and your relationship, it is important that we agree on these policies:

1) I may share any information conveyed to me by either of you with the other member of the couple. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in therapy. This includes all verbal, written and phone conversations and messages.

2) If I meet with one or both of you in an individual session, we will likely share the contents of that meeting with the partner in a couples' session in the near future.

3) The continued participation by each person is voluntary. Either participant may suspend or terminate the therapy at his or her individual request. At that time, client confidentiality remains solely with the client who is continuing therapy.

For educational purposes, I will record our sessions. The only person with access to these recordings besides me is my supervisor. In order to serve you better, I may also receive peer supervision from other counselors at LifeCare Counseling and Coaching. This will be done without revealing any of your identifying information.

Please see "Notice of Privacy Practices" for more detailed information about confidentiality of service and records.

_____ _____

Client Date

_____ _____

Counselor Date