Newcastle Family Therapy, PLLC
5200 Park Road, Suite 104E
Charlotte NC 28209
(704) 650-9425

Professional Disclosure Statement

Thank you for choosing Newcastle Family Therapy, PLLC. Starting therapy is a major decision and you may have questions—feel free to ask and I will try my best to provide you with the information you need. This document is intended to inform you of my policies and of your rights as a client. Your rights are also listed in the Notice of Privacy Practices.

Professional Credentials

Laurie W. Howell, LMFT earned a Masters degree in Marriage and Family Therapy from Virginia Polytechnic and State University in 2001. I am a Licensed Marriage and Family Therapist (#977) through the North Carolina Marriage and Family Therapy Licensure Board. My education and experience have prepared me to provide therapy to children, adolescents, adults, couples, and families.

Informed Consent and Counseling Agreement

By reading and signing this document you are consenting to treatment with Laurie W. Howell, LMFT and acknowledging that you have been informed of your rights related to therapy.

Counseling Relationship

During the time we work together, we usually will meet weekly or bi-weekly (depending upon your needs) for 45-50 minute sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contacts will be limited to our sessions together and necessary phone conversations. Please do not offer me gifts or ask me to engage in social activities with you (this includes social networking).

Social Networking Policy

As stated above, this relationship is a professional one and not a social one. With this in mind, I do not interact with patients or their family members online via social media sites such as Facebook, LinkedIn, YouTube, Instagram, Twitter, WordPress blogs, and/or Tumblr. Please be aware that I respect your privacy and will not search your private information online without your consent. There may be a time when social media issues are relevant to your treatment plan and goals, and in this case I would get your written consent to review this material.

Effects of Counseling Relationship

At any time, you may initiate with me a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing therapy. Although I expect you to benefit from therapy, I cannot guarantee any specific results. Therapy 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/or your understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. Although the exact nature of changes resulting from therapy cannot be predicted, I intend to work with you to achieve the best possible results for you.

Record Keeping

Initial paperwork from today, my notes, any billing records, and any work shared and completed during therapy will become a part of your record. Your record is stored in a locked file cabinet.

Cost of services for self-pay clients

The cost of services is $130.00 per session. Payment is expected at the end of each session. Longer or shorter sessions are prorated from these basic fees. A receipt will be provided including all information necessary for insurance carriers and health savings accounts. Phone consultation may be billed as a session if the call exceeds 15 minutes. Written reports requested by clients will be completed at a rate of $50.00 per hour. The cost of services may be re-assessed annually. Cash, check, and credit (VISA/MasterCard) are acceptable methods of payment.

Cost of services for insurance clients

Co-pays, when applicable, are due at the end of each session. You may be expected to pay for the session in full until your annual deductible is met.

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Overdue fees

Payment is expected at the time of the session. However, there are some cases when insurance may be filed prior to payment being expected. In the event that fees have not been paid in a timely manner, I will make reasonable attempts to contact you by phone and by postal service. If the balance has not been paid in a reasonable time frame, I reserve the right to use a collection agency or to inform you on my intentions to file with small claims court in Mecklenburg County. The cost of using these services would be added to your balance due.

Cancellation and No-show Fees

Please keep your scheduled appointments and arrive a few minutes prior to your scheduled appointment time. If you need to cancel an appointment, please provide 24-hours advance notice. If adequate notice is not provided, you may be charged a $75 cancellation/no show fee (unless we both agree that circumstances preventing you from attending were beyond your control). This fee must be paid in full prior to your next scheduled appointment.

Client Initials: _____

Court

It is my policy not to testify in court unless subpoenaed. Fees for court appearances (including preparation and travel time) and court reports will be $250.00 per hour; a $500 retainer fee is due up front and will be applied to any incurred court costs. Court costs are generally not insurance reimbursable.

Confidentiality

Treatment is confidential. This means the client's name and any information about the client will not be discussed without the client and/or guardian's permission. The confidentiality of information you share with me is protected by law and by my professional ethics. **There are several exceptions to laws about privacy that are outlined in the Privacy Practices Notice**. Some of these exceptions include: **Suspected child abuse and/or neglect must be reported; action must be taken if it is determined a client is in danger to themselves or to others; and it is possible that client information/records will be released if ordered by a court**. In the event that I am ever unable to continue providing therapy, either temporarily or permanently; I have requested for my colleagues Trent Morrow, LCSW and/or Marlea Leary, LCSW to contact my clients and offer their services.
I provide the above-mentioned colleagues with a list of my clients' names and numbers.

Emergencies

You may call my office phone (which is also a cell phone number) and I will return your call as soon as I am able. There are times when I may be in session with other clients, but your call will be returned. Please do not hesitate to call 911 or the psychiatric emergency room at 704-358-2800 in the event of a life-threatening emergency.
In the event of an *extended leave of absence* during which I am out of town or unable to manage phone calls due to illness or personal emergency, my voicemail will indicate who current clients should call for assistance.

Contact and Communications/Electronic Communication Policy

Telephone contact: You may reach me by calling (704) 650-9425. Unfortunately, I will not always be available to answer your call. Please leave me a message and I will return your call as soon as possible. This is confidential voicemail.
Email contact: Please feel free to email me at laurie.howell@gmail.com. Please be aware that emails sent from this address are not encrypted. Please limit emails to appointment requests or cancellations. Email is not a substitute for seeing me. If you feel you need to be seen, please call and request an appointment. Email should NOT be used to communicate sensitive medical information such as diagnoses, testing results, or substance abuse information. Emails sent will become a part of your record; a copy will be printed and put in your chart.
Texts: Texts to your therapist, like emails, should be kept to appointment requests, appointment cancellations, or requests for a telephone call.

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Grievances

If you are dissatisfied with any aspect of our work, please talk with me about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you may contact the North Carolina Marriage and Family Therapy Licensure Board, for clarification of clients' rights as I've explained them to you or to lodge a complaint.

Client's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, this provider is NOT required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing this provider. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This provider may deny your request. On your request, this provider will discuss with you the details of the amendment process.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, this provider will discuss with you the details of the accounting process.

Right to Treatment: You have a right to treatment, including access to medical care and habilitation, regardless of your age/degree of Mental Health/Developmental Disability/Substance Abuse disability. The treatment you receive will be age-appropriate.

You have a right to refuse treatment.

You have a right to privacy, humane care, and collaboration with therapist regarding goals.

You have the right to contact us to request a copy of your treatment plan.

You have the right to a paper copy of this notice.

Please sign below indicating you 1) have read and understand this counseling agreement and you consent to treatment and 2) you have read and understand your rights as a client.

Client Name: _____Signature: _____ Date: _____

Legal Guardian: _____ Signature: _____ Date: _____

Therapist: Laurie W. Howell, LMFT Signature: _____ Date: _____