

Cathy Battle, EdS, LMFT, LPC

Counseling

8014 Myrtle Trace Drive

Conway, SC 29526

843 347-5239 phone/fax

www.imagosouthcarolina.com

Information and Consent

I am pleased that you have selected me as your counselor. I welcome you as a new client, and look forward to working with you. This document is designed to inform you about my educational background, my approach to counseling, let you know what you can expect from counseling, and ensure that you understand our professional relationship.

Education, Training, Licensure, and Professional Memberships:

BA of Arts from the University of South Carolina

MEd from the University of South Carolina

EdS from the University of South Carolina

National Board for Certified Counselors #67228 (NBCC) 1999

South Carolina Licensed Professional Counselor #3409 (LPC) 1999

South Carolina Licensed Marriage and Family Counselor #3716 (LMFT) 2001

Advanced Imago Relationship Therapist 2006

Certified Imago Couples Workshop Presenter- "Getting the Love You Want"

EMDR - Level II

The Haden Institute - Dream Leadership Training

The American Counseling Association

The South Carolina Counseling Association

The American Association for Marriage and Family Therapists

The South Carolina Association for Marriage and Family Therapists

Past Board Member SC Association for Marriage and Family Therapists

Clinical Member Imago Relationships International

Confidentiality:

Every thing that is discussed with me will be kept confidential. This applies to conversations with children as well as to adults..

Release of information to others:

- ☞ If your fees are paid by a third party, such as an insurance company, certain details of your treatment must be revealed to the insurance company in order to receive reimbursement. Part of this information is a diagnosis that you and I will discuss before it is submitted.
- ☞ If there is a need to share information in your record with someone such as your physician, or another therapist, you will first be asked to sign a release of information form authorizing your therapist to transfer the information. This authorization may be revoked at any time.

Exceptions to confidentiality:

It is my legal responsibility to preserve the confidentiality of the information that you share with me. However, there are several important instances when confidential information may be released to others without your permission. They are as follows:

- ⌞ If you threaten to harm either yourself or someone else, and I believe your threat to be serious, I am obligated under the law to take whatever actions seem necessary to protect you or others from harm. When possible, I will share my intention with you beforehand.
- ⌞ If I have reason to believe that you are abusing or neglecting a child, or a vulnerable adult, I am obligated by law to report this to an appropriate state agency. This law also applies if you report that you have reason to believe another person is/was abusing or neglecting a child or a vulnerable adult.
- ⌞ It is my policy not to participate in client's legal actions such as custody suits, divorce proceedings, personal injury suits, etc. If you are considering or are involved in such actions. I will help you find another therapist who is experienced in legal matters. Thank you.

Your signature below affirms that you have read this and understand.

Date: _____ Client Signature: _____

Dual Relationship:

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. I am the hired help. The American Counseling Association's ethical guidelines caution against dual relationships. Therefore, our contact will be limited to the paid sessions you have with me. Please do not offer me gifts or ask me to relate to you in any way other than in a professional context. Your interests will be best served if our relationship is strictly professional and if our sessions concentrate on your concerns. The State Code of Ethics also states that sexual intimacy between a practitioner and a client is never acceptable.

Counseling Outcomes:

- ⌞ Each client comes to therapy with unique concerns. For this reason, some clients only need a few counseling sessions to achieve their goals, whereas others need months or even years. At times counseling can deal with painful emotions, challenging situations, and problems. While it is impossible to guarantee results regarding your counseling goals, I can assure you that I will render my services in a professional, ethical manner in hopes of achieving the best possible outcome for you. It is my hope that you will find this counseling experience to be a challenging, growth experience.
- ⌞ I do not have specialized training in treating clients with addictions. If this is a counseling need for you, I will refer you to a therapist with specific training in this area. In cases where I feel another therapist is better suited to meet your specific counseling needs, I will readily refer you.
- ⌞ Completing needed therapeutic goals and ending the counseling process is a primary goal from the beginning of therapy. At times termination can be difficult because a close bond

develops between the therapist and clients. Keep in mind that the ending of treatment is an important step toward successful personal growth. As a client, you may decide to end our counseling relationship at any point. I will be supportive of your decision.

- ⌞ If at any time you are dissatisfied with my services, please let me know. If I am not able to help you resolve your concerns, I can refer you to another therapist, or you may report your concerns to the SC Board of Licensure for Professional Counselors.

Practice Availability:

- ⌞ I work by appointments made in advance. I do not carry a pager, nor am I available 24 hours a day, or seven days a week. If you call during the work week, I will do my best to get back with you that same day. If you call over the weekend, I will most likely return you call on Monday.
- ⌞ When I am gone from the office for an extended period, I will leave a message to that effect on my answering machine. I am a solo practitioner and do not have backup coverage with another counselor. If you have a crisis and I am not available, you need to go to your nearest hospital emergency room or dial 911.
- ⌞ At times you may need extra time and support for your issues. There are options, such as scheduling extra sessions, or making an appointment with a psychiatrist who has 24 hour coverage. Let me know if you need extra support, so I can help you get it.

Signing here indicates you understand my availability:

Date: _____ Client Signature: _____

Billing Policy:

- ⌞ In return for a fee of \$100 per session, I agree to provide counseling services to you for sessions lasting 50 minutes. The fee for each session will be due and must be paid at the **beginning** of each session. Cash, personal checks, or credit cards are acceptable for payment. Please have your money ready when you come to save time in the session. I will provide you with a receipt for all fees paid.
- ⌞ I set aside time in order for scheduled appointments with you. Consequently, I require 24 hours notice if you are not going to be able to attend your session. You can leave a message to that effect on my answering machine. If you cancel less than 24 hours in advance, I will bill you at one half your full fee. Insurance will not cover missed appointments.
- ⌞ When a client has canceled three sessions it is often a sign that their schedule is not allowing time to focus on counseling. I will address this if there are frequent cancellations.
- ⌞ During sessions I ask that you turn your cell phones off.

Insurance:

- ⌞ Some health insurance companies will reimburse clients for counseling services and some will not. It is your responsibility to check your policy and consult with your representative about your coverage. Generally, insurance does not cover marriage and family counseling unless it is related to the treatment of a specific diagnosable problem (e.g. depression or anxiety) for an individual within the couple or family. I am an approved provider with many insurance companies and bill these companies electronically at no extra charge.

- ⌞ If you wish to seek reimbursement for my services from your health insurance company, **it will be your responsibility to pay the total counseling fee if your deductible has not been met** or **if you are in doubt** about your deductible being met. I will reimburse you when the fee has been paid by your insurance company. If your deductible has been met, it will be your responsibility to pay your **co-payment** (percentage of my fee) for counseling services received.

- ⌞ Health insurance companies often require that I diagnose your mental condition and indicate that you have an “illness” before they will agree to reimburse me. In the event a diagnosis is required, I will inform you of the diagnosis I plan to give before I submit it to the health insurance company. I will do my best to release the minimal amount of information needed in order to obtain benefits for you. Any diagnosis made will become a part of your permanent insurance records.

Please sign and date this form below indicating that you understand and agree to my payments, cancellation and insurance policies and that you give permission to release information by your insurance company..

Date: _____ Signature: _____