CAS Counseling Psychotherapy Associates

3622 Lyckan Parkway, Suite 3002, Durham, NC 27707
2310 S. Miami Boulevard, Ste 236, Durham, NC 27703
1042 Washington Street, Raleigh, NC 27604
Phone: (919) 602-6766
Fax: (919) 402-1755
www.cascounseling.com

Client Disclosure Statement – Information and Consent

Congratulations on your choice to pursue psychotherapy at this time. This undertaking is significant and not a decision that one often makes easily. Likewise, the choice of a psychotherapist is important and one that should be made by clear choice and free will, not by pressure or control. Please read the following information carefully, as it will help to establish an understanding between yourself and your therapist, prior to beginning the treatment process.

THE THERAPEUTIC PROCESS:
Psychotherapy is a complex process and not typically described in general statements. There are numerous approaches that can be used to address the problems you are experiencing. Psychotherapy (or "counseling") differs somewhat form standard medical treatment in that psychotherapy often requires a more active effort on your part. In order to be most successful in treatment, you will need to work on change, both in the therapy sessions and outside.

Psychotherapy has the potential of resulting in both pleasant and unpleasant emotions. Unpleasant emotions might include various levels of distress, including sadness, grief, anxiety, and anger, among others. The benefits of therapy in general have been clearly demonstrated. Therapy often leads to a significant reduction in distress, improvement in relationships, resolution of specific problems, personal growth and development, increased clarity regarding one's self and one's goals, and greater self-knowledge. In any given individual case, however, the benefits of therapy cannot be guaranteed, nor would it be possible to predetermine the time required for achieving therapeutic goals.

CONFIDENTIALITY:
The information that you share with your therapist is regarded with respect and complete confidentiality, within legal limits. The privacy and confidentiality of your therapy sessions and treatment records are protected by both State law and by the ethical and regulatory mandates of the professional licensing board of your therapist. Some legal and ethical circumstances can occur, however, which would allow and/or require confidentiality to be broken. These circumstances are: (1) when your therapist has reason to believe that you are intent on inflicting serious harm on either yourself or others; (2) when you reveal information that indicates that a child or senior citizen has been or will be abused or neglected; (3) if a judge in a judicial proceeding orders your therapist's testimony in the interests of justice.

At times clinicians find it helpful to consult with each other regarding their work with a particular client. The goal of such consultation is to lead to better treatment for you and is an important part of ongoing quality assurance. The consultant(s) are legally bound to keep all information confidential. Nevertheless, when and if such consultation occurs, neither your name nor any identifying details will be shared. When insurance is used to pay for all or part of treatment, insurance companies generally require a clinical diagnosis and occasionally expect additional clinical information. If your therapist accepts direct payment from your insurance company or provides direct billing services, your signed consent below allows your therapist to share any required information for billing purposes.

SESSIONS:
Sessions will normally occur once per week. Sessions may become less frequent as treatment nears the end. Unless otherwise arranged, sessions will be approximately 53-60 minutes in length and will begin and end promptly.

In the case of a missed appointment, if your therapist does not hear from you after the missed appointment and has reason for concern, they may reach out to your identified emergency contact to ensure your well-being.

COMMUNICATION:
Due to work schedules, your therapist may not be immediately available by telephone. When your therapist is unavailable, their telephone is answered by a voicemail that they monitor frequently. Your therapist will make every effort to return your call within 24 hours, with the exceptions of weekends and holidays. See the below emergency procedures regarding contact during emergencies.

CAS Counseling Psychotherapy Associates and some individual associates maintain social media accounts for the practice. This account serves to promote services and offer encouragement and resources. It is not a substitute for treatment by a licensed mental health professional and nothing shared should be interpreted as a personal message. You are not expected to "follow" or "like" any CAS Counseling social media accounts based on your work with your therapist. Any direct messages sent via professional social media accounts will be declined.

It is a standard practice of CAS Counseling Psychotherapy Associates to not interact with clients via social media (including Facebook, Instagram, Twitter, Snapchat, LinkedIn, etc). Should you request to friend, follow, or message an Associate's personal social media account, they will decline your request and discuss it further in the next session.

INSURANCE:
Our practice accepts most Blue Cross Blue Shield insurance plans (**please note that we are NOT in network with Blue Home**). If you will be using insurance benefits, your copay is due at the time of service. We will file the claim and you will be informed if any other payments are necessary due to deductibles, insurance denial, etc. We recommend that you contact your insurance provider prior to attending your scheduled intake session and beginning treatment to inquire about mental health benefits, deductibles, and the copay rates for your plan.

If your therapist does not accept your insurance and you would like to use out of network benefits with your insurance provider, your therapist can provide you with a monthly statement ("superbill") to present to your insurance company for possible reimbursement. Out of network reimbursement eligibility or rates of reimbursement vary based on your insurance plan. We recommend you call your insurance provider prior to beginning services to ask about your plan's out of network mental health provider reimbursement.

FEES AND PAYMENTS:
Copays/session fees are due at the time of service. Forms of payment accepted include cash, check, credit card, and HSA card. You may receive a receipt for your payments upon request.

CANCELATIONS AND MISSED APPOINTMENTS:
Please provide 48-hours notice if you must cancel an appointment. If you arrive more than 15 minutes late, you will not be able to be seen for your session. The session will be considered a late cancellation. **A charge of the FULL SESSION FEE is applied when appointments are missed or cancelled with less than 48 hours notice. Missed sessions are not billable to insurance and you will be charged the full fee as published in our fees, not your copay amount or your insurance company's contracted amount.**

Fees are structured as follows:

- 90791 – Diagnostic Evaluation $225
- 90837 – Individual Psychotherapy (53-60 minutes) $170
- 90834 – Individual Psychotherapy (38-52 minutes) $125
- 90832 – Individual Psychotherapy (16-37 minutes) $75
- 90847 – Family Psychotherapy $225
- 90833 – Additional 30 minutes $75
- 90853 – Group Psychotherapy Varies by Group
- Special Documentation and Insurance Reviews (out of network) will be charged in 15 minute increments at $170/hr.

COURT POLICY:
Please be advised that should your therapist be requested to write a letter on any court related matter, they will NOT be stipulating in writing or in person as to an opinion. As your therapist, they may only provide observations and feedback. At no time will they make a recommendation with regard to custody or any other court related matter.

If a court order is served and is requesting that your therapist be present in person and/or there is a request for records, they will request your consent before turning over confidential information. Your therapist will discuss with you exactly what has been requested by court and there is no guarantee that the information can be kept confidential. This information includes mental health history, current status and may not be in your best interest. The therapist-client relationship does not render your therapist as your advocate. Your therapist will withhold any opportunity to engage in a dual relationship in this way.

Should your therapist be ordered by court to write a letter to the court, the time to write such letter shall be billed in 15 minutes increments at $350 per hour. Should your therapist be court ordered to appear in court, the fee stipulation is as follows:

- $1,000 per day plus $170 per hour for travel to and from the court.
- $170 per hour for preparation

Your therapist will not be on-call at any time for court/legal related matters. Should a case be trailed, your therapist will be paid in full for each day as well as an additional $1,000 per day as it hinders their ability to be available to other clients.

All court fees must be received by cashier's check 14 days prior to the court date. Should the court calendar the hearing for another date, your therapist must be re-issued a court order with the new court hearing date.

Should your therapist be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

EMERGENCY PROCEDURES:
If you are experiencing a mental health emergency, please call 911, visit your local emergency room or call Holly Hill Hospital's 24hr intake line at 800-447-1800. Telephone, text, or email contact with your therapist should NOT be used as communication for emergency mental health needs.

DISCONTINUATION OF SERVICES:
Your therapist will work with you to determine the need for ongoing therapy and when it is appropriate for discontinuation of services. If you are not keeping your appointments and/or have had multiple late cancellations or no-shows, you may be discharged from treatment at the discretion of your therapist. If this were to occur, you would be notified by telephone and postal mail, if unable to reach you or leave a voice message by telephone.

PLEASE KEEP THE FIRST 4 PAGES OF THIS DOCUMENT FOR YOUR RECORDS.
SIGN AND INITIAL THE NEXT PAGE AND GIVE IT TO YOUR THERAPIST.
THANK YOU.

Signature Page

YOUR CONSENT:

Your signature below acknowledges having read and understood the information in the "Client Disclosure Statement – Information and Consent." While you are under no obligation to continue the therapeutic process and may terminate treatment at your discretion, your signature provides your informed consent to undergo psychotherapy services with CAS Counseling Psychotherapy Associates, according to the above-stated procedures and conditions. Your signature allows CAS Counseling Psychotherapy Associates to bill and accept direct payment from your insurance company. Your signature also allows CAS Counseling Psychotherapy Associates to release information regarding your treatment to the person you designate (below) as financially responsible for your treatment (if other than yourself).

I understand that a charge of the FULL SESSION FEE is applied when appointments are missed or cancelled with less than 48 hours notice. Missed sessions are not billable to insurance and I will be charged the full fee as published in CAS Counseling's fees, not my copay amount or my insurance company's contracted amount, and that this amount may be charged to my credit card on file.

Initial _____

I understand and consent that in the case of a missed appointment, if my therapist does not hear from me after the missed appointment and has reason for concern, they may reach out to my identified emergency contact to ensure my well-being.

Initial _____

I understand the fee structure of services listed in the Client Disclosure Statement – Information and Consent, provided to me on the date noted with my signature below.

Initial _____

*Note that your signature below acknowledges your personal responsibility to pay for services in the event that neither your insurance nor party you have named below makes complete payment.

I HAVE READ AND UNDERSTAND THE CAS COUNSELING CLIENT DISCLOSURE STATEMENT – INFORMATION AND CONSENT.

______________________________	______________________	___________
Name (print)	(signature)	Date
______________________________	______________________	___________
Guardian Name (print)	(signature)	Date

* Name, Address, and Phone of Person Financially Responsible (if other than yourself):

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