**Lindsay Cooper LAC, LCPC**

410 Central Avenue Suite 308

Great Falls, MT 59401

406-836-7494

**Professional Disclosure Statement Client Information, Agreement and Consent for Treatment**

I would first like to thank you for choosing me to pursue your therapeutic services. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

**Professional Credentials**

I received a Master’s in Counseling, and a Certificate in Addictions Counseling from the University of Great Falls. I have ten plus years of direct counseling experience. I am a Licensed Addictions Counselor along with a Licensed Clinical Professional Counselor in the state of Montana. I am a member of the American Counseling Association. I have had experience working with customer service within the community of Great Falls for a number of years. I have also had experience in the managerial role in group home settings. I have experience working with Individuals, Couples and Group Counseling. I also have experience in areas such as Psychosis; Depression and Bipolar; Crisis Intervention; Anxiety; along with Borderline Personality Disorder.

**Philosophical Base/Counseling Approach**

I operate from a Dialectical Behavioral model standpoint. Along with Dialectical Behavioral Therapy, I also tend to function from a Cognitive-Behavior model. I believe changing one’s thoughts or cognitions, can change one’s dysfunctional behaviors and emotions. Person-centered is another direction I tend to follow. I believe that you are the expert in your life and with positive direction, you will discover your own solutions.

I believe therapy can be helpful in the exploration of yourself and your current situations. Along with the cognitions that tend to be explored in the therapy setting, your feelings may be looked upon as well in this safe and secure environment. I will incorporate many different research based therapeutic approaches within the therapeutic alliance to support you with your presented difficulties.

**Counseling Services**

Counseling is directed by the client and if you choose to end the therapeutic alliance at any time I will support you in your decision. If at any point in the therapeutic alliance, I feel I’m not the right therapist for you, I will make a referral to another therapist.

Some clients only need a few therapeutic sessions, while others may need more. Therapy sessions can be associated with both positive and negative feelings. Negative feelings may arise when discussing unpleasant experiences in your lifetime. Positive feelings and experiences may arise with growth and change.

**Services**

It is impossible to guarantee any specific results regarding your counseling goals. However, I assure you that my services will be rendered in a professional manner, consistent with accepted ethical standards. If you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns about my services, you may report you complaints to the Montana Board of Social Work Examiners and Professional Counselors, Business Standards Division, 301 South Park, 4th Floor PO Box 200513, Helena, MT 59620-0513.

Fees/Cancellations $125.00

Intake/initial consultation $200.00

Individual Counseling $180.00 Per session

Due to the time commitment I make to you, if you fail to show without having given at least 24 hours notice, you will be charged $125.00 appointment fee, which is not covered by insurance. I will not be able to reschedule you if you have not paid the appointment fee. You may leave message 24-hours a day at 406-836-7494 if you are not going to be able to make you appointment. I am currently accepting cash, checks, and credit cards. If a check is returned there will be a $30.00 fee added to the original payment amount.

**Insurance Reimbursement**

Services provided by my office may or may not be covered by your health or medical insurance policy. I am able to file insurance claims for reimbursement with some insurance companies. As a courtesy, I will file with your insurance company for you. Fees are payable in-full at the time of each visit. It is not my general policy to finance services, however, other payment arrangements are sometimes possible, but must be pre-approved. It is also important to understand that I am a separate entity from the insurance company and that the insurance company may reimburse at a different rate then the billed amount. This would not release you from your financial responsibility.

**Use of Diagnosis**

A diagnosis must be made if the client desires reimbursement from insurance or if the client’s care must be coordinated with other health care providers. Once the diagnosis is given, it becomes a part of the client’s records and the same privacy/confidentiality rulings and exceptions apply.

**Confidentiality**

I respect your right to privacy and avoid unwarranted disclosures of confidential information. All information discussed in counseling will be treated as confidential except in instances when the client becomes a serious threat to self or others, when there is an indication of child or elder abuse, when mandated by the law, upon an insurance company’s request for information regarding reimbursement of fees, or for third party billing purposes.

**Emergencies**

Emergency phone calls will be returned as soon as possible. If you feel you are in crisis and need to speak to a counselor immediately, relay this information via a voicemail message at 406-836-7494. If I am unavailable or cannot return your call immediately and you cannot wait for a call back, please call 911 or go to your nearest emergency room. I return phone calls as soon as I am able. I return messages during normal business hours. Normal business hours are Monday thru Thursday 8:00 am to 5:00 pm. If you are calling outside of those hours I will get back to you during normal business hours.

**Ethical Standards**

I subscribe to the code of ethics of the American Counseling Association.

By your signature below, you are indicating that you have read and understand this statement, and that any questions you have about this statement have been answered to your satisfaction.

Your signature indicates agreement and compliance with the aforementioned conditions and receiving client rights information.

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Counselor’s Signature Print Name Date

By your signature below, you are indicating that you have read and understand the Notice of Privacy Practices, and that any questions you have about the Notice of Privacy Practices have been answered to your satisfaction.

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Counselor’s Signature Print Name Date