Relationship ReDiscovery Center
Disclosure Statement Page 1

The purpose of this document is to provide you with important information about your rights, my professional qualifications, administrative policies and a brief description of the counseling process.

Professional qualifications: Diverse educational, employment and life experiences have prepared me to offer counseling services to couples and individuals; addressing relationship issues, life transitions, infidelities, grief and loss, trauma, self esteem, depression, anxiety, ADHD, and other life challenges .

BS in Education from the University of Maine at Farmington in 1979
MS in Counseling from the University of Southern Maine in May of 2000
NCC, National Certified Counselor, Certificate # 62890, June 2000, expires May 31, 2021
LCPC, Licensed Clinical Professional Counselor, Maine, license # CC2120, June 2000, expires June 30, 2022
LMHC, Licensed Mental Health Counselor, Florida, license #MH12390, March 2014, expires March 31, 2021
American Mental Health Counselor Association, member since August 2005

Your Rights: If at any time you have questions, concerns or dissatisfactions please bring the matter to my attention so that we can jointly address the situation.

Concerns and complaints unresolved to your satisfaction may be filed at:
Maine Board of Counseling Professionals Licensure, 35 State House Station, Augusta, Maine 04333; (207) 624-8626
http://www.maine.gov/pfr/professionallicensing/professions/counselors/index.html
Florida Department of Health, 4052 Bald Cypress Way, Bin C, Tallahassee, FL 32399-3260, (850)245-4339
http://floridasmentalhealthprofessions.gov

All counseling services are provided in a professional manner consistent with acceptable professional practices as outlined in the ethical standards of state regulations as well as the National Board of Certified Counselors, http://www.nbcc.org, the American Mental Health Counselors Association, http://www.amhca.org and The Gottman Institute, http:/www.gottman.com.

The Federal Health Information Protection Act (HIPA) also outlines your rights in detail, which is available upon request and at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/

Service Limitations: This clinician's availability is extremely limited outside of session times. Therefore, I am not able to properly treat acute mental health needs include psychosis, hallucinations, active suicidal ideation or needs which require supports beyond weekly sessions. In such cases referrals to more appropriate services will be provided. - The services provided by this office do not include assessments or data collection for forensic purposes; include disability determination, parental assessments, DEEP, anger management or similar kind of needs. Referrals to more appropriately trained providers will be offered.

Confidentiality: All information will be held in strict confidence, except in the following circumstances:
- My counselor will take action if there is a threat of serious harm to myself or others.
- My counselor will take action if there is suspicion of abuse to a child, elder or any incapacitated person.
- My counselor will release Information when court ordered by a judge.
- My counselor will release information to others with my written permission.
- When services are provided to couples, written consent from both is required prior to any information release.
- Your confidential information may be utilized in my counselor's defense, should I take legal action against my counselor or file a formal complaint with any regulatory board.
-My counselor may anonymously discuss your case with clinical supervisors. These colleagues are also bound to the ethical confidentiality rules of the profession.
- When I use my medical insurance, I understand that any related information will be released as required for billing and any audit process as initiated by my insurance provider.
- I understand that if I see this counselor in public, my counselor will not acknowledge me to respect and honor my confidentiality, unless I initiate otherwise.
- I understand that my counselor, at his discretion, will inform me of any required information release, mentioned above, unless such notification could result in greater harm to myself or others.

_____ _____ _____ _____
Client's Signature Date Client's Signature Date

Crisis Support is available 24 hours a day, 7 days a week at: 1-888-568-1112

Relationship ReDiscovery Center
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The Counseling Process: In our first few sessions we will explore these policies, why you are seeking support, any related history and how you have tried to address your issues of concern. Counseling sessions typically are weekly or every other week and will last 45 minutes or longer depending upon insurance eligibilities and your desires. Sessions may include discussion, processing, exploration, and optional homework. Referrals to other possible valuable community resources may be offered as appropriate. Periodically, we will check our progress by revisiting your treatment needs and goals. You always have the right to revise your goals or to end counseling at any time. Once the treatment goals have been met, an additional session is recommended in support of continued success and to evaluate your counseling experience.

There Are Risk: When entering into a commitment of exploration and growth through counseling, very often one will feel worse before getting better. Successes in counseling often include going into difficult life challenges that may have been avoided or hidden because of the related discomforts. Counseling includes exploring these discomforts and finding healthy ways to go forward onto a more pleasurable life experience. Counseling services may also impact ones view of current relationships in their lives. Goals typically include finding ways to gain increased trust and support from family and friends. However, in some cases, counseling can result in distancing within certain relationships and in some cases result in seperation and or divorce. There are no guarantees for desired outcomes.

Gottman Institute Disclaimer: While I have been trained in the Gottman Method of Couples Therapy, I want you to know that I and The Relationship ReDiscovery Center LLC are completely independent in providing you with clinical services and I alone am fully responsible for these services. The Gottman Institute or its agents have no responsibility for the services you receive here.

Rates: Intake Session: $150 / hr. All following sessions: $100/hr /individual: $125 /hr/couple. Returned check fee: $15. Sliding fee adjustments maybe possible upon request.
Payments / Billing: Most insurances are accepted. It is the your responsibility to contact your insurance company before the first session to verify coverage. The client is responsible to pay all fees not covered by their insurance. (See Insurance Guidance at https://relationshiprediscoverycenter.com/forms) Co-payments are collected the day of service. Unpaid balances will be billed monthly. Fee reductions maybe possible upon request.

Cancellations: 48 hours of advanced notice is expected, exceptions include emergencies and extenuating circumstances, Otherwise, a $35 fee will be changed. If a session is missed and you do not call, all previously scheduled future appointments will be removed and made available to others. It is your responsibility to initiate the rescheduling of cancelled and missed sessions.

Over Due Balances: Balances over 60 days due will be subject to a 1.5% service fee per month. If collection services become necessary, you will be held liable for all cost incurred, including collection agency fees, attorney fees, and court costs.

Emergency Response Procedures: I understand that if I present with an emergency; serious suicidal or homicidal thoughts or other high risk life threatening concern, my counselor may request assistance from my emergency contacts and or local authorities.

Emergency Contacts: (Please do not list your partner if you are receiving couple services)

Name: _____ Address:_____ Phone: _____ Relation: _____

Name: _____ Address:_____ Phone: _____ Relation: _____

Your signature(s) indicates that you have received, reviewed and agreed to this Disclosure Statement and you give consent for these services. If you are attending as a couple you also give consent for both to be involved conjointly. You have the right to withdraw this consent at anytime.

_____ _____
Client's Clearly Printed Name Client's Clearly Printed Name

_____ _____ _____ _____
Client's Signature Date Client's Signature Date

Relationship ReDiscovery Center
TeleHealth Therapy: Policies, Procedures and Disclosures

When using my medical insurance as payment for TeleHealth Services (video or phone therapy), I understand that it is my responsibility to contact my insurance company before the first session to verify coverage forTeleHealth Services. (See Insurance Guidance, Form 1 at https://relationshiprediscoverycenter.com/forms) I understand that I am responsible to pay the fees not covered by my insurance.

This form and any other documents containing confidential information are to be exchanged only by HIPA compliant, secure means including; fax 239-345-9743 or mail Relationship ReDiscovery Center, 444 Main St, Lewiston, ME 04240 or through a HIPA compliant electronic method if available.

I understand that these video sessions will be transmitted over HIPA compliant software as provided by Relationship ReDiscovery Center.

I understand that it is my responsibility to supply my own needed technology; cell phones, tablets, laptops, and or desktops computer. I understand that I am responsible for the security of all my electronic devises and related data, including any digital copies of any documents stored on my electronic devises.

I understand I am responsible for my data charges that may occur. These charges may be avoided by using a secure wifi connection. When using Wifi, I understand that it is my responsibly to use only secure password protected wifi connections and not use unprotected public wifi.

I understand there are risk associated with video and phone therapy, including, but not limited to, disruption of transmission by technology failures, interruptions and /or breaches of confidentiality by unauthorized persons.

I understand that there will be no uninformed recording of any session by myself or my counselor. I may give my counselor permission to record session for educational and training purposes by signing a separate consent which I can retract at any time.

I understand that all policies as outlined in the Relationship ReDiscovery Center *Disclosure Statement* also apply to Video and phone sessions.

I agree to participate in TeleHealth sessions while dressed as if I were in public.

I agree to not participate in TeleHealth sessions while driving or while under the influences of substances.

I understand that TeleHealth sessions may not be appropriate in situations of high need; In such cases, referrals to more appropriate services will be offered.

I understand that in case of an emergency, my counselor will need to know my present location. At the start of each session I agree to inform my therapist of my current location. I understand that if I present with an emergency; serious suicidal or homicidal thoughts or other high risk, life threatening concern, my counselor may request assistance from my emergency contacts, as listed on the Disclosure Statement, and or local authorities.

My signature below indicates that I have read and understand the above and give my consent to participate in TeleHealth services.

_____	_____
Client's Clearly Printed Name	Client's Clearly Printed Name
_____ _____	_____ _____
Client's Signature Date	Client's Signature Date

Crisis Support is available anywhere in Maine, 24-7, by calling 1-888-568-1112 or by going to the nearest emergency room.