Mindful Beginnings of Lake Norman
A Counseling and Play Therapy Practice
17105 Kenton Dr. Suite 207C
Cornelius, NC 28031

Sarah Beth Maier, MA, NCC, LPCA

Service Agreement & Professional Disclosure Statement

Welcome**!** I am honored to be able to provide you, your family, and our community with counseling and play therapy services that strive to strengthen family units and promote positive relationships and experiences. I provide the Lake Norman and surrounding communities with professional quality, evidence-based mental health counseling to support individual, family, and community wellness. I am dedicated to practicing with the utmost professionalism, integrity, confidentiality/privacy, respect, and cultural sensitivity in order to create a positive and collaborative therapeutic relationship. I guide clients in the exploration and achievement of their unique, personal needs and goals. My ultimate goal is to help my clients enhance their overall sense of well-being and life satisfaction.

My counseling journey began when I obtained my bachelor's degree in psychology from Appalachian State University in May of 2009. I received my master's degree in Clinical Mental Health Counseling and Graduate Certificate in Play Therapy from University of North Carolina at Charlotte in August of 2014. I am currently a Licensed Professional Counselor Associate (LPCA - #A11452) in North Carolina which means that I am required to complete additional supervision requirements to practice. I am currently under the supervision of Isis Reddick-Umoja, LPC, DCC. Isis can be reached by phone at (704) 733-7475 or by email at ireddickumoja@tpfservices.org. In addition to my North Carolina licensure, I am also a member of the National Board for Certified Counselors.

My experience includes individual and group counseling in a variety of clinical and community settings. I have received extensive training in these areas and have also been specifically trained in the utilization of Play Therapy with children between ages 3 and 12. I have worked with clients struggling with substance abuse, behavioral concerns, normal developmental difficulties, psychopathology, dual diagnosis, and diverse backgrounds. Specific client concerns range from anxiety, depression, defiance, social delays, self-esteem, adjustment to life changes, grief and trauma. Trauma has been an additional area of focus for my work and I consistently work from a trauma informed approach to healing. I have completed supervised work in this area with children, adolescents, and adults exhibiting symptoms of trauma exposure. Throughout my practice, I work from a Cognitive Behavioral Therapy and Person Centered Therapy approach, in addition to incorporating Child Centered Play Therapy with younger children. I firmly believe in the connection of our thoughts, feelings, and behaviors and the influence they have over one another. I also truly believe each individual is built with the strength and capability of directing their own process of growth and healing. I consistently empower my clients to utilize their inner strengths and knowledge of their own needs and desires.

In the process of growing up, children often experience difficulty coping at some time in their lives. It may be as a result of a specific transition to which the child is adjusting, such as divorce or a

significant loss. It is also possible that the source of the child's difficulties may not be easily explained or identified. Whether emotionally, socially or academically, children may exhibit behaviors of concern to parents, caregivers or teachers. Some children may need more help than others at times like these. Child Centered Play Therapy is an established intervention that is developmentally attuned to children and their unique needs. Until children are approximately twelve years of age and develop the ability to use cognitive reasoning skills more fully, they tend to process information and develop their physical, mental, and social skills through their use of imagination and play. Most children, even children who are quite talkative, tend to express themselves more fully through their play. Emotions are often difficult to understand for children and even more difficult to express. Play therapy provides a non-threatening treatment milieu for children to express themselves.

It is important to remember that counseling is a process and there are no instant cures. Some change will be easy; more often, it will be slow and demanding. As with any intervention, there are both risks and benefits. Risks may include experiencing uncomfortable feelings like sadness, anger, frustration, and anxiety. It is also possible to see an increase in children's behaviors as changes are made, interventions are used, and thoughts and feelings are uncovered. Should you ever decide that you or your child's counseling sessions are not as effective as you would like, it is important to discuss these concerns with me. These discussions are pertinent to our work together so that I may provide you with appropriate support and collaboration.

Ultimately, my goal is to help my you or your child address current concerns and grow toward more fulfilling and healthy relationships. I view counseling as a collaborative experience and a safe place where one can explore their thoughts, feelings and behaviors in a non-judgmental atmosphere. The counseling process for children and adolescents will require active involvement of parents/caregivers as we mutually address the issues, concerns and problems and work towards finding effective interventions and outlets for expression. Parents/caregivers of child clients will be asked to participate in consultation sessions outside of the child's scheduled appointments to allow a space where we can freely discuss concerns, observations, and progress. This approach also ensures your child is able to take ownership of their time in the office and upholds a positive atmosphere for initiating change and healing.

Please review the following information and provide the requested signatures to confirm you have received, understand, and agree with my policies, procedures, roles, and responsibilities. Please feel free to ask any questions or present any concerns you may have, and I will gladly address any of these matters with you.

Appointments Acknowledgement and Agreement:

You can schedule an appointment by calling **(704) 534-4283** or by emailing me at **sarahbeth@mindfulbeginningslkn.com.** You may also make an appointment at the end of the counseling session or set up a weekly "standing" appointment. Once a client initiates treatment and signs this agreement, they are considered an active client. A client becomes inactive after 30 days if the client has not been seen in the office. A client is officially considered discharged after 60 days. Therapy sessions typically run a clinical hour, which is 50-55 minutes. I am committed to beginning and ending counseling sessions on-time to respect the schedules and time allotted for every client I serve; therefore, it is important that you understand that lost time is *not* made up at the end of an

appointment if you arrive late. On the rare occasion that I may be running behind schedule, you will be guaranteed to be seen for a minimum of 50 minutes.

If you need to contact me between sessions, you may do so by phone at **(704) 534-4283** or direct email at **sarahbeth@mindfulbeginningslkn.com**. If I am in session and unable to take your call, please leave a message with your name, phone number and a brief reason for your call. **Unfortunately, I am not available 24/7 so if you are in an emergency and need immediate assistance, call 911 or go to the nearest emergency room.** Additionally, if you are experiencing a mental health, substance abuse, or developmental disability crisis, you may call Mecklenburg County's Mobile Crisis Team at **704-566-3410,** and they will assess your urgent needs. Mobile Crisis is available 24/7.

I will respond to you within <u>48 business hours</u> if contacted outside of session via phone or email. Please remember that due to the nature of my business, each session is an hour allotted for *you or your child* as my client. I do not answer calls, texts, or emails during sessions; this courtesy unfortunately limits my ability to communicate quickly outside of session.

Please limit communication via text or email to scheduling and general updates as these are not secure or confidential means of communication. Text messages and email are **not** appropriate means to communicate sensitive, urgent or therapeutic information. Please do not email me content related to your therapy sessions, as these forms of communication are not completely secure or confidential. **You should also know that any text messages or emails I receive from you and any responses that I send to you become a part of your legal medical record.**
In case of a personal emergency, a representative of Mindful Beginnings will reach out to you directly via phone or email to cancel any standing appointments.

Social Media Policy

If you have any questions about our communication outside of session, I encourage you to bring them with me directly. As new technology develops and the Internet changes, there may be times when I need to update this policy. I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Linked In, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

No-Shows/Late Cancellations Acknowledgement and Agreement:

The time you schedule for counseling is reserved specifically for *you or your child*. If you fail to come to your appointment, the hour goes unused. Please notify me as soon as you realize you cannot keep your scheduled appointment. **There are no charges for cancelled appointments provided that you give <u>24 hours</u> notice; however, a fee of $75 will be applied to your account for no-shows and cancellations made with less than 24 hours notice.** This additional fee is not reimbursable by insurance and will be due prior to the start of the next scheduled session.
If you miss a session and owe a no show or late cancelation fee, your credit card on file with IvyPay will be charged. *IvyPay is a secure processing system specially designed for therapists and*

will be covered during the intake session. Please initial below indicating that you understand that your card will be charged for late cancelations.

Please Initial:

_____ I understand I will be charged $75 for no show/late cancelation fees as detailed above.

_____ I will update my credit card information on file with IvyPay if it changes.

Fees Acknowledgement and Agreement:

The full fee is due at the beginning of each session in order for counseling services to be provided. Cash, personal checks, credit cards, and debit cards are all accepted forms of payment, and I will gladly provide you with a receipt for each session if requested. If you anticipate difficulty with payment, please discuss your concerns with me. I strive to provide services to anyone wanting help and will do what I can to accommodate your financial circumstances, even if referring you to an alternate provider may be more feasible for you.
Please note that a $30 charge will be applied to your account for any returned checks. These fees, along with any outstanding balances, must be paid prior to your next session. Should two consecutive sessions remain unpaid, the full balance would need to be settled within one week from the date of non-payment of service in order to be able to schedule further appointments. Additionally, after two declined payments, cash or money order will be the only accepted form of payment to settle the balance and for all future appointments.

Please be sure to contact your insurance company prior to your first session to confirm your mental health and/or substance abuse benefits or that that reimbursement is an option. If you plan to submit your receipt for reimbursement from your insurance company, I will provide you with a "Superbill" upon request in order for your insurance to recognize me as an Out-of-Network Provider.

Should your insurance provider reject your claims, if there is a deductible that needs to be met, *or* if mental health services are provided and not covered by your insurance company for any reason, you are responsible for the full fee as detailed below. Your credit card on file will be charged for any missed payments or when payments are not covered by the insurance company.

Provider Out of Pocket Fees:

- **Individual Therapy:** First session for full 90-minute assessment is $150. Subsequent 60-minute sessions are $115.
- **Parent Consultation:** 60-minute sessions are $115. 90-minute family sessions are $150.

Reduced rates are available for economic hardship. I'm committed to providing clients with the therapeutic services that they need and deserve. Please let me know how I can assist you in the continuity of treatment.

Notice of Privacy and Limits of Confidentiality Acknowledgement and Agreement:

Your therapy is confidential and will not be disclosed to anyone else without your written consent. However, there are at least four exceptions to this rule:

1. If information is conveyed to me that indicates you are **dangerous to yourself or others**, I am required by law to take action, to assure that no one is harmed.
2. North Carolina State law requires therapists report to the Department of Social Services any abuse or neglect or suspected **abuse or neglect of a child or dependent adult**. If this is a topic of concern to me, I will inform you prior to contacting authorities.
3. If you plan to use your receipt for reimbursement by your insurance company, they may inquire about your therapy. No information will be provided without a written *consent for release of information* from you in which, if you choose to release this, your diagnoses and date of service will be the sole information provided unless you specify otherwise. Please be aware that I cannot control how your insurance company uses information about you, and/or your dependent(s) once it is in their possession.

Use of Diagnosis: Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before I submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

4. In rare circumstances, therapists can be **ordered by a judge** to release information. I do my best to keep my clients protected by following the standard ethical practices of keeping case notes brief and refraining from using specific information such as the proper names and details regarding incidents or events which could identify the client or those they come in contact with. The purpose of notes is for our personal use for treatment, not testimony.

Confidentiality also applies to **child and adolescent clients**. This means that as your child's therapist, I may be privy to information, which you, as a parent, could consider important. Except for the above-mentioned conditions, confidentiality must be maintained to assure complete honesty, openness, and therapeutic benefit. Please continue to be watchful of your child and continue to trust your instincts and act when necessary. If your child or adolescent is participating in therapy with me, it is **vital** for you and any other parent(s)/legal guardians, and sometimes other immediate family members, to be present and participate consistently in therapy depending upon the discretion of the therapist and whether including such family members would be beneficial to the process. If you have concerns regarding your child, please feel free to discuss these concerns with me directly.

Client Rights and Responsibilities Acknowledgement and Agreement:

Right to request how I contact you. You have the right to request how I communicate with you outside of session. Please check off below your preferred methods of contact and check off and initial next to the method of contact in which I may leave a message.

Right to release your medical records. You may consent in writing to release your records to others. You have the right to revoke this authorization, verbally or in writing, at any time; however, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records. You have the right to inspect and obtain a copy of the information contained in my medical records. Under limited circumstance, I may deny your request to inspect and copy records, particularly in matters of family counseling. If you ask for a copy of any information, I reserve the right to charge a reasonable fee for the costs of copying, mailing, and supplies.

Right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend the record. I will decide on your request within 30 days. Under certain circumstances, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree with this decision. Your statement and my response will be added to your record. I will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures. You may request an accounting of any disclosures, if any, I have made related to your medical information, except for information used for treatment, payment, or health care operational purposes that I shared with you or your family, or information that you gave us specific consent to release. It also excludes information I was required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing. I will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing. However, I am not required to agree to such a request.

Right to file a grievance. Although clients are encouraged to discuss any concerns with me directly, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics, which can be found at the link provided: www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx. **Individuals will *not* be retaliated against for filing such a complaint.** If you wish to file a complaint, you may contact the North Carolina Board of Licensed Professional Counselors at P.O. Box 1369 Garner, NC 27529 (P) 919-661-0820 (F) 919-779-5642 or email ncblpc@caphill.com.
Right to receive changes in policy. You have the right to receive any future policy changes secondary to changes in State and Federal laws.

Authorization to Receive Treatment Acknowledgement and Agreement:

Authorization for Treatment: I voluntarily request and consent to routine diagnostic, prevention, and therapeutic services and procedures. I authorize the performance of appropriate treatment, including diagnostic and therapeutic treatment that may be determined necessary or beneficial by the provider in care of the consumer. I understand that the practice of behavioral treatment is not an exact science and acknowledge that no guarantees have been made as to the results of treatment or care.

Follow-Up: I agree to be contacted after I leave services in order for Meagan McCabe, MA, LMFT to inquire about my condition and satisfaction with services.

Authorization for Emergency Treatment: In case of an emergency, I authorize Sarah Beth Maier, MA, NCC, LPCA to obtain emergency treatment from my family physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum necessary health information, written or verbal, may be released to emergency treating providers to meet the needs of the emergency.

Client Rights and Responsibilities: I have received *Client Rights and Responsibilities* information that explains consumer rights and responsibilities. I have also received additional information that explains the consumer grievance process. I understand that I may ask questions for clarification if I have questions or concerns. I agree to keep all information about other individuals confidential and will not disclose or discuss with any person or agency.

Court Testimony, Custody Matters & Consultation Acknowledgement and Agreement:

I, _____, understand that Sarah Beth Maier, MA, NCC, LPCA solely provides therapeutic services. I understand that she will evaluate and/or treat me or my child with the ultimate goal of helping move toward wellness and recovery. I also understand that **she will not participate in the determination of disability or make specific recommendations on child custody or fitness to parent**, but can refer me to another practice, agency or professional that does provide disability and/or custody evaluations.

This contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for any reason. All parties acknowledge that the goal of therapy is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore, it is understood by all parties that if they request my services as a therapist, they are expected not to use information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

_____ **Date_____**

Signature of Client

_____ **Date_____**

Signature of Legal Guardian | *Relationship:*

_____ **Date_____**

Signature of Legal Guardian | *Relationship:*

If I am requested to testify in court on your behalf despite the above agreement, you will be billed at a rate of **$350.00 per hour to include travel time, mileage, time preparing notes, forms or files, time directly spent in court, speaking with attorneys or other involved parties, or any other required court testimony responsibilities. Court appearances can be very costly and <u>are not reimbursable by insurance</u>.

Methods of contact: During and after treatment I may be contacted in the following way(s):

( ) Cell Phone: _____ ( ) Leave a voicemail message

____(client(s) initials) ____(legal guardian(s) initials)

( ) Email: _____

____(client(s) initials) ____(legal guardian(s) initials)

( ) Home Phone : _____ ( ) Leave a voicemail message:

____(client(s) initials) ____(legal guardian(s) initials)

Release must be signed if granting permission to speak with someone other than you.

*****I understand it is my responsibility to inform my therapist, in writing, when I desire changes in the method of contacting me.*****

Notice of Privacy Practices: I have also received, and had the opportunity to read, the *Notice of Privacy Practices* that explains how confidential information about me is used and disclosed by my therapist. I understand that I should ask questions or discuss any concerns at the time of my first contact with my provider. I understand that I may request restriction(s) on how confidential information is used and disclosed, and that in specific situation my request for restriction(s) may not be honored because of the State and Federal laws or other special situations.

My signature indicates receipt, review, understanding, and agreement to all of Sarah Beth Maier's policies, procedures, acknowledgements, agreements, and forms including:

Office Hours and Appointments	***Notice of Confidentiality and Limits***
Client Rights and Responsibilities	***No Shows/Late Cancellations Fees***
Authorization to Receive Treatment	***Fees***

_____ **Date**_____

Signature of Client

_____ **Date**_____

Signature of Legal Guardian

_____ **Date**_____

Signature of Legal Guardian

_____ **Date**_____

Signature of Witness (Therapist)