PROFESSIONAL DISCLOSURE STATEMENT & INFORMED CONSENT

Qualifications: I am a licensed professional counselor supervisor (LPC-S) in the state of Texas. I hold a Bachelor of Arts from McMurry University (Abilene, Texas). I then received a Master of Arts in Counseling and a Ph.D. in Educational Leadership, from Prairie View A&M University. I have worked at a psychiatric hospital in Houston, at serval non-profit organizations counseling families and children, as a school counselor in Fort Bend ISD and Houston ISD, and at a local college as a counselor. I have a passion for working with youth and children and have done so for the last 13 years.

Nature of Counseling: My belief is that the counseling process is a collaborative partnership between therapist and client(s). Working together, we will explore current concerns and develop goals which are measurable and realistic. It is important to realize that it will be difficult to achieve progress in counseling if you are unable or unwilling to complete homework assignments, arrive to appointments on time, or be completely honest with your therapist always bringing up your thoughts and concerns. I utilize a significant amount of Cognitive Behavioral Therapy and Solution Based Therapy. I work with my clients to integrate their own concerns about life and beliefs to move past barriers and fears toward success.

Please initial indicating that you have read and understand the above section: _____

Counseling Relationship: Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. I cannot be invited to social gatherings, receive gifts, write references for you, or relate to you in any way other than the professional context of our counseling sessions. I highly value our professional relationship and am confident that you will be best served if our sessions concentrate exclusively on your personal concerns.

Please initial indicating that you have read and understand the above section: _____

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your perspectives and decisions. Some of these changes could be temporarily distressing. I ask that if you are concerned about anything you are experiencing as part the counseling process, you please initiate a discussion with me immediately. The exact nature of changes within yourself cannot be predicted. Together we will work to achieve the best possible results for you.

Please initial indicating that you have read and understand the above section: _____

Client Rights: Some clients need only a few counseling sessions to achieve their goals; other may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. You also have the right to refuse or discuss modifications of any of my counseling techniques that you believe may be helpful to you.
I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540

Please initial indicating that you have read and understand the above section: _____

Postponement and Termination: I reserve the right to postpone and/or terminate counseling of clients who come to their session appearing under the influence of alcohol or drugs. I also reserve the right to discontinue counseling of clients who do not comply with the medication recommendations of their psychiatrist or doctor. If at any time, I assess that you are no longer benefiting from our counseling relationship, I have the right to terminate our relationship after first discussing my assessment with you.

Please initial indicating that you have read and understand the above section: _____

Appointments, Cancellation and Crises: Counseling sessions last 45-50 minutes. In the event that you cannot keep your scheduled appointment, please notify me at least 24 hours in advance. If you do not cancel your appointment at least 24 hours prior to your appointment time or do not show for a scheduled appointment you will be billed $60. Messages may be left for me on my voicemail. In respect to our clients, clients arriving late for a session will receive their normal appointment slot and will be responsible for the full fee. 15 minutes is the customary time I will wait for a client. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room.

Please initial indicating that you have read and understand the above section: _____

Fees: In return for a fee of $100 per session, I agree to provide counseling services to you (January 1, 2018 sessions will increase to $110 per session). The fee for each session must be paid in full at the time services are rendered. Cash, personal checks made out to "Hope Pamplin, LPC-S" and pay pal payments are accepted. If a check is returned, you will be billed a processing fee of $25. After a returned check, I reserve the right to require cash for future sessions. If you are choosing to pay via your insurance company, I will bill the insurance company. It, however, is your responsibility to educate yourself on your insurance's policies related to out of network benefits. If a claim you file is denied, it is your responsibility to address this with your insurance company. I do not communicate with insurance companies on your behalf.

Please initial indicating that you have read and understand the above section: _____

Records and Confidentiality: All of our communication becomes part of the clinical record. Records are property of Hope Pamplin, LPC. Adult records are disposed of seven (7) years after services end. Minor client files are disposed of seven (7) years after the client's 18th birthday.

Most of our communication is confidential, but the following limitations and exceptions do exist:
a) I am using your case records for purposes of peer supervision, training, or professional development. In such cases, to preserve confidentiality, I will identify you by a pseudo-name and change other identifiable characteristics (i.e., sex, marriage status, age),
b) I determine that you are a danger to yourself or someone else,
c) You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person,
d) You disclose sexual contact within the context of a professional relationship with another mental health professional,
e) I am ordered by court to disclose information,
f) You direct me in writing to release your record,
g) I am otherwise required by law to disclose information.
If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family's or spouse/s/partner's knowledge. However, I do encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge any confidential disclosure to be detrimental to the therapeutic process.

Please initial indicating that you have read and understand the above section: _____

By your signature below, you indicate that you have read and understand this complete document, any questions that you have about this statement have been answered to your satisfaction, that you were furnished a copy of this statement, and consent to enter a counseling relationship Hope Pamplin, LPC-S By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____ _____

Client's Signature Date Hope Pamplin, LPC-S Date

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices
(review and retain following pages)

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____ _____

Client signature (parent or guardian if minor patient) Date