

John DeMarco M.Ed., LPC
LICENSED PROFESSIONAL COUNSELOR
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License No. 37PC00115000

STATEMENT OF UNDERSTANDING

The words “your counselor” in this document mean John DeMarco M.Ed., LPC.

1. Limits of Confidentiality—Your counselor will keep your counseling records and everything you (or your minor child) discuss strictly confidential, except for matters pertaining to:

- Suicide or self-harm
- Harm to another person or property
- Physical/sexual abuse or neglect of minors, persons with disabilities, and the elderly
- Information about your diagnosis and dates of treatment requested by your insurance company to process your claims
- Consultations with other appropriate mental health professionals regarding treatment decisions on your behalf. Your confidentiality is still protected during consultations by your counselor and such professionals.
- Court ordered disclosures, and anything else required by law
- Disclosure of your name and services provided (e.g., individual counseling) in the event outside agents are used to collect fees that have been neglected to be paid.

2. Referral to Additional Services—If your counselor, after a review of your needs, recommends an educational, vocational, medical, psychiatric or psychological evaluation, it is your counselor’s policy that you comply with this recommendation and provide to your counselor written permission to communicate with these professionals. This will enable your counselor to have important information he/she may need to ensure that you receive quality and necessary care. Non-compliance with this policy will necessitate the discontinuance of services from your counselor, as could failure to comply with recommendations from these other professionals.

3. Consultation and Supervision—Please be aware that your counselor has a professional responsibility to provide you with the best possible services. Therefore, your counselor may be discussing aspects of your case, if and when necessary, in consultation or supervision with appropriate mental health professionals.

4. Referrals to More Appropriate Services—If, during counseling, it is found that the services offered by your counselor are not suitable to your needs, your counselor may recommend other more appropriate resources and will assist you in any reasonable way to make contact with such services. If, for a particular reason, another resource or service is recommended by your counselor, your counselor then reserves the right to discontinue services to you if you do not accept the recommendation(s).

5. In-session Client Crisis—If another client during a session prior to your session experiences an in-session crisis, it may necessitate abruptly canceling your appointment. Your counselor will either reschedule an appointment with you or contact you as soon as possible to do so.

6. Crisis Intervention—Other than attending to an in-session client crisis, your counselor does not provide crisis intervention or emergency services. If you experience a crisis or emergency call 911 or go to the emergency room of the nearest hospital.

7. Length of Sessions—A clinical session is one fifty (50) minute period of time.

Initials of client or person authorized by law: _____
Date _____

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Date _____

8. Telephone Consultation—Telephone conversations that you initiate with your counselor are billed per minute based on your regular therapy session fee (i.e. the fee divided by 50 equals the per minute charge). Telephone consultations may not be billable to your insurance. There are no fees for calls you make regarding cancellation or rescheduling of appointments. Additionally, your counselor’s primary telephone for interacting with you is a

cellular telephone, and as such is not a secure line, and therefore your counselor cannot guarantee privacy while talking to you on the telephone.

9. Cancellations and Missed Sessions—If you must cancel an appointment, your counselor requires that you provide a minimum of 24 hours advanced notice. If you give notification to cancel in less than 24 hours, or if you fail to call at all to cancel, you will be charged a \$40 service fee. This fee is not billable to your insurance. After two consecutive “no show” sessions, your relationship with your counselor may be discontinued.

10. Authorization to Release Information—Your counseling records and discussions are strictly confidential. With very few exceptions (as required by law), if there is ever a need for your counselor to communicate with people outside of your client/counselor relationship, you will need to sign an authorization for release of information form. If your counselor believes it is in your best interests to communicate with your family, a medical, mental health or other professional or organization/service, your counselor’s policy is that you grant permission in writing. Failure to cooperate with this policy will result in discontinuance of counseling services.

11. The Nature of Therapy—Please be aware that counseling is a process in which you share a responsibility for the outcome. You will need to become actively involved. It is a process that frequently requires time for changes to occur. Often, during the course of counseling, additional problems may become identified, which were not known by your counselor or by you at the onset of counseling. As you and your counselor discuss your problems, you may at times experience depression, frustration, fear, anger, uncertainty, guilt, anxiety, confusion, sadness, unpleasant memories, or other painful experiences. However, as you might expect, many clients experience positive outcomes, too. Among them are increased assertiveness, self-confidence, greater job satisfaction, improved interpersonal relationships, enhanced decision making ability, greater self-understanding, independence, and stronger motivation. Additionally, if you are requesting marital or relationship counseling, please be aware that divorce, or the end of a relationship, is still a possible outcome for some couples. Unfortunately, counseling cannot guarantee the expected changes that may or may not occur for individuals, couples, or families.

12. Marriage Counseling— Information discussed in marriage counseling is for therapeutic purposes and is not intended for use in any legal proceedings involving either of you. By signing below you agree not to subpoena your counselor to testify for or against either party or to provide records in a court action.

13. Request for a Letter or Documentation— The preparation of a letter or document by your counselor disclosing any of your counseling information, is billed at your regular therapy session fee per letter or document. The fee is not reimbursable by your insurance. The request must be made a minimum of two weeks in advance of when you want it and you must: (1) furnish the accurate name and address of the letter’s recipient and (2) sign an authorization for a release of information form.

14. Termination—Ideally termination occurs when you have achieved all of your counseling goals and a therapeutic closure of your treatment was completed in the last session. However, should you miss a session and not reschedule a next appointment your counselor will assume you are discontinuing therapy. After 10 business days, if you have not rescheduled a next appointment, your counselor will close your file and consider you as a termination without closure.

15. Closing Your File—As a client, once you have completed therapy, your file will be considered active and will remain open for 60 days following your last date of service. If there are no services provided after the 60th day, your file will be closed and your case will be considered terminated. Of course, you are welcome to again request services from your counselor at any time in the future. Your counselor will retain your file for a period of seven years following the last date of service provided to you. After that seven-year period, your file will be destroyed in a professional and confidential manner.

16. Insurance Claims—If you are using your health insurance to help with the cost of your counseling, it is important for you to be aware that insurance companies vary in terms of the amount of client information they require when determining reimbursement. Your counselor *strongly advises that you speak* with your insurance

company concerning this important matter. Your counselor will release all requested information to your insurance company unless otherwise directed by you.

17. Confidentiality for Couples and Families—Partners and family members may attend a counseling session together (conjoint session) and each individual member may attend alone for a private session. Whenever a member attends a private session his or her disclosures are

Initials of client or person authorized by law: _____
Date _____

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Date _____

respected as confidential and every effort will be made by your counselor to keep confidentiality during subsequent conjoint sessions. However, you need to accept that inadvertent breeches in this type of confidentiality are possible during conjoint sessions and that you agree to the risk.

18. Duel Relationships—Your counselor relates to you professionally and is ethically responsible not to enter into a personal relationship with you.

19. Copy of Your File—Any request by you for a copy of your clinical file, in whole or in part, must be made in writing with your signature and dated; and must contain an explanation of the intended use of the copy. If your counseling is conjoint with other individuals entitled to confidentiality, their consent and signatures are also required. Any information in your file pertaining to an identified individual or individuals outside of the counseling relationship will be edited out of the copy. A service fee of \$3 per page will be charged.

20. Payment Procedure—Payment for a session is required at the beginning of the session. It is your counselor’s policy, that when payment is not made for a session it is expected that at your next session you will make payment in full for both the previous (unpaid) session and the immediate one. Failure to follow this policy will result in termination of service. Additionally, should you default on paying your balance due, your counselor has the option of using legal means to secure payment including using collection agents, attorneys, or small claims court. Further, upon non-payment, your counselor also reserves the right to report the “bad debt” to relevant credit bureaus. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim and you as the client, or responsible party will be accountable for all costs of collection, litigation, and attorney’s fees. In such cases, the only information that is released about your treatment would be your name, the nature of the services provided (e.g., individual counseling), dates of service, and the amount due.

21. Non Sufficient Fund Check (NSF Check)—In the event that you make payment to your counselor with a NSF check (bounced check), and consequently your counselor incurs a banking penalty fee you agree to reimburse your counselor for the incurred penalty. Failure to follow this policy will result in termination of service.

22. Unattended Children in the Waiting Room—Children under the age of fifteen are not permitted to wait in the waiting room without the supervision of an adult at all times. If you bring your child to the counseling office he or she will have to attend the session with you.

23. Food and Beverages—Food, beverages, and gum chewing are not permitted in the office or waiting area. Bottled water only is permissible.

24. Scheduling Appointments—You are expected to schedule your next appointment during your counseling session. If you are unable to do that then you are expected to contact your counselor within seven (7) days of your last appointment and schedule your next appointment. Otherwise your counselor cannot guarantee that your preferred appointment time or any time will be available, in which case you may have to wait for time to become available again.

25. Agreement Priority—This statement of understanding replaces and supersedes any previous statement/s of understanding you have acknowledged and signed.

I/we, have read and understand this policy statement or my/our counselor has explained it to me/us.

I/we, also certify that I/we am/are voluntarily seeking treatment from John DeMarco M.Ed., LPC or that as the parent/guardian, I/we give my/our consent to treatment of my/our minor child(ren) by John DeMarco M.Ed., LPC.

Client Signature

Date

Client Signature

Date

Parent/Guardian Signature

Date

Counselor Signature

Date