Tracy Carter

M.S., L.P.C., LLC

Licensed Clinical Professional Counselor

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INFORMED CONSENT

I am pleased you have chosen me to provide you with your counseling needs. This document is designed to inform you about my counseling practice and policies, my theoretical orientation and background, rules and regulations, and your responsibilities of being an effective person as part of the counseling process. This is yours to keep. I will need you to sign the last page and return it to me for my records. Please feel free to ask any questions.

INTRODUCTION

I am a Master's level Licensed Professional Counselor in Maryland and West Virginia. I am not a doctor. I am certified by the National Board of Certified Counselors, a private certifying agency. This license grants me the authority to conduct counseling to children, individuals, families, and couples.

I have a Master's degree in Psychology from the University of Baltimore. I have also graduated from the University of Baltimore's Licensed Clinical Professional Counseling Program.

I am also a Certified Brain Trainer and have successfully fulfilled the certification criteria set forth by NeurOptimal Certification course.

THE COUNSELING PROCESS

I cannot guarantee any results from you engaging in counseling with me; however, I will always work with you to the best of my training, knowledge, and abilities. If I, at any time, feel I am unable to help you, it is my ethical duty to refer you to another therapist that may better suit your needs and I will assist you in finding the appropriate one.

Counseling sessions are normally 45 minutes and will be scheduled in advance unless it is an emergency. An emergency is considered to be a life threatening event that may put your life and/or someone else's life in danger because of your actions. In the event of an emergency, you should immediately call 911 or go to the closest emergency room.

You may contact me several ways. I can be reached via my cell phone at 410-598-3186, email at cartertracy@comcast.net or by texting me at 410-598-3186. Please do not disclose your full name if you are texting me. Please provide me with your first name and the first initial of your last name only. Texting and emailing are not for the purpose of therapy. It is for the convenience of quick communication involving appointments and scheduling. Please do not email or text me if you are in an emotional crisis. It is always best to call me first on my cell, but please be informed that I DO NOT provide 24/7 on call services.

COUNSELING APPROACHES

I use a variety of counseling techniques and approaches depending on what particular family or person presents at the initial interview. This may include, but is not limited to, cognitive behavioral therapy, behavior modification, anger management, family systems theory, trauma reprocessing (EMDR), solution focused, relaxation training, insight oriented, and parenting skills. Every effort is made to tailor the therapy to fit your needs and to involve you in treatment decisions.

CONFIDENTIALITY

I comply with the professional counseling ethics as set forth by the American Counseling Association (ACA). I will keep confidential all that you share with me EXCEPT in the following situations:

1. If you direct me to tell someone else.
2. If I determine that you are a danger to yourself or others.
3. If I am subpoenaed and ordered by a judge to disclose information.
4. If I suspect or you report the abuse of a child, elderly person, or disabled person.
5. If your insurance company requests information regarding your care for financial reimbursements.

6. Information as released in the HIPAA notice of privacy practices.
7. Consultations with other therapist as necessary and appropriate.

Except in the circumstances described above, information about you will not be released without your written permission. Once information is released to a third party, the third party recipient is responsible for how the information is handled. You have the right to revoke at any time your consent to release information.

Families, couples, and group counseling involves multiple members within a session. In this case, every effort is made on my part to provide confidentiality to each member in order to build and maintain a therapeutic relationship. However, I cannot guarantee that the information discussed in these sessions will remain confidential by the other members within these sessions.

When working with children, I will usually respect any wishes he/she may have for me not to share information with you. This may include things such as drug use, alcohol use, and sexual behavior. This is for the purpose of getting the child to comfortably and honestly "open up" in the counseling process. If you object to this, please tell me right away.

BILLING/FINANCIAL ISSUES

The following is a list of my routine fees for my services:

Initial session	$200.00
Follow-up sessions	$165.00
Extended Sessions	$200.00
NeurOptimal Session	$150.00
Court appearances	$800.00 up to 4 hrs, $1600.00 up to 8 hrs
Written correspondence	$35.00
Late cancellations/No-shows	$75.00

Payments, including copays and deductibles, are payable at the time services are rendered. I accept credit cards, cash or checks. I do participate with many insurance companies and will make a good faith effort to collect payment from them. However, if in the event, your insurance company denies payment, the sole responsibility for payment will be yours. If you do not pay your bill within 30 days of the billing statement, I reserve the right to send your account to a collection agency. If this is the case, you will be billed the full amount of any and all collection agency fees.

If I am ever called to testify, for or against your interests, as either a lay witness, expert witness, or in any other capacity, with regard to matters concerning my counseling services to you or your ward, the rates posted within this agreement will apply. The rate must be paid in full 7 days prior to the

hearing date. Additionally, this fee is a reflection of my preparation and guaranteed availability for the hearing and is not refundable should the hearing not occur.

Phone calls for the purpose of scheduling appointments and other general information are not a charged a fee; however, telephone calls that are therapeutic in nature and lasting more than 5 minutes will be billed at the rate of $30.00 per 10 minutes.

A cancellation notice of at least 24 hours is required. If in the event that you do not give the appropriate notice, YOU WILL BE RESPONSIBLE FOR A FEE OF $75.00.

BENEFITS AND RISKS OF COUNSELING

There are risks to counseling. Some risks to counseling include, but are not limited to, experiencing uncomfortable thoughts and feelings, being distressed by unpleasant memories, and experiencing relationship difficulties. Couples may even decide to divorce as a result of counseling. Some individuals, despite my best effort, may find no benefit from counseling. Some people may even feel worse as a result of the counseling experience.

There are also benefits to counseling. They may include a reduction of or control over distressful feelings or emotions, overall improvement in self concept, and overall improvement and satisfaction in relationships. But as mentioned earlier, I can not guarantee that your counseling with me will be successful.

HOW TO MAXIMIZE YOUR BENEFIT FROM THE COUNSELING PROCESS

Counseling can be very brief or it can be quite lengthy. I would encourage you to look at the counseling experience as a journey of healing. There is much you can do to contribute to the success of your counseling. I recommend for you to:

1. Think about how much time and effort you want to devote to making the changes you want.
2. Take an active role in counseling: ask questions, don't be afraid to challenge me as to what I am saying and tell me when something doesn't work for you. Don't be concerned about my feelings; after all, this is your therapy and not mine.
3. Be truthful to the best of your ability.
4. Decide to step out of your comfort zone.
5. Understand that no amount of counseling will change those things you do not have direct control over.

CONSENT TO TREAT MINORS

If you are under the age of 18, you need a parent or guardian's permission to consent to therapy. If you are the parent of a child or children, and are divorced from your spouse, you must provide me with a copy of the custody agreement. This provides me with the legal evidence that you have the right to make the medical/mental health decisions for your child. If you are the guardian, I will also need the court documents assigning you guardianship over the designated minor. Please understand, at times, I may need to get permission from several parties in order to treat a certain child or children.

TERMINATION OF THERAPY

It is important that you understand that you can stop counseling with me at any time for any reason. I will typically not end our counseling relationship before you are ready. I do, however, have the ethical obligation not to continue with you if I feel I am unable to help you as mentioned earlier. However, it is possible for unforeseen circumstances to force me to end the relationship. In such instances, I will provide you with a referral to another therapist.

KEEPER OF THE RECORDS

If I would become incapacitated in any way that would prevent me from continuing my counseling business, your records will be held and managed by Cheri Timko, M.S., L.C.P.C. She can be reached at 304-680-7622.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I have read the information in this informed consent agreement with Tracy Carter, M.S., L.C.P.C., L.L.C. My signature indicates that I understand and have voluntarily agreed to the conditions of therapy that are either stated or implied within this agreement. I understand the potential risks and benefits to counseling and hereby agree to enter into counseling. Tracy Carter, M.S., L.C.P.C. has answered all of my questions to my satisfaction about this agreement. I understand that I retain the right to withdraw consent to participate in therapy at any time. I also understand that Tracy Carter, M.S., L.C.P.C. is not affiliated with any other therapist or agency and does not share any liability with any other professional including any who may share office space within this building. I have also read the Notice of Privacy Practices and Clients Rights as governed by HIPAA and understand that upon request, I can obtain a copy of them.

Client signature _____ Date _____

Spouse/Significant Other _____ Date _____

Parent/Guardian Signature _____ Date _____

Revised as of 11/2018