Charlotte Therapy Associates
Ashleigh E. Bryan, MS, LMFT
Professional Disclosure Statement

Overview:

I, Ashleigh Bryan, am a Licensed Marriage and Family Therapist in the state of North Carolina (license number 1028). I received my Master's of Science in Marriage and Family Therapy from East Carolina University in May of 2008. I also received my bachelor's degree in Psychology with a minor in Child Development and Family Relations from ECU in May of 2006. As a Master's degree candidate, I held two different internships. The first, working at the Family Therapy Clinic at ECU providing individual, family and couples therapy. The second internship was at the ECU Pediatric Healthy Weight Clinic in which I utilized the bio-psycho-social model to provide therapy to children and families struggling with weight issues. I also have experience working in an agency setting providing intensive in home family therapy and community support services for both children and adult. I have been practicing in the private outpatient setting since February of 2008.

Experience

I have experience working therapeutically with individuals, couples and families. I have had the privilege to work with people of all ages, genders, ethnicities, religions, sexual orientations, and races. I have also facilitated parenting support groups of preschoolers and toddlers. My previous positions include: Marriage and Family Therapy Intern at the East Carolina University Family Therapy Clinic where I worked therapeutically with families, couples and individuals from eastern North Carolina; Family Therapy intern at the ECU Pediatric Healthy Weight Clinic serving overweight and obese children ages 0-18 in Eastern North Carolina. In that position, I worked with children and families on making positive life changes, depression, anxiety and other mental health and relational issues. I then worked with a local agency providing Intensive In Home Family Therapy promoting family preservation and reunification for close to two years. In the private practice setting I have provided family, couples and individual therapy to those experiencing trauma, crisis, stress, depression, grief, relational issues, ADHD, anxiety, major life changes, violence, PTSD, developmental issues and many other psychological and relational issues. My experience also includes working with couples, families, and individuals who were experiencing marital stress and strain, co-parenting skills, adolescent issues, family relational issues, grief, parenting concerns, domestic violence and other issues.

Nature of Counseling

I strongly believe that change is possible and people seek good in their lives. I believe in the human capacity for growth and change. I am trained in systems theory and our work will explore many interconnected systems in your life throughout the change process. I also take a strength based perspective, which will utilize things that are going well and explore your strengths in our work toward the goals set. We will set goals to work towards that are both realistic and meet your needs where you are, driven by what changes you wish to make. This process will utilize self-reflection, insight and promote gaining increased self-awareness. Our families of origin have made lasting impacts on how we function on a day to day basis. Through exploring our past and gaining new insight about ourselves, we are

empowered to make positive change and better choices towards the change we seek. I believe the power of the therapeutic relationship and therefore will provide honest and straightforward feedback to promote growth and ask you provide this to me as well through open and honest discussion and expression of thoughts, feelings or concerns. We will assess progress towards goals throughout our work together. I will strive to develop a relationship with you based on trust, acceptance, honesty, encouragement and mutual respect. This is your time to change and achieve what you want; therefore, you will be the director of your change process!

My services will be rendered in a professional manner consistent with accepted ethical standards set forth by the American Association of Marriage and Family Therapists. **Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results.** Your sessions are your time to discuss any topics which you feel appropriate. You may end our therapeutic relationship at any time but I do ask that you participate in a closure session. You have the right to refuse or negotiate modifications of any of my suggestions that you believe may be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques. It is not unusual that as the counseling process progresses you may feel as though things are getting worse before they get better. I strive to make the relationship as open and honest as possible and will express my concerns as I hope you will also express yours.

Emergencies

I DO NOT provide any emergency therapeutic services. In the case of an emergency, please contact 911, or contact your primary care physician. You can also go to the local emergency room request the psychiatrist on call. Here at the numbers to two local hospitals with emergency behavioral healthcare:

Carolina's Medical Center, Randolph Rd.- 704-358-2700 Presbyterian Hospital Behavioral Health- 704-384-4255

Referrals

If at any time for any reason you are dissatisfied with my services, please let me know. Should you and/or I believe that a referral is needed, I will provide you with some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon your request. If you have a complaint, which you believe needs to be registered with my governing board you can send them a written complaint utilizing the form from the North Carolina Marriage and Family Therapy Licensure Board provided at www.nclmft.org or call 919-772-6600. I do not provide intelligence and educational testing nor do I give testing for jobs as I am not qualified to do so. Referrals are given for these services if needed.

Fees and Billing Practice

The Initial Diagnostic Interview lasts 60 minutes unless other arrangements are made. Fee: $165

Individual Sessions (adult or adolescent) last fifty (60) minutes beginning on the hour. Fee: $135

Couple and Family Sessions last sixty (60) minutes beginning on the hour and ending on the hour unless

other arrangements are made. Fee: $145

Couple and Family Sessions last eighty (80) minutes beginning on the hour and ending ten (10) minutes before the half hour unless other arrangements are made. Fee: $185

Payment of services is expected at the time of each session and a receipt will be provided. If we have made arrangements to file insurance directly you are responsible for any co-pays due and **ultimately responsible for payment in full if your insurance company does not pay within 90 days for any reason**. It is your responsibility to file with your insurance unless other arrangements have been made with me. If payment for services is not made at that time and it is not a matter of special arrangement agreed upon by you and me, such payment must be made within 10 working days of the session in question AND before a new appointment can be made. If payment is not made within this time period, I have the option of informing you in writing, that future services might be jeopardized and even discontinued. In this instance, I will provide you with names of other practitioners if requested.

If you fail to cancel scheduled therapy appointments at least 24 hours in advance, an automatic charge of the full session fee will be made for the missed appointment and added to your fee during the next scheduled session. Cancellations for Monday appointments need to be made before noon on the prior Saturday. If the therapist is working with you as a couple and if you come alone without your partner, the therapist will need to assess the risk versus value to your partnership of seeing only you. If the therapist determines it is not in the interest of your relationship, then you will, nonetheless, be charged for the entire session. Please understand, that insurance companies may not reimburse for charges resulting from missed appointments. If you fail to attend two consecutively scheduled sessions without notifying me, I will assume that you wish to terminate services and I will notify you in writing, that services have been terminated. Two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. You may terminate services at any time by notifying me.

If a check is returned due to insufficient funds, there will be a $50.00 charge to cover bank fees. Payment of the session fee and $50 charge must then be made at or before your next scheduled appointment. There is a $2 charge per transaction when paying for services with a credit card.

Phone Calls

I am happy to speak with you by phone if a pre-arranged time is scheduled to do so. It is often easier to reach me and communicate with my by e-mail (my e-mail address is ashleigh.bryan@live.com). However, should you prefer to speak with me by phone for any reason any phone calls lasting over 10 minutes will be billed at my normal hourly rate and payment due at the next scheduled session or within 7 business days of the phone consultation, whichever comes first.

Emails

E-mail communications requiring 15 minutes or more, between your therapist and you regarding matters of ongoing therapy will be charged in 15-minute increments $30 per 15-minutes. There is no charge for

emails concerning administrative and scheduling matters.

Records and Confidentiality

If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this it is suggested you contact your insurance company so that you know what access they are allowed to have as part of your policy agreement. **Additionally, in order to file through insurance, it is required that I give you a diagnosis**. **It is important that you understand that not all diagnosis' are covered under any given insurance plan and that when a diagnosis is given it becomes part of your records with the insurance company.** Should you choose to forgo use of your insurance and pay out of pocket, the insurance company does not have any rights to information from our work together.

Your counseling sessions, and the discussions therein, remain confidential unless I obtain a signed release from you for me to discuss your case with another professional. Case records are confidential and will not be released without written permission from you. As your therapist, I may be receiving on-going consultation from an individual who is bound by the same rules of ethics as I am. In such an instance, information will be discussed for professional purposes only and every effort will be made to protect the client's identity and information.

However, in certain circumstances it is required that confidential information is disclosed without your consent which include, but are not limited to the following: 1) If you are evaluated to be a danger to yourself or others; 2) If you are a minor, elderly or disabled and the counselor believes you are the victim of abuse or if you divulge information about such abuse; 3) if a court order or other legal proceedings or statute require disclosure; 4) Your insurance company requires information in order to pay claims; 5) As stated above, at your request.

By signing below, I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality. I have also discussed the goals of therapy with Ashleigh and understand that therapy is a joint effort between the counselor and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates.

By signing below, you are indicating that you have read and understand the information contained in this statement, that you have been given a copy of this form for your records, and that any questions you have about this statement have been answered to your satisfaction.

Client Name (Printed)

_____

Client /Legal Guardian Signature Date

_____ _____

CLIENT INFORMATION SHEET

Charlotte Therapy Associates
Ashleigh Bryan, MS, LMFT
5200 Park Rd, Suite 219 Charlotte, NC 28209

Important information in order for me to work with you:

NAME(1):_____

NAME(2):_____

ADDRESS:_____

CITY:_____ST:_____ZIP:_____

BILLING

ADDRESS:_____

CITY:_____ST:_____ZIP:_____

PHONE 1: DAY (_____)_____EVE(_____)_____

PHONE 2: DAY (_____)_____EVE(_____)_____

E-MAIL 1: _____

E-MAIL 2: _____

DATE OF BIRTH: (1)_____(2)_____

Instructions regarding contacting you concerning scheduling and other matters:

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A MESSAGE IDENTIFYING THERAPIST'S NAME AND NUMBER:

HOME_____WORK_____CELL_____ Referral Information:

Referral Source:

Name Agency Telephone #
Referred To: _____

A CONTACT PERSON IN CASE OF EMERGENCY:
NAME:_____Relationship_____

DAY(_____)_____EVE (_____)_____

Insurance Information:
WILL YOU BE USING YOUR INSURANCE? YES ___ NO ____ INSURANCE COMPANY:_____

MEMBER ID NUMBER: _____
DOB OF INSURED:_____
Are you or any family members in therapy now? Previously? If so, when, with whom, and for what reasons?

NAME OF INSURED:_____ INSURANCE PHONE #:_____

YES _____OR NO _____

DO YOU WANT THE THERAPIST TO TALK WITH A PREVIOUS THERAPIST(S)?
IF YES: GIVE ADDRESS:_____
PHONE NUMBER:_____

SIGNATURE For Consent:_____
DATE:_____
LENGTH OF PERMISSION:_____

SIGNATURE For Consent:_____DATE:_____

Family Information:

Start with all family members, and nonmembers, who live in the household and then include those outside the household that may also participate in the therapy.

• Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

• Are any of those who will be coming for therapy involved in divorce proceedings? If so, who has sole custody or is there joint custody of the minor children?

• Are you, or is anyone else in your family, experiencing thoughts of harming oneself or someone else?

• Have you or anyone in your family experienced instances of physical violence now or in the past?

• Have you had problems with a natural disaster (i.e., flood, hurricane) or another traumatic event?

• Do you have any special needs regarding therapy, such as a physical disability?

MEDICATION/PHYSICIAN SUMMARY

Please list any current medications (use reverse if needed):

Primary Care Physician:

_____

Signature for Consent _____ Date _____

Other specialists:
Specialist: _____
Signature for consent _____Date _____

Specialist: _____
Signature for consent _____Date _____

Specialist: _____
Signature for consent _____Date _____

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Ashleigh E. Bryan, MS, LMFT, to provide counseling services to:

Client Name: _____

Date of Birth:_____

I understand that Ashleigh Bryan, MS, LMFT will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

I understand that payment for services are expected at the conclusion of each session and that a receipt will be provided for me. If insurance arrangements have been made prior to the session and a co-pay is

applicable, it is due at the time of my session. If for any reason your insurance does not agree to pay your fee (co-pay or percentage), **you are ultimately responsible for payment in full**.

Cost of Treatment:

$165.00 Initial session (60 min)	$145.00 Couples or Family Therapy (60 min)
$135.00 Individual Therapy (50-60 min)	$185.00 Couples or Family Therapy (75-90 min)
$135.00 Consultation or Report writing (per hour)	$135.00 Phone Calls per hour (billed after 10 min.)
$45.00 Emails requiring 15 min. or more (billed in 15 min increments)	$2.00 Credit Card processing fee

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Ashleigh Bryan, MS, LMFT for a missed or unpaid for appointment.

I agree to allow Ashleigh Bryan, MS, LMFT, bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Ashleigh Bryan, MS, LMFT, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Ashleigh Bryan, MS, LMFT has the option of informing me, in writing, that future services might be jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an *automatic* charge of the full session fee will be made for the missed appointment and added to my fee during the next scheduled session. I understand that I will be responsible for this fee as insurance does not pay for missed appointments. You can call me at 704-705-4550 ext 1. to notify me or leave a message as well as via email at ashleigh.bryan@live.com. If I fail to attend two consecutively scheduled sessions without notifying Ashleigh, she may assume that I wish to terminate services. I also

If for any reason I am subpoenaed to testify in court on your behalf or regarding your case my fee is $200.00 per hour. This fee will include travel and waiting time as well as preparation time. I require a $500.00 retainer fee in advance. You will be responsible for payment of this fee in full.

I agree to the terms of the counseling and fee agreement as stated above and understand the above requirements. I release Ashleigh Bryan, MS, LMFT from liability.

Client Name (Printed)

_____

Client Signature & Date

_____

Therapist Signature & Date

_____

Charlotte Therapy Associates
Ashleigh Bryan, MS, LMFT
5200 Park Rd, Suite 219
Charlotte, NC 28209

Notice of Privacy Practices

HIPPA (Health Information Portability & Accountability Act) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider *all information* about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also,

Professional Disclosure.) ***Disclosure of Information***
Whenever your PHI is released or obtained, it will be the *minimum* information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics. These include:
• Emergencies.
• Reporting of abuse or neglect.
• Disclosures required by court order.
• Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Your Rights Regarding Privacy
By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:
• The right to inspect and obtain a copy of your medical record.
• The right to request an amendment of any section of your medical record.
• The right to request *restriction* of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
• The right to request an accounting of the disclosures that we make of your health care information.
• The right to request confidential communication.
• The right to a copy of this notice.
• The right to *refuse* to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800 368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

THIS NOTICE IS EFFECTIVE OCTOBER 1, 2011

PLEASE KEEP THIS FOR YOUR RECORDS

Ashleigh Bryan, MS, LMFT
5200 Park Rd, Suite 219 Charlotte, NC 28209
Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name:_____ DOB:
_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Ashleigh Bryan, MS, LMFT at ashleigh.bryan@live.com or at 704-705-4550

_____ Signature of Patient/Client Date

_____ Signature or Parent, Guardian or Personal Representative Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member & Date

_____