Charlotte Therapy Associates
Rose Richardson, MA, LMFTA
Professional Disclosure Statement

Qualifications

I received my Master's of Art in Marriage and Family Therapy from Appalachian State University in May of 2015. I also received my bachelor's degree in Psychology from Wofford College in June of 2013. As a Master's degree candidate I held three different internships. The first, working at Daymark Recovery Services as an outpatient therapist where I provided individual, family and couples therapy. The second internship was at Daymark Recovery Services with their ACT Team in which I utilized an integrated approach to provide therapeutic services to the chronically mentally ill. Lastly, I was the therapist intern at Watauga High School in which I provided therapeutic services to the students on a regular basis. I am a Licensed Marriage and Family Therapist Associate in the state of North Carolina (license number 10095A).

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 a positive discipline parenting group. My previous positions include: Marriage and Family Therapy Intern at Watauga High School, Marriage and Family Outpatient Intern and ACTT Intern for Daymark Recovery Services in Jefferson, North Carolina. During my time in those locations: I worked with a wide range of topics such as: addiction issues, an imbalance of family dynamics, structural issues, 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. When working with me, I will create an open and trusting space that fosters the personal growth of my client's. As a Marriage and Family Therapist, I practice from a system's perspective, and believe that my job is to remain as objective as possible. I believe that change is a result of finding a balance between thinking and feeling when in the face of anxiety. I am passionate about working with clients undergoing grief and other emotional disruptions in their lives. I integrate multiple theories into my work such as: Bowenian, Experiential, Solution Focused, and Attachment. Goals will be set depending on what the client needs, and the process of therapy will entail moments of self-reflection, esteem-building, emotional regulation, and stress management.

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

Session fees are as follows:

$150.00	Initial session (60-75 minutes)
$120.00	Individual Therapy (adult or adolescent 50-75 minutes)
$130.00	Couples or Family Therapy (60 minutes)
$165.00	Couples or Family Therapy (75-90 minutes)
$120.00	Consultation or Report writing (per hour)
$120.00	Case Management (per hour)
$120.00	Phone Calls per hour (billed after 10 min.)
$ 30.00	Emails requiring 15 min. or more (billed in 15 min increments)
$ 2.00	Credit Card processing fee

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. There are two exceptions; if the roads are dangerous due to snow or ice or if you have a contagious disease that the therapist or others in the office might contract. 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.

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

______________________________________ ___________________
Legal Guardian (2nd Parent) Date

______________________________________ ___________________
Counselor's Signature Date

Rose Richardson, MA, LMFTA
5200 Park Rd, Suite 219
Charlotte, NC 28209

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Rose K Richardson MA, LMFTA, to provide counseling services to:

____ ____________________
Client Name Date of Birth

I understand that Rose Richardson, MA, LMFTA will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

$150.00 Initial session (60-75 min)	$120.00 Individual Therapy (50-60 min)
$130.00 Couples or Family Therapy (60 min)	$165.00 Couples or Family Therapy (75-90 min)
$120.00 Consultation or Report writing (per hour)	$120.00 Case Management (per hour)
$120.00 Phone Calls per hour (billed after 10 min.)	$ 2.00 Credit Card processing fee
$ 30.00 Emails requiring 15 min. or more (billed in 15 min increments)	

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**.

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Rose Richardson, MA, LMFTA for a missed or unpaid for appointment.

Credit Card #__________________________________ **Exp.**________________

Billing Address Zip Code__________________ **VISA** **MASTERCARD** **Security Code** ______

Your insurance company has informed me that your benefits are as follows:

Insurance Company:______________________**Deductible:**_________________ **Co-pay:** ____________

Max. # of sessions/Amount_________________ **Per Calendar Year/Benefit Period:**_______________________

I agree to allow Rose Richardson, MA, LMFTA, 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 Rose Richardson, MA, LMFTA, 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, Rose Richardson, MA, LMFTA 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 5. to notify me or leave a message as well as via email at rose@charlottetherapyassociates.com. If I fail to attend two consecutively scheduled sessions without notifying Rose, she may assume that I wish to terminate

services. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Rose Richardson, MA, LMFTA.

If for any reason I am subpoenaed to testify in court on your behalf or regarding your case my fee is $150.00 per hour. This includes 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 Rose Richardson, MA, LMFTA from liability.

____

Client Name (Printed)

__________________________________ ____________________

Client Signature Date

__________________________________ ____________________

Therapist Signature Date