

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Mariana R. Glass – Licensed Clinical Mental Health Counselor #4210

I. Professional Background and Orientation

Education

- Master of Arts in Christian Counseling, May, 2001, Gordon-Conwell Theological Seminary – Charlotte. Magna Cum Laude, Phi Alpha Chi Theological Honor Society
- Bachelor of Science in Business Admin, May, 1986, University of North Carolina at Chapel Hill
- Licensed with the NC Board of Licensed Clinical Mental Health Counselors, #4210
- Professional Membership: American Counseling Association; Licensed Professional Counselors Association of NC; Focus on the Family Christian Counselors Network; Person Centered Tech.

Professional Experience and Populations Served

As of January, 2020 I have over 21 years counseling experience, including two years of part-time internship experience. I am owner and sole practitioner of Asheville Counseling and Training Services, Inc. (ACTS, Inc.), a North Carolina Professional Corporation. My current expertise is with people 13 years and older, primarily with individuals and couples. Areas of competence include the following areas: anxiety and depression; relationship challenges (e.g., temperament, boundaries, conflict); stage of life adjustments; and application of Christian faith to daily living. My counseling experience also includes work with employment or school transitions; grief from loss; and limited work in trauma and substance abuse.

What is Professional Counseling? Per the American Counseling Association (www.counseling.org): *Professional counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.*

Counseling Orientation

My counseling orientation is grounded in a biblical worldview, and is informed by a variety of counseling theories, models, and fields of study including: Client-Centered, Cognitive-Behavioral, Transactional Analysis, Family Systems, Learning Competence (Burch), the Change Model (Satir), Psychosocial Development (Erikson), temperament (Myers-Briggs, Keirsey), and neuropsychology. I work from the perspective that God ultimately is the source of healing through His love and truth, and I strive to demonstrate these attributes by treating my clients with acceptance, respect, and compassion. I specialize in helping people find greater health and wellness in their lives by applying Scripture to the context, experiences and challenges of their daily living.

II. Practice Management and Operations

Office Hours and Scheduling

My typical office hours are 9am – 6pm Mon-Thurs. Clients schedule initial appointments with me by phone, and ongoing appointments via the secure Client Portal, by phone or in-session, only if payment on the account is current (no later 60 days). It is the client's responsibility to initiate scheduling.

Client Portal

I utilize a secure practice management system (see www.therapyappointment.com) for various tasks, including client scheduling, billing, insurance filing, credit card processing, document completion and storage, and (brief) secure messaging. I ask my clients to enroll in the secure Client Portal in order to facilitate such processes related to your counseling. You can access this portal at my website:

www.ashevillecounselingandtraining.com under the Forms & Scheduling tab. If you are unable or do not wish to utilize the Client Portal, we can discuss other means to achieve these tasks in a secure manner.

Fees and Payment

The following fees are subject to change and will be communicated in advance, when feasible.

90791 Initial session (approx. 55 minutes)	\$130.00
90837 Regular session (approx. 55 minutes)	\$115.00

Payment by cash, check, and credit cards is accepted. Credit card information is stored securely; the card on file will be charged for fees incurred if prompt payment is not made by another means.

Other Fees. Phone calls lasting longer than 10 minutes are subject to the hourly fee to include all time spent in discussion. Special rate terms may be discussed and agreed upon depending on circumstances and/or need, including but not limited to services related to legal proceedings, consultation, etc.

Court Proceedings. Ms. Glass does not offer court testimony or evaluations, and requests that neither you nor your attorney subpoena her for records. In the event she does receive a subpoena, Ms. Glass may provide a short summary of services and treatment for a fee of \$100 with signed client consent.

Crisis Situations. I understand that Ms. Glass is not accessible and/or available 24/7 for emergencies. If I feel that I or someone else is in danger of serious physical harm, I understand that resources to call immediately include: 911, National Suicide Prevention Lifeline 1(800)273-8255, and Mobile Crisis 1(888)573-1006. Note: If Ms. Glass spends time interacting outside of a scheduled session in person or on the phone with a client regarding a crisis situation (e.g., risk of suicide), and/or problem-solving and/or coordinating with others to resolve the situation, a fee of \$130/hour may apply.

Payment without Insurance Filing. Full payment is required at time service.

Payment with Insurance Filing. Mariana Glass, M.A., L.C.M.H.C. is a contracted provider with BlueCross BlueShield of NC only. If the client has an insurance carrier other than BCBSNC, a receipt or superbill can be provided monthly to the client upon request for potential insurance reimbursement.

BCBSNC members: Prior to the initial session as well as ongoing, it is the client's responsibility to check with his/her insurance company to determine mental health benefits.

If a client does not have mental health benefits for services with Ms. Glass, or it appears possible and/or likely from initial information that services will not be covered and/or will go against a deductible, the client must pay for each session in full at time of service until such time as coverage is confirmed.

If a client does have mental health benefits (via BCBSNC) for services with Ms. Glass, s/he agrees to pay co-payments and co-insurance if wanting Ms. Glass to file for insurance reimbursement. Payment by the insurance company is not guaranteed. If claims are denied at any point in our counseling process (e.g., changes to primary diagnosis, insurance plan), client agrees to make payment in full for non-covered services (past and future). **LCMHC initials:** _____ **Client initials:** _____

Financial Institution Fees. Clients are responsible for any financial institution fees incurred by ACTS, Inc. on their behalf, such as returned check charges.

Late Cancel and Late Arrival Policy. Appointments cancelled without 24 –hour weekday notice are subject to a \$80 late cancel fee (please account for holidays). Arriving 15 minutes or more after the designated appointment time qualifies as a late cancel. Exceptions to this policy include unsafe weather conditions or unexpected personal illness.

III. Counseling Process and Techniques

Counseling Venue. Counseling sessions are held at my business office in north Asheville. Occasionally we may find it beneficial to engage in distance counseling via phone or video call. These venues may help with unexpected, time-sensitive matters and challenges getting to my office (e.g., car failure, weather conditions, illness, travel). In such cases, we will schedule a time to meet via secure technology. Note: I am not licensed to practice across state lines and therefore limit distance counseling to within the state of North Carolina.

Assessment and Diagnosis. We will discuss your reason(s) for counseling and related concerns. I will provide a diagnosis/es according to criteria in the DSM-V and ICD-10 coding systems. Assessment and diagnosis are ongoing and may change depending on progress and focus of counseling.

Treatment Process and Techniques. I will develop a counseling plan for you to include focus areas, objectives, and strategies that may help achieve your counseling goals. This document is meant to be collaborative and dynamic. Counseling techniques may include: client story-telling, reading of recommended books and articles, feedback on communication and conflict style, understanding of personality and relationship through assessment(s), and occasional homework assignments.

Record-Keeping. I keep both paper and electronic records. Please see “Use of Technology”.

Responsibilities and Risks. My responsibility as your counselor is to facilitate the counseling process for your well-being in a caring, ethical, and professional manner. Your responsibility as the client is to identify your desired outcomes and, if I am able to support those outcomes, work with me toward achieving those outcomes. Achieving your desired outcomes is not guaranteed and/or may not be achieved with the speed you desire, especially if you refuse recommended actions, services or therapy modalities; you have the right to refuse any of my recommendations. As you continue counseling, your symptoms may worsen as we explore sensitive areas and you make healthier decisions. However, if a client perseveres through the counseling process, s/he likely will realize benefits through the process.

Termination of Treatment/Referral. You may terminate your counseling process at any time, without any discussion with me, although I welcome such discussion. I may terminate the counseling process for any reason that inhibits our counseling work, including: if I determine I cannot provide adequate help; if you are non-compliant in our work toward agreed-upon outcomes; if you do not make payment for services. When appropriate and feasible, I will discuss this with you and offer referral to other resources. Except in the case of involuntary commitment (e.g., to a hospital), the choice to accept such a referral is yours. Such referral may be in place of and/or in addition to my counseling service.

IV. Privacy and Confidentiality

Our communication becomes part of the clinical record. I will keep confidential our counseling relationship and communication, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information. Please see the following detail:

1. *Danger and Legal Cause.* If I have reasonable cause to believe you may cause serious and foreseeable harm to yourself, to someone else, or to another’s property, and/or to commit a felony, I may take whatever actions I deem necessary to protect you and any other involved parties from such harm. Such action may include a request for your admission/commitment to a mental facility, and warning any person to whom you may do physical harm to their body or property, including violent acts as well as undisclosed danger of life-threatening diseases.

2. *Child, dependent, and elderly abuse or neglect.* This includes if I believe you or someone in your household commits severe physical punishment, sexual molestation, neglect or abandonment.
3. *Legal consultation/proceedings.* This may include information required by the court or requested by attorneys on your behalf, or for purposes related to the administration of my business practice. The disclosure of confidential information discussed in the context of a counseling relationship, whether by providing written information to attorneys or to a court or by live testimony, is generally inconsistent with the foundations of a productive counseling relationship and I urge you to be protective of that relationship.
4. *Third party payment/consultation.* This may include information for submitting the cost of your sessions for reimbursement, or for purposes related to professional insurance for my individual and/or business practice.
5. *Consultation/Support.* In order to consider relevant issues and information in developing an appropriate counseling plan for you, I may discuss your case with a person who has provided counseling or medical services to you, and/or with a professional advisor, confidante and/or colleague. In such event, I will keep undisclosed information that could reasonably identify you to the extent that confidentiality is consistent with your counseling and the purpose of the consultation.
6. *Multiple individuals as "client."* If therapy is conducted with two or more individuals seeking assistance for their relationship (e.g., marriage or family counseling), confidentiality between these parties is not guaranteed. I may share information between these multiple clients in order to help the individuals and/or their relationship. Confidentiality is not guaranteed if an individual shares private information with me that he/she is unwilling to share with the other party(ies) and that, if kept hidden, is detrimental to the health of the relationship and/or progress in the counseling process.
7. *Minor child.* If you are below the age of 18 and un-emancipated, I may be required to provide information from our sessions to your parent(s)/ legal guardian.
8. *Secure and unsecured means of communication.* (see section in this document "Use of Technology" and also separate document HIPAA Notice of Privacy Practices/Client Rights).
9. *Written permission.* Unless I come to a professional conclusion that disclosure would likely be harmful to you and/or another client, I will release confidential information, to the extent necessary, if you provide written permission and directions to disclose information to someone else.
10. *Counselor's termination of practice, incapacitation or death.* If I am unable to work with you or your file for a significant period of time, a trusted adult and/or designated colleague(s) will have instructions for handling your information in a confidential manner and can provide referral recommendations for your continued counseling.

Use of Technology

I use a variety of technology in my practice, including computer hardware and software; landline and cell phones; internet-based applications; data storage devices. Such use enables me to provide counseling services in a manner that is timely and informative (e.g., real-time scheduling, quick insurance filing). However, these means also pose security risks such as loss of information, and the access/reading/use by authorized and unauthorized people. I strive to maintain security as well as streamline my communication channels.

Communication. Therefore, I request that you communicate with me solely via the secure Client Portal of my practice management system, or by phone call/voicemail, unless we agree to an exception to regular email and texting. While email and texting are a convenient and normative means of communication in our society, they can diminish our professional relationship and are not practical for maintaining your health information in a secure manner. I also offer encrypted email and secure fax as options for you and others acting on your behalf (with your signed consent). That being said, my practice management system offers appointment reminders, alerts to portal activity (e.g., secure messages sent), and credit card receipts via one or both of these nonsecure channels. Please see related waiver/informed consent form for using non-secure forms of communication.

Methods of Security. These include combination/key locks; passwords, encryption (e.g., full disk for desktop/laptop, smart phones, tablets; SSL certificate for website; WPA2 for Wifi; email upon need/request), and firewalls. Records stored in paper files or data storage devices (e.g., computer hard drives and flash drives) are securely stored for a minimum of 7 years after the last date of service. Records stored on internet-based systems are stored according to security policies of each company as specified in their Business Associate Agreement and other policy communications.

All forms of information and communication – paper, electronic and otherwise – have some security risk inherent in their storage and transmission; such risks include the information being lost, or being accessed, viewed, and used by authorized and unauthorized parties (e.g., technology administrators). Therefore, be aware of what information you choose to share in written or electronic form. By signing this document and related documents, you indicate your understanding of these risks and hold harmless Ms. Glass and her practice from security failures that may occur apart from industry-standard precautions.

V. Professional Ethics

I abide by the ACA Code of Ethics (<https://www.counseling.org/resources/aca-code-of-ethics.pdf>). Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these ethical codes.

North Carolina Board of Licensed Clinical Mental Health Counselors
PO Box 77819 Greensboro, NC 27417 <https://ncblcmhc.org/Complaints>
Telephone: (844)622-3572 Fax: (336)217-9450

VI. Informed Consent

I have received and had the opportunity to read and inquire about a copy of *HIPAA Notice of Privacy Practices/Client Rights* for the counseling practice of Mariana R. Glass, M.A., L.C.M.H.C. I agree to adhere to the policies therein unless otherwise indicated to and accepted by Mrs. Glass in writing.
Client initials: _____

Client Attestation and Consent to Treatment: I have received and had the opportunity to read and ask questions about this Professional Disclosure Statement and Informed Consent of Mariana R. Glass. I accept and agree to all information, policies and/or requirements set forth for and related to me as the client. I understand that I can obtain a signed copy of this form upon request. I hereby authorize Mariana R. Glass to provide counseling services to me, and understand that I may ask questions about my treatment, request a review of my progress, and discontinue treatment at any time.

_____ Signature of Client #1	_____ Date
_____ Signature of Client #2	_____ Date
_____ Signature of Counselor	_____ Date