**C. Stephen Morris LCSW**

**15 Larchmont Road**

**Asheville NC 28804**

**Phone # (828) 424-5646**

***PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED***

***CONSENT***

**Disclosure Statement**

This is a statement of your rights and responsibilities for our therapeutic relationship.

The Disclosure Statement is designed to inform you of my professional credentials, types of service offered, fee schedule, and therapeutic orientation and style. You will receive this copy for your records and I will keep the signature pages for my records. Please read this carefully and if you have questions that are not covered here or want further clarification please ask me when we discuss this statement during the session.

**Education and Credentials**

I received a Masters of Social Work degree from University of North Carolina, Chapel Hill in 1983. I am licensed as a Clinical Social Worker (LCSW) in North Carolina under #C000-339.

**Services Offered & Length of Session**

I provide individual, family and couples psychotherapy. Services will be rendered in a professional manner consistent with ethical standards. It is impossible to guarantee any specific results regarding your counseling goals because the outcome is dependent on your work as well as mine. Typical sessions are 45-53 minutes in duration. We will schedule our sessions by mutual agreement. If you are unable to keep an appointment, please call at least 24 hours prior to cancel or reschedule.

\*\*\*\***See cancellation policy below**.

**Counseling Process and Approach**

I use Family Systems, Transactional Analysis, Solution Oriented, Cognitive Behavioral Therapy and Experiential theories as a foundation for my practice and beliefs around change and growth. I also utilize strategies from other therapy approaches as it fits with my individual clients needs. These theoretical orientations and their accompanying techniques are empirically-based and may sometimes cause some discomfort before relief.

**Insurance Reimbursement & Diagnosis**

Should you wish to use an insurance policy for counseling services, it is your responsibility to contact your insurance company to inquire about specific coverage for mental health services. Please note that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. I am an “in network” provider for Blue Cross Blue Shield and United/Optum. In addition, I work as an “out-of-network” provider with any other insurance plans that provide out of network coverage. Any diagnosis made will become part of your permanent insurance records. Counseling Fee payment or co-payment is due at the beginning of each session. Regardless of insurance, you agree that you are responsible for payment of all fees for services rendered. Cash, personal checks, Visa, Mastercard, American Express, and Discover are acceptable methods of payment and I will provide a receipt for all fees paid. Private pay rates are as follows: 110.00 for intake sessions, $95.00 for follow up family, couple and individual sessions.

**Cancellation Policy**

You will be charged from 50-100% for missed appointments or failing to cancel your appointment with 24 hours notice depending on the circumstances. Please understand that your insurance will not reimburse you for any portion of a missed appointment and you are responsible for the full charge.

**Emergencies**

I do not provide 24-hour on-call emergency services. You are free to call me after hours

and leave a message on my voice mail. *Should you have a mental health emergency and are unable to reach me, please go to your nearest hospital emergency room, call 911, call the Mobile Response Team at 1-800-573-1006, call 1-800-SUICIDE, call your*

*psychiatrist/physician, or a family member/friend.*

**Confidentiality**

All information shared in session is confidential, with these few exceptions:

(1) For case consultation purposes, I may consult with other therapists, who are required to keep client information confidential.

(2) The State Law of North Carolina requires that suspected abuse or neglect of a child, elder, dependent adult, or developmentally disabled person be reported.

(3) The State Law of North Carolina also requires that others be informed if a client threatens suicide or harm to herself/himself, or others. If that threat is clear and imminent danger, the proper individuals and law enforcement must be contacted.

The person against whom the threat has been made may also be contacted to prevent harm.

(4) Should I be presented with a court order, I may be required to disclose information in the presence of a judge; however, I will first assert legal privilege in an effort to protect your confidentiality.

(5) Information, which may jeopardize my safety, will not be kept confidential.

(6) In the event of a medical emergency on your part, emergency personnel may have to be provided with some of your information.

(7) If you bring a complaint against me with the North Carolina Board of Social Work, information will be released.

(8) Children and adolescents must have permission from a parent or legal guardian before receiving services. Confidential information will be shared with a parent or legal guardian only if the child or adolescent is in imminent physical or emotional danger.

(9) If I am made aware that you have a communicable and fatal disease and that you have willfully exposed an identified third party to it.

**Complaint Procedures**

I adhere to the highest ethical and professional standards. If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, please contact the North Carolina Social Work Certification and Licensure Board in Asheboro NC for further assistance (336) 625-1679.

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Consent and Acknowledgment of Receipt of Professional Disclosure Statement

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name) hereby acknowledge that

during the initial contact with Charles S. Morris LCSW, we discussed

confidentiality and privacy issues. I was provided a written Notice of Privacy Practices which outlines how protected health information will be treated in

his practice. By my signature, I acknowledge that I have read and understand this

Professional Disclosure Statement. I consent to therapy with

Charles S. Morris LCSW, according to the terms described here. I have read the preceding information and understand my rights as a client.

Please initial where applicable:

\_\_\_\_\_\_ I have been informed about how my privacy and confidentiality will be

maintained by Charles S. Morris LCSW.

\_\_\_\_\_\_ I have reviewed and received a copy of the Notice of Privacy Practices.

\_\_\_\_\_\_ I have read the Professional Disclosure Statement of Charles S. Morris LCSW and I have been provided a copy.

\_\_\_\_\_\_ I consent to treatment and voluntarily agree to participate in all treatment

and may stop such treatment at anytime.

\_\_\_\_\_\_ I intend to use insurance and I do want my therapist to file my insurance

claims and have payments sent directly to him. (Please attach insurance card for me to copy.)

\_\_\_\_\_\_ I do not intend to use insurance and will pay for my sessions out of pocket.

\_\_\_\_\_\_ I consent to treatment for my child, minor or dependent.

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Signature of Client Date

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Signature of Partner/Spouse Date

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Signature of Parent/Legal Guardian Date

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Charles S. Morris LCSW Date