

Beth Messiah Congregation 4950 Morse Road, Columbus, OH 43230 Also via Skype	Phone: 614-423-9421 Fax: 614-407-0554 E-Mail: dawncounselor@gmail.com Website: www.dawncounselor.com
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Dawn L. Uhrick, MA, PC

DISCLOSURE AND CONSENT

I am pleased that you have selected me to be your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I. I have been approved by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board as a Professional Counselor (license #C.1100511). I am a member of the American Counseling Association. My practice includes counseling children, adolescents, adults, couples, groups, and families, including the diagnosis and treatment of mental and emotional disorders under supervision. I hold a BS in psychology from Duke University from 1993, and I graduated with a MA in Clinical Mental Health Counseling from Ashland Theological Seminary. in 2013.

II. I accept clients into my practice who I believe have the capacity to resolve their issues with my assistance. Some clients only need a few sessions to make the changes they desire and others may require longer term therapy which could last months and in some cases years. The first few sessions are diagnostic sessions designed to determine whether further treatment with me is appropriate. You have the right to end treatment at any time; however, it is recommended that we discuss this decision to make sure you have considered all the options and potential results of ending treatment. If counseling is successful, you should feel better able to face life's challenges without my continued support and intervention.

III. Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Thank you for not inviting me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling, however, you must realize that you are only experiencing me in my professional role.

IV. I will keep confidential anything you say, with the following exceptions: 1) meeting with my supervisor, Millie McCarty, a Professional Clinical Counselor licensed by the State of Ohio, 2) if I determine you are in danger to yourself or others, 3) on the rare occasion that a court subpoenas records, 4) child, elder, or dependent person abuse is discovered, and 5) when you request in writing that we communicate information to someone else. If during the course of treatment you have any questions about the goals, procedures, or nature of your treatment, or about office procedures or fees, please feel free to ask. If you desire, you have the right to have Millie McCarty, PCC-S (license # E00002379-S) present during this discussion, or you can meet with him directly or contact him at 1-614-561-1493. In addition, you can contact the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board at 1-614-466-0912. Millie McCarty is required to have direct knowledge of your counseling needs through supervisory meetings and testing or audio taping of our sessions. If I do audio

or video tape any session, I will inform you before the session begins. Your signature at the end of this document indicates that you are aware of these supervision provisions.

V. Limitations of electronic therapy. Engaging in therapy by telephone or webcam has a wide range of benefits, but you should also be aware of the limitations of the use of technology to conduct personal therapy. These include but are not limited to:

- 1) Potential for lost electronic connection, thereby disrupting your therapeutic process.
- 2) Less ability to see important characteristics in communication such as detailed facial expressions or non-verbal gestures which are normally present in an in-person session.
- 3) Potential for the clinician to misunderstand important cultural nuances if you live in a different culture than the therapist.
- 4) Complications in obtaining support in the event of an emergency. I will make every effort to contact your local emergency services or emergency contact(s) provided by you in the new client paperwork and the e-therapy consent form. Since the therapist is trying to accomplish this at a distance it may be more complicated than it would be in a clinical office setting.
- 5) Potential limits in privacy in the end user environment. I maintain the security and privacy of our software, phone and internet connections, and office space but cannot guarantee the security and privacy of your software, phone and internet connections or meeting space.

VI, In return for an initial fee of \$50 for the first session, and a flat rate of \$70 for each additional session, I agree to provide counseling services for you. Our sessions will be 45-50 minutes in duration. The fee for each session will be due at the time of service and must be paid at the end of the session. Cash, personal checks, or online electronic payments are acceptable. There is a \$50.00 charge for any returned checks. A monthly receipt for all fees paid is available at your request. In the event of financial hardship, alternative payment arrangements can be made as necessary. Please inform me with a 24 hour notice if you can't make your scheduled appointment. Emergencies do happen at times; however, you will be charged the normal session rate of \$80 for all missed appointments that are non-emergencies without the 24 hours notice. I will not be billing your insurance for your counseling services.

VII. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. These may or include physical, mental, emotional, and spiritual interventions during sessions. 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 for you. If you have any questions, please feel free to ask. Please sign and date this form and fax or e-mail it to me prior to your first session. Thank you for choosing me as your counselor!

Counselor's signature / date

Client's signature / date

This information is required by the board which regulates all licensed counselors:

Counselor, Social Worker, Marriage and Family Therapist Board

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revised: 10/28/13