Marcy Houston
Mental Wellness Center of the Lowcountry

Professional Disclosure Statement and Consent for treatment

The majority of this document is mandated by both South Carolina State law and Public Law 104-191; it is provided for your protection. Mental Wellness Center of the Lowcountry, LLC has tried to anticipate any risks you may face as a result of being in therapy. If you ave any questions regarding the documents you have received, please feel free to discussed them with Marcy Houston.

Contact Information: Mental Wellness Center of the Lowcountry is located at 25A Marshellen Drive, Beaufort SC 29902 This is also our mailing address. Our usual office hours are 9:30-5:00 Monday through Friday. Our telephone number is 843-325-2223(the voicemail is confidential). Our email address is **mentalwellnesscenterlc@gmail.com** it is checked at least once every working day.

Personal Qualifications: Marcy Houston is a clinical counselor of Mental Wellness Center of the Lowcountry. Please note some of her credentials listed below:

- National Certified Counselor
- Hawaii Licensed Mental Health Counselor
- Michigan Licensed Professional Counselor
- South Carolina Licensed Professional Counselor

Marcy Houston received her Bachelor's Degree, BA, from California State University San Marcos in psychology and her Master's Degree, MA from University of Maryland in Counseling and Personnel Services.

Services: Marcy Houston provides a number of psychotherapeutic services which include:

- Therapy involving adjustment to changes encountered by individual life cycle development.
- Therapeutic assessment and treatment of Post Traumatic Stress Disorder (PTSD) in individuals and families.

- Parenting skills including Nurturing Parenting and Parent Child Interaction Therapy (PCIT).

Fees: Fees for professional services are rendered at the time of service. The two hour initial clinical assessment will be a flat fee of $120. The hourly fee for individual, marital and family therapy is $70 per hour. Group therapy is $20 per hour per person.

Cash or personal checks made to Mental Wellness Center of the Lowcountry, LLC are accepted, as well as credit/debit cards.

As Mental Wellness Center of the Lowcountry, LLC does not accept insurance at this time, clients must file their own insurance claims with the receipt that is provided. The receipt will contain all the information your insurer will require if you qualify for and choose to file for out-of-network benefit coverage. A sliding fee scale may be available, please discuss payment matters with us prior to the beginning of the counseling session.

Confidentiality: The information you share in therapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed by a judge) but is considered privileged in federal court system. Marcy Houston is mandated by standards-through Duties to Warn- to breach confidentiality if she discovers: 1) you are threatening self-harm or suicide, 2) you are threatening to harm another or homicide, 3) a child has been or is being abused or neglected, and/or 4) a vulnerable adult has been or is being abused or neglected. Finally, if you wish your protected health information released to another party, you must sign a specific Release of Information.

Ethics: Marcy Houston follows the Code of Ethics of the South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists.

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Informed Consent: You will be asked to sign the last page of this document. Your signature verified you have been given this document and the HIPAA document that follows; that you have read and understand these documents, and that you consent to treatment. Further you need to be aware:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- Marcy E Houston is not a physician and cannot prescribe medications
- Marcy E Houston is not available 24 hours a day.
- Appointments may be successfully canceled as late as 24 hours prior to the scheduled time. If this is not done, you will be charged $50.00 for a missed appointment.
- Marcy E Houston is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational specialists; this board is located in The Synergy Center in Columbia, South Carolina at 803-892-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information **cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your counselor's Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information <u>does not require</u> your consent or authorization:

1. Uses and disclosure required by law-*like files court-ordered by a judge.*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence- *like the duties to Warn explained in your counselors disclosure statement.*
3. Uses and disclosures for health and oversight activities- *like correcting records or correcting records already disclosed.*
4. Uses and disclosures for judicial and administrative proceedings- like a case where you are claiming malpractice or breech of ethics.

5. Uses and disclosures for law enforcement purposes- like if you intent to harm someone else (see Duties to Warn in you counselor's Disclosure Statement).
6. Uses and disclosures to avert a series threat to health or safety- life calling Probate Court for a commitment hearing.

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Professional Disclosure Statement and Consent for treatment

PARTICIPANTS RIGHTS AND RESPONSIBILITIES

You have the right to:

1. Privacy with respect to your past, present and future mental health treatment and medical information.
2. Know the limitations of confidentiality.
3. Understand how to give permission to release or obtain information about your treatment, as well as how to revote the permission.
4. Be involved in planning your treatment.
5. Have services provided in a way that fits your individual characteristics, needs, and abilities.
6. A written, upon request, Treatment plan and be fully informed of any changes in the plan,
7. Refuse or discontinue services.
8. Be treatment with dignity, respect and kindness; free of abuse.

You have the responsibility to:

1. Behave in a manner which maintains the therapeutic environment and is respectful of others in session.
2. Participate fully in each session and the treatment plan established.
3. Be honest and not to willfully withhold information that is pertinent to the success of your mental health.
4. Abstain from inappropriate sexual contact, sexual advances or criminal activity of any kind while on the premises.
5. Abstain from bringing any weapons of any kind on the premises.

If the participant behave in a manner that willfully disrupts or hinders their treatment or the treatment being provided to others, they may be told to leave the premises and treatment may be rescheduled or terminated. If the behavior is deemed to be of imminent danger to self or others, staff will contact police officials.

_____ _____

Signature of Parent/ Guardian Date

_____ _____

Printed Name Clinician Signature

Mental Wellness Center of the Lowcountry, LLC Professional Disclosure Statement and Consent for treatment with Marcy E Houston

I acknowledge that I have received and read the Mental Wellness Center of the Lowcountry, LLC Professional Disclosure Statement and Consent for Treatment and the HIPAA Clients Rights. I further acknowledge that I see and consent to treatment with Marcy E Houston. My signature below confirms that I understand and accept all the information contained in the Mental Wellness Center of the Lowcountry, LLC Professional Disclosure Statement and Consent for Treatment and the HIPAA Clients Rights.

_____ _____

Signature of Parent/ Guardian Date

_____ _____

Signature of Counselor Date

CHILD INFORMED CONSENT FOR TREATMENT

I, _____ , born _____ and residing at _____ give my authorization and consent for my child to receive outpatient diagnostic treatment services from Mental Wellness Center of the Lowcountry, LLC.

PLEASE READ THOROUGHLY AND INITIAL BESIDE EACH BELOW:

1. _____ I have been given information regarding my rights and responsibilities as a participant.
2. _____ I have been given information regarding the limits of confidentiality of my records.
3. _____ I have been given information regarding the cost of services from Mental Wellness Center of the Lowcountry, LLC. I understand that I am responsible to pay any fees due and that it is payable each time I receive services.
4. _____ I have been informed of my clinician's level of licensure and training and of how clinical information may be used.
5. _____ I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
6. _____ I understand that there is a $50 cancellation fee for appointments not canceled at least 24 hours prior to a scheduled session. I understand that it is my responsibility to cancel and/or reschedule my appointment by calling or emailing my therapist.

_____ _____
Client Signature Date

_____ _____
Printed name Clinician Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant's Name:_____ Last 4 of SSN_____

List all persons/ organizations authorized to provide/receive the information (with their phone number) from and/or between Mental Wellness Center of the Lowcountry, LLC:

_____

_____

_____

Specific description of information to be used or disclosed (including date):_____

_____

Specific purpose of the disclosure: **Continuity of Care**

This authorization will expire: _____

I authorize the release of any medical or other information necessary for continuity of care.

_____ _____

Parent/ Guardian Signature Date

_____ _____

Printed name Clinician Signature

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