

CARTER COUNSELING

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My clinical approach is a blend of Client-Centered, Family Systems, Cognitive-Behavioral, Gestalt, Imago, and EMDR therapies. We may discuss other treatment techniques/strategies as we work together. State licensure does not imply endorsement by the counselor licensing board or the effectiveness of treatment.

Consent to Treatment: It is important that your therapy be based on as honest and full a disclosure of information as possible relative to your rights as a patient/client, treatment procedures used, any known potential risks and any legal and/or ethical obligations I have which might effect your treatment.

Client Rights: It is important that your needs be addressed and the best effort be made that they be met. You are the consumer of services and as such have the rights of any consumer. These include, but are not limited to, the right to ask questions about procedures, theoretical orientation, or personal bias related to therapy and assessment practices. **Please** address any concerns during your therapy. It is my desire that your commitment to and hard work during therapy will bring growth and positive results. You have the right to terminate treatment at any time. You also have the right to request a referral to another health care provider if you desire.

Potential Risks: Research has demonstrated that psychological therapy is generally helpful and positive, but can also, in a small percentage of cases, have negative effects. I will take great care to insure that you benefit from your therapy experience.. Therapy may be painful and you may experience periods of unpleasant emotion; these are generally short-lived and will pass with resolution of your problems. Negative outcomes are generally related to an individual feeling alienated and uncared about as a result of the treatment. **Please** bring these emotions up if they emerge during your therapy because working them through can be a source of therapeutic progress. If the treatment is for a relationship problem (i.e. marital or family, etc.), the outcome may not always be what is most desired by one party or the other. The goal is to make relationships work; however, on occasions, therapy leads to dissolution rather than resolution of difficulty.

Confidentiality: At the base of an effective therapeutic relationship is your right to privacy and confidentiality with regards to what you disclose in therapy. Our communications are considered privileged and legally protected. This protection is not absolute, however, as detailed below.

Legal and Ethical Responsibilities: As a health care provider, I am responsible to protect consumers and the public from harm. At times, your rights of an individual in treatment may come into conflict with my responsibilities, both legally and ethically, to society in general. In these fortunately rare cases, I am legally and ethically mandated to “break” confidentiality to protect either the individual in treatment or third parties from harm. Suspected or reported child abuse requires that the situation be communicated to the Idaho Department of Health and Welfare Child Protective Services within 24 hours. If a client/patient should become dangerous to an identifiable third party, it is required that both the individual in potential danger and local law enforcement officials be notified. If a client/patient threatens to hurt him or herself in a clear and planful manner, necessary steps will be taken to protect life. This might include insistence on voluntary inpatient hospitalization, the notification of local law enforcement and/or the initiation of involuntary commitment procedures. In addition, there is no privileged communication in the circumstances determined under the Idaho Rule of Evidence #517.

Insurance Billing/Financial Policy: My policy is payment at the time of visit unless other arrangements are made. The first session is to be paid in full. Once payment status with your insurance has been established and benefits assigned, your co-payment at time of visit will be sufficient. Your insurance is a contract between you and your insurance company. I am not a party to that contract. My fees generally fall within the range allowed by most companies and therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on a “schedule” of fees, bearing no relationship to the standard and cost of care in this area. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to learn from your company what it will or will not cover. Please confirm with your insurance their policies relating to outpatient mental health services. Your insurance company will be provided with information necessary to pay your claim. I must emphasize as your medical care provider, my relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy which I extend to my clients, all charges are your responsibility and must be paid within thirty (30) days from the time services are rendered. Feel free to discuss any financial concerns you might have. Finance charges may be added on any balance past 30 days.

Current fees are based on a 45-50 minute session:

Diagnostic Intake	\$125.00
Individual Therapy	\$110.00
Employee Assistance Therapy	-0-- employer pays for authorized sessions
Phone Consultation/Therapy*	\$ 50.00

*Most insurance and EAP companies will not cover telephone therapy
(Fees for hospital, court related work, or the sending of records must be discussed with me.)

The following applies to ALL clients:

No Show/Late Cancellation Policy: Failure to contact my office 24 hours in advance (unless you have a last-minute emergency) will cause your account to be charged \$50. Insurance will not cover these charges. If you are coming to my office under an EAP Program, some EAP Programs will allow me to bill against sessions authorized for missed appointments. If your EAP Program does not allow me to bill against sessions authorized, I will deduct one session from your total authorized. Or if you have exhausted your EAP sessions, I will charge your account \$50 for missed appointments.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

I/we understand the above and have been provided the opportunity to discuss any area addressed above or other concerns related to my treatment (or treatment of my /our minor child). I/we have been offered a copy of this document for future reference. My/our signature(s) below confirms that I/we have read the above and give my/our consent to treatment.

Client/Parent Signature	Minor Child Name	Date
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Client/Parent Signature	Date
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HIPPA PRIVACY POLICY

I/we have been given the opportunity to read and receive a copy of the **Notice of Privacy Practices**, and I/we fully understand the Notice.

(Signature)_____ (Date)_____
(Name, printed)_____

(Signature)_____ (Date)_____
(Name, printed)_____