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Declaration of Policies and Procedures

This document contains important information about my professional services and business policies and procedures. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although this document is long and sometimes complex, it is important that you read it carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. Please take a moment to review the information below.

Qualifications: I am licensed in Marriage and Family Therapy, (NC #1375). I also have a Master of Arts degree in Special Education with an emphasis on working with troubled youth.

Areas of Expertise: In addition to marriage and family counseling, and addictions, my training and experience qualifies issues such as anxiety, depression, stress, pain management, grief, and life transitions.

Professional Fees:

All fees are to be paid at the time of service unless prior arrangements have been made.

Other services performed on your behalf including but not limited to report writing, telephone conversations lasting longer than 10 minutes, preparation of records or treatment summaries, legal proceedings that require my participation or any other services you may request of me, will incur a fee which will be discussed should the need arise.

Meetings and Length of Therapy: Therapy sessions are normally a 50 minute "hour." I provide targeted, goal directed therapy sessions but the length of treatment varies from case to case.

Services Offered and Clients Served: My goal is to help promote improved relationships with one's self and others by focusing on health and personal awareness. My therapeutic approach is cognitive-behavioral, balanced with mindfulness to increase psychological flexibility. Clinical hypnosis may be offered as strategic tool to support and expedite desired change. In addition, the holistic nature of my views concerning mental-health recognizes that a person's spirituality is a vital component in his/her lasting mental-health and relationships. Though I do see individuals alone, I attempt to involve the entire family where appropriate and if possible. I see clients of all ages and backgrounds. Should I find that a client presents a particular problem that needs assistance that is beyond my scope of abilities, I will address this with client (s), and I will make referral to another mental-health professional.

Code of Conduct: I am required by state law and my own personal convictions to adhere to those ethics codes endorsed by the NC Board of Professional Marriage and Family Therapists. These ethics codes are produced by the American Association for Marriage and Family Therapists. Copies of these codes are available upon your request.

Confidentiality and Privileged Communication: The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements. Exceptions would include information disclosing harm to a child or elderly person or intent to cause violence to any person.

Privileged communication is a legal concept that protects against forced disclosure in legal proceedings that would break a promise of privacy. Certain information is protected by law. If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, that information may be covered by this law. Privileged communication is designed to protect sensitive information from being unnecessarily disclosed.

As mandated by my licensing board, I do not provide expert testimony in custody hearings.

I protect your privacy and confidentiality by using a HIPPA approved platform for all telehealth therapy. Please read the additional information provided on the website and sign the telehealth agreement document.

Client's initials: _____I recognize that any electronic communication will not be sent through a secure server or encrypted and should never include any confidential information but I am willing to receive appointment reminders and possibly credit card receipts via email.

Emergency Situations: The nature of my practice is that of outpatient psychotherapy services and I do not provide 24-hour emergency services. However, in most cases you may leave a message for me at (828) 372-2434. If you're unable to speak to me and you have an emergency, you and your family members are instructed to contact Daymark Recovery Mobile Crisis (866-275-9552) or present at Appalachian Regional Medical Center Emergency Department in Boone or call 911.

Interruptions in Therapy: Occasionally there will be interruptions in therapy. Interruptions can be because of vacations, illness or other personal reasons. In case of planned interruptions, I will notify you as far in advance as possible and provide names of trusted colleague (s) that will be available to you in case of emergency. In the event of an unplanned interruption, I will notify you as soon as possible and provide information regarding rescheduling your appointment.

Potential Counseling Risks: While the counseling process is immensely advantageous for most clients, there are instances in which individuals experience feelings of sadness, fear, anger, anxiety or guilt. Any time a person makes major life decisions, it is natural to experience disturbing thoughts and feelings. Other risks include remembering traumatic experiences and confronting distressing thoughts and/or beliefs. In addition, major life changes may be made as a result of therapy. Such decisions can lead to unwanted outcomes. When one member of a marriage or family experiences intense emotions or makes major life changes, all members are affected. Therefore, it is essential that all members of the counseling experience commit to the therapeutic process. Though I cannot foresee all potential risks, I will attempt to inform you of expected potential risks specific to our work. I cannot guarantee a positive outcome to our work. The responsibility for your therapy rests ultimately with you.

Client Responsibilities:

- Client's initials: _____Clients agreed to make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Your welfare is most important, and your full cooperation is crucial. You may be asked to complete assignments between sessions. If you come seeking therapy in conjunction with another mental health care relationship you must first be granted permission by that therapist for me to assist you.
- The Client agrees that all fees/copays shall be due and paid at the time of treatment and the payments in arrears/debts over two session may result in the cessation of therapy.

Cancellation Policy

- **A $50 no-show or late cancellation fee will be automatically charged for clients that do no provide 24 hours' notice. Extenuating circumstances may be considered in the case of severe and sudden illness or accident.**

Please Ask Questions: Feel free to ask questions about me, my qualifications, or anything else which has not been addressed in the previous paragraphs.

It is expressly understood that Bonnie Perkins, has not and will not issue any guarantee of cure or treatment effect, number of sessions necessary, or total cost of service. It is further understood that Bonnie Perkins shall be obligated to maintain a reasonable standard of care for practicing master level counselors.

The Client agrees that all fees shall be due and paid at the time of treatment and the payments in arrears/debts over two sessions may result in the cessation of therapy.

Signatures: By signing below you indicate that you have read and understood this declaration statement. Please sign the form and return it at the next counseling session. We, the undersigned Counselor/Therapist and Client(s), have read, discussed together, and fully understand this agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate, and will respect each other's views and differences in their outworking.

This agreement is entered voluntarily by the Client(s) with competency, and with knowledge and understanding of the consequences.

Client(s) Signature(s):

_____ Date: _____/_____/_____

_____ Date: _____/_____/_____