Welcome to the Office of

TRACY BOYER-MATTHEWS LCMHC

LICENSED CLINICAL MENTAL HEALTH COUNSELOR, NC#3735

CERTIFIED IMAGO RELATIONSHIP COUNSELOR

1904 EASTWOOD ROAD, SUITE 313

WILMINGTON NC 28403

Name:_____

DOB:_____ SS#(needed if filing insurance) _____

Address including Zip Code: _____

Relationship Status:_____

Children or dependents:_____

Employment Status:_____

Please list any physical or mental health diagnosis or issues that would be important for me to know to best be of help to you:

_____

_____

_____

Current Medications today or in the past 6 months:_____

_____

_____

_____

Referral or how you found me:_____

Any other important information that you would like me to know?

_____

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DISCLOSURE STATEMENT

I am pleased that you have selected me as your counselor, and I look forward to our work together. This document will inform you of my background and treatment modality so that you are well prepared for our professional relationship. I earned my Master's Degree in Counseling from Webster University in 1998. I am a Licensed Clinical Mental Health Counselor in North Carolina. I have completed 96 hours of specialized training in Imago Relationship Therapy, and have been a Certified Imago Therapist since 2001. Since January 1998 I have done direct counseling work primarily with families and couples, populations I serve are 18 and older and on an outpatient basis only.

COUNSELING SERVICES AND THEORETICAL APPROACHES Counseling involves your active participation and commitment to change from perspectives that include thinking, feeling and behaving. You will be challenged to question your worldviews and lifelong ways of doing things. It is my belief that people do what works, and when they grow uncomfortable enough they seek out ways to do something different. Our work together will be an analysis of your ability to use your strengths, and a journey to uncover and address your challenges. The amount of progress you make will be contingent upon both your willingness to embrace new insights about yourself and your level of investment in the process of making changes. My commitments are: 1) to help you develop goals that are long-term and significant for you, and 2) to use my experiences and expertise to assist you in pursuing your goals. My approach to theoretical application is eclectic. I feel that it is in the best interest of the client to use what will be most effective and beneficial for that particular individual. During assessment I use a psychoanalytical approach to investigate the client's developmental experiences and significant issues in early life. This helps me understand how perspectives on major issues were formed and what relationship models were present in childhood. Once dysfunctional patterns and barriers to goal attainment are identified, I rely more on a cognitive/behavioral therapy combined with a structural/systemic perspective to address specific steps and strategies towards positive change. As with any endeavor in life worth taking, therapy involves both benefits and risks. Potential benefits include a deeper understanding of ourselves which allows for more fulfilling relationships with others; a decrease in self-destructive behaviors, as well as a greater awareness of our true wants and needs, all of which contribute to a happier and healthier lifestyle. Risks include possibly experiencing intense feelings of anxiety, guilt, anger or depression, as well as difficulties in personal relationships if others in your life are not comfortable with your decision to change.

CONFIDENTIALITY Due to the personal and confidential information you will be sharing with me, it is important that you understand the manner in which it will be handled. The privacy and confidentiality of all conversations and my records are your privilege and are protected by state law and my professional ethical principles, in all but a few cases. All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information. In rare circumstances, professional counselors can be ordered by a judge to release information. Otherwise, I will not disclose to anyone anything about your treatment, diagnosis, and history or even that you are a client, without your full knowledge and a signed Release of Information form. Please be aware: Our community is small and there is always a possibility of a client/therapist encounter outside the office. You are more than welcome to approach or initiate a conversation with me, yet my policy is to never acknowledge clients first when outside the therapeutic environment. This is my way of honoring your confidentiality and not compromising your comfort level in a public setting.

EXPLANATION OF DUAL RELATIONSHIPS Although our conversations will be centered around intimate topics and private matters, it is important for you to understand that our relationship is a professional one rather than a social one. Our contact will be limited to sessions you arrange with me. Please understand that gathering for social outings, exchanging gifts, or relating to each other in any way outside of the client/counselor dynamic is unethical, unprofessional and would jeopardize the validity and productivity of our work in therapy. You will learn a great deal about me as we work toward your goals, and I will gain valuable experiences through our relationship as well. It is vital that you understand that you are experiencing me in my professional role.

LENGTH OF SESSIONS I guarantee that my services will be rendered in a professional manner consistent with accepted ethical standards and norm. Sessions will be 45 minutes long unless otherwise agreed upon beforehand. **_____*(Initial)*** If you are unable to keep an appointment, IT IS YOUR RESPONSIBILITY to notify me at least 24 hours in advance, or you may be responsible for paying a "nopshow" fee equivalent to the full amount of our agreed upon contractual fee. Missed appointments are not billable to insurance. **_____*(Initial)*** This is also true for appointments that fall directly after a weekend or holiday. Cancellations must be made via voice mail (910-231-7047) at least 24 hours in advance. I acknowledge that your time is important and valuable as well. If I am unable to keep an appointment, I will also inform you at least 24 hours in advance.

FEES/METHOD OF PAYMENT Fees will be discussed and agreed upon prior to the first session. It is required that you pay at the time of the session. Acceptable payments are in the form of cash, personal checks, or Debt/Credit Card/HSA Card. Sessions are 1 hour for an initial assessment, then 60 minutes in duration unless differently agreed upon beforehand. Fees are $135 per hour for couples and $125 for individuals. If using insurance, individual sessions 53-60 minutes in duration, family or couples sessions are 60 minutes in duration and fees depend upon our fee agreement or your insurance coverage. Some companies that cover Mental Health services require that you meet a deductible first, and after that, they reimbursement only a percentage of the fee. Many require only a co-pay. You should contact your insurance representative to determine what you company will reimburse and what schedule of reimbursement will be used. PLEASE NOTE THAT YOU ARE RESPONSIBLE, NOT THE INSURANCE COMPANY, FOR PAYING FEES AGREED UPON, AND THE INSURANCE COMPANY'S VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OR REIMBURSEMENT. **_____*(Initial)*** Please be aware that claims are filed bi-monthly on average, yet this is not a guarantee. Health insurance benefits also require a diagnosis of your mental health conditions and an indication that you have a mental disorder of a "mental illness" before they will agree to reimburse you. In the event that a diagnosis is required, I will inform you of the diagnosis I plan to render before I submit it to your insurance company. Any diagnosis made will be part of your permanent insurance records.

COURT INVOLVEMENT If ordered by a judge, I am legally obligated to appear in court or release records. Please note that if I am required to appear in court as a result of our therapeutic relationship, you will be responsible for all fees associated with missed or cancelled sessions as well as a fee of $110 per hour to prepare for court. **_____ *(Initial)***

COMPLAINT PROCEDURES If, in the process of our work together, you are unhappy with my services or unhappy with any aspects of our work together please inform me immediately. This will make our work together more effective and will ensure that the counseling process is productive. If you think that you have been treated unfairly or unethically by me or any other counselor, and you cannot resolve this problem with me directly, you may contact the organization below. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Clinical Mental Health Counselors P.O. Box 77819 Greensboro, NC 27417 Phone: 844-622-3572 or 336-217-6007 Fax: 336-217-9450 E-mail: Complaints@ncblcmhc.org

_____

Counselor's Signature Date

_____

Client's Signature Date

NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF

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his notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review carefully. **_____*(initial)***

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I also am required by law to keep your information private. These laws can be complicated, but I must give you this important information. This document is shorter than the full legally required NPP, which you may receive upon request. I cannot cover all possible situations so PLEASE talk with me about any questions, problems or extenuating circumstances.

I will use the information about your health, which I get from you or from others to provide you with treatment, arrange payment for my services, and for other business activities called, by the law, “health care operations”. After you have ready this NPP I will ask you to sign a consent form to let me use and share your information with authorized entities (ie. villing assistant, your insurance carrier, etc). If you do not consent and sign this form, I cannot treat you. **_____*(initial)***

If you or I want to use or disclose (send, share, release) your information for any other purposes, we will discuss and I will ask you to sign an authorization form prior to any sharing of information.

I will keep your health information private when possible, but there are some times when the laws require me to use or share it. Some examples are:

- When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to prevent or reduce the threat.
- Some lawsuits and legal or court proceedings.
- If law enforcement requires me to do so.
- For Workers Compensation, Disability, or similar benefit programs.

There are other situations like these but which do not happen frequently and are described in the longer version of the NPP.

Your rights regarding your health information:

You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

You can ask me to limit what we tell others involved in your care or the payment of your care, such as family members and friends. I am not required to agree to your request, but if I have done so, I will keep our agreement unless it is against the law to do so, or in an emergency situation when the information may be necessary to treat you.

You can review the health information I have about you such as medical and billing records. You can get a copy of these records, though there may be a charge. Contact Rebecca Petruck (charis4014@yahoo.com) , my Privacy Officer, to arrange you to review your records.

If you believe the information in your records is incomplete, you can ask me to amend your health information. You must make this request in writing and provide it to the Privacy Officer. You must explain to me why you wish to make these changes.

Any changes to this NPP will be posted in my office and/or waiting room. To receive a copy for yourself, please contact the Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer and the Secretary of the Department of Health and Human Services. All complaints must be in writing and will not change the healthcare I provide to you.

BILLING INFO

(AFTER INITIAL SESSION)

Name:_____

Email:_____

Address including zip code: _____

_____

SS# if filing insurance: _____

Debt or Credit Card on File: # _____

Exp. Date_____ 3 Digit Code_____ Zip Code_____

Appointment Reminders and Confirmations! In an effort to eradicate or at *least* minimize appointment miscommunications please read and initial the following updated procedures!

*If you do NOT get a text appointment reminder from me 48 hours before your appointment please reach out at my direct line 910-231-7047 ASAP. **_____(initial)**

*If you get a reminder and do NOT have an appointment on your calendar please also reach out to resolve the confusion. **_____(initial)**

*Please read the confirmation in its entirety to ensure the time and date match your calendar. **_____(initial)**

*Cancellations are required no less than 24 hours in advance but are appreciated ASAP to allow me to fill your spot. If you are charged for a session please note it is not your co-pay but the full contracted fee either as a private pay or BCBS client that is due for the missed session. **_____(initial)**