LCMHCA Professional Disclosure Statement

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I am a *Licensed Clinical Mental Health Counselor Associate* (LCMHCA) in North Carolina. I work under the expertise and supervision of: Linda Harrison who can be reached by email: lharrison255@gmail.com or by phone: 828-380-2949.

Previously, I served for 25 years as a *Child Development Specialist* and *Licensed School Counselor* in Salem, Oregon, working extensively with child, teen, and young adult populations in the public schools, both individually and in small group formats. Emphasis on high school-college preparation, transitions, identification of emotions and effective expression of needs, building positive relationships, mindfulness training and awareness, development of sexual identity and boundaries, goal setting, trauma, grief and loss recovery, ADD/ADHD, as well as anger management and impulse control.

As a LCMCA, I continue my work with the child/adolescent populations in a private setting, while offering my expertise as a liaison to both school and home settings, as appropriate, to ensure my client has a full spectrum of support to develop the skills and awareness to live a happy and successful life.

I incorporate the use of *Expressive Therapies* in my practice with all age populations, and will incorporate expressive techniques, such as the Active Imagination, and other expressive based modalities as deemed useful (e.g. Art, Movement/Dance, Poetry/ Writing/Bibliotherapy, Sand Tray, Play, and Drama therapies. Expressive Therapies have been found to be extremely effective for expression of non-verbal feelings, such as those underlying trauma. I draw from the models of *Emotionally Focused Therapy* (EFT), and *Accelerated Experiential Dynamic Psychotherapy* (AEDP), another extremely effective model that shares many similarities with EFT. A substantial body of research on the effectiveness of EFT now exists. This research demonstrates that individuals improve significantly over the course of treatment and continue to improve at a 2-year follow-up. The primary goals of EFT are: 1) to expand and reorganize key emotional responses; 2) to create a shift in interactional patterns; 3) to foster the ability to form secure bonds. For further information about the EFT treatment model and additional outcome research, please refer to: www.iceeft.com.

Informed Consent Policies

•Your Rights as a Client:

You have the right to ask questions about the therapy process at any time during our work together. You have the right to decide at any time to stop seeing Melina Bridges, and if you wish, she will provide you with the names of other qualified professionals whose services you might prefer. You have the right to end therapy at anytime without any moral, legal or financial obligations, other than those already accrued. Although clients are encouraged to discuss any concerns with me should they arise, you may also file a complaint against me with the organization below if you feel I am in violation of any of the ACA Codes of Ethics by which I abide.

(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
Email: Complaints@ncblcmhc.org

•Confidentiality:

Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. At times therapy may involve the participation of more than one family member and/or significant person(s). While Melina Bridges will attempt to follow your wishes, she does not guarantee confidentiality among participants in family therapy (see "No Secrets Policy" below). There are certain situations in which Melina Bridges is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These would include: a) If you threaten bodily harm or death to another person, Melina Bridges is required by law to inform the intended victim(s) and appropriate law enforcement agencies. b) If you threaten bodily harm or death to yourself, Melina Bridges will inform law enforcement agencies and others (such as your spouse, friends or inpatient psychiatric institution) who could aid in prohibiting you from carrying out this threat. c) If you reveal information related to the abuse or neglect of a child, dependent adult or elderly person, Melina Bridges is required by law to report this to the appropriate authorities. "No Secrets" Policy for Family and Couple Therapy: (Please skip this section and proceed to #3, if you are coming for individual work). This policy is intended to inform you, the participants in family therapy, that when I agree to work with a family, I consider that family to be the "treatment unit" or patient. For

example, if there is a request for the treatment records, I will seek authorization from all members of the treatment unit before releasing confidential information to any one person. And if my records are subpoenaed, I will assert the psychotherapist/patient privilege on behalf of the patient (again, the treatment unit). During the course of our work together, I will likely see a smaller part of the treatment unit (e.g. an individual or sibling[s]) for one or more sessions. These sessions should be seen by you as part of the work that I am doing with the family. If you are involved in any such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any information to a third party unless I am required to do so by law, or unless I have your written authorization. In fact, since these sessions can and should be considered part of the family therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit present) with the entire treatment unit – that is, the family, if I am to effectively serve the entire unit being treated. I will use my best clinical judgment as to whether, when, and to what extent I will make disclosures to the treatment unit. If appropriate, I will also first give the individual or smaller part of the treatment unit being seen the opportunity to make the disclosure themselves. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. (I will always be happy to refer you to such a person.) This "no secrets" policy is intended to allow me to continue to treat the patient (or family unit) by preventing, to the extent possible, a conflict of interest in which an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the family, and if I were not free to exercise my clinical judgment regarding the need to bring this information to the family during the process of therapy, I might be placed in a situation where I would need to terminate treatment of the family. This policy is intended to prevent the need for such termination.

We, the members of the_____
(family or other treatment unit) being seen, acknowledge by our initials and signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss it's contents with Melina Bridges, and that we are entering into a family therapy in agreement with this policy.

Each person must initial: Initials _____ Initials _____ Initials _____
Initials _____ Initials _____ Initials _____

- **Explanation of therapy for minors:**

If you are the parent or guardian of a minor, please read the following section: Some children experience difficulty in adjusting to normal life experiences, and others struggle with feelings about hurtful situations from the past. Therapy provides a unique opportunity for working through these problems in

a relationship with an accepting adult who is specially trained in understanding the complexity of children's emotional life. The therapy process for older children consists primarily of helping them to share about their life and feelings, drawing both from emotional and expressive therapies. Younger children, however, use various forms of play in addition to talking. Therapy during childhood is particularly worthwhile because it can resolve conflicts and also prevent the development of unhealthy attitudes and behaviors that might become a staple part of the child's personality. There is a large variation in the length of effective therapy, but if problems are serious, it is not uncommon for a child to need two years of continuous treatment. Parents should be willing to support this length of time from the outset, since it can be detrimental to a child to begin treatment and then prematurely terminate it.

Parent Conferences:
It is important that parents maintain contact with me and communicate any concerns about your child that may develop. Please feel free to call me at any time or set up an appointment to speak in person. I will request regular conferences in order to get feedback about how the child is doing at home and at school. PLEASE NOTE: When parents have their own individual therapist(s) in addition to their contact with me, it invariably has a positive effect on the child's progress.

Confidentiality with Children:
Effective treatment is dependent upon the child being able to maintain a confidential relationship with the therapist. Therefore, it is essential that the child not feel any necessity to give an accounting of the events during the therapy hour. This time should be viewed as her own private time with the therapist. For this reason, parents are asked to refrain from questioning the child about what she talked about or whether or not she liked the session. Under ordinary circumstances I will not tell parents (or anyone else) specifics about the treatment hour. Revealing any information will be solely at my discretion (except as mandated by law), and the decision to do so will be based on whether or not a particular disclosure is necessary to promote or protect the welfare of the child. The signing of this agreement indicates your understanding that I am not willing to testify in court or be involved in any litigation related to the child's psychological functioning. If an evaluation of the child's psychological condition is needed, it is agreed that another professional will be consulted for that purpose.

By signing below, I give my consent for Melina Bridges to conduct therapy sessions with the minor listed below. I have been informed about the limitations to confidentiality regarding certain topics, such as: substance abuse, harming behavior (to self or other), and inappropriate or illegal sexual activity. By my signature below I accept Melina Bridge's judgment regarding the release of information related to the treatment of this minor. I also

understand that if at anytime Melina Bridges believes this minor is in danger of hurting him- or herself, I will be notified immediately.

Parent or Legal Guardian (Please print)

_____ Minor's Name

_____Parent's Signature(s)

_____;

_____Guardian's Signature(s)

_____;

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- **Video Consent for Training, Supervision & Consultation**:

In order to provide my patients with the best possible treatment, it is common for me to participate in consultation and supervision with other seasoned mental health professionals. Part of this process entails the occasional use of short video segments of my sessions. With your consent, I may present a video clip to a supervisor/consultant or small group of therapists. Typically, a short segment of our session will be shown along with a brief background of our work together. At no time is any identifying information presented to the supervisor/consultant or training group members, aside from the use of your first names, which may be spoken in the video. By law, all mental health professionals in the consultation and/or training group must follow the same confidentiality guidelines as I do. Furthermore, if by chance a member of the training group were to know you – they are shown a brief still photo before beginning – they would be asked to leave the group and would not be permitted to participate in that (or any) portion of the meeting involving our work together. Your recorded session will be either deleted immediately after our session – this is the case 95% of the time – or remain with and be protected by me. It will never become a part of your file; neither will it ever be reproduced or shared with anyone, other than as outlined above.

By initialing below, I/we give my/our consent to allow my therapy session(s) with Melina Bridges to be:

a) recorded via video and used solely by Melina Bridges for her private review and/or in conjunction with an expert clinician(s) for private supervision/consultation purposes only.

b) used as described in the paragraph above, and also solely by Melina Bridges for training and/or supervision purposes. By signing below, I/we acknowledge that we are not being offered any compensation, nor are we under any duress to give our consent. We understand that our status as client(s) of Melina Bridges will not be affected in any way by our consent or lack of consent. Although Melina Bridges will retain certain recordings for a

period of time, they will never become a part of a patient's file or clinical record, either temporarily or permanently. We understand that the recordings are for the private use of Melina Bridges as described above and that we will not have access to the recordings. I further understand that I have the right to revoke this consent – to the extent that Melina Bridges has not already relied on it – at any time.

1) Name (Please print) _____
Signature _____
Date: _____
2) Name (Please print) _____
Signature _____
Date: _____

•Fee Acknowledgement and Agreement:

The fee for your initial 80-minute evaluation has been set at $190. Subsequent individual sessions will be billed at $125 for 50-minute sessions. Paperwork requiring more than 15-minutes will also be billed according to the above numbers. If your session goes longer than the allotted time or if you are participating in intensive (multiple sessions per week) therapy, your fee may be negotiated with Melina Bridges. All session times, however, and the corresponding fees may be changed by mutual agreement between you and Melina Bridges. If for any reason you are unable to attend your scheduled appointment, you must call a minimum of 24-hours in advance or you will be charged a full session fee. Additionally, if your personal check is returned for insufficient funds, you will be charged $45.00 (the fee my bank charges me). Payments are expected at the time of your appointment unless other arrangements have been made in advance. Kindly have your check ready before we begin our session, as this will alleviate our having to stop early to handle invoice and billing matters.

•Insurance Policies:

The invoices I provide contain all of the information necessary for you to submit them for "out-of-network" insurance reimbursement, which I will provide on a monthly basis. I do not accept insurance, nor do I work with insurance organizations or their representatives, as they typically limit sessions, require regular treatment reports, and generally create policies that interfere with effective therapy. In addition, I do not submit paperwork on the behalf of my patients, nor do I engage in any correspondence, written or verbal, with insurance companies or their representatives. Some insurance companies will reimburse clients for counseling services and some will not. In addition, most will require a diagnosis of a mental health condition and indicate you must have an "illness" before they will agree to reimburse you.

If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before it is submitted to your health insurance company. Any diagnosis made will become part of your permanent insurance records.

•Melina Bridge's Contact Information:

I can be reached at 828-747-8900. If I do not answer your call is urgent, please leave a voicemail message on that number. If you are experiencing a clinical emergency, please call 911 or proceed to the nearest emergency room. Please note: because email is not 100% private, email communications should be used for non-emergencies and non-clinical correspondence only (appointment changes, referrals and other non-clinical issues). I check my emails regularly, but if you are canceling an appointment with less than 24-hours notice, kindly also call my mobile number (828-747-8900). My email address is m.bridges@ashevillechildtherapist.com.

•Signatures:

The undersigned, by providing his/her signature, agrees to accept the therapy services provided by Melina Bridges, in accordance with and pursuant to the terms and conditions set forth in this agreement.

1) *Name (Please print)* _____
Signature _____
Date: _____

2) *Name (Please print)* _____
Signature _____
Date: _____

3) *Parent or Legal Guardian (Please print)*
_____,

_____;
For Minor _____
Signature _____
Date: _____

*Melina Bridges*_____