**Professional Disclosure Statement**

*Qualifications*

I, Amanda M. Sehr, am a Licensed Professional Counselor in the state of Texas and a Board-Certified Music Therapist. I am in private practice providing mental health services to adults and adolescents at Shambhala Wellness Center. I earned both a master’s degree in Counseling and Development and a master’s degree in Music with a specialization in Music Therapy from Texas Woman’s University. My certification in music therapy also qualifies me to provide music-based expressive arts techniques in conjunction with traditional psychotherapy techniques. If you are interested in utilizing an integrated music therapy-counseling approach in the course of your sessions, we can discuss whether this would be an appropriate approach to your treatment.

*Experience*

My counseling practice is primarily focused on adults and adolescents dealing with a variety of personal and emotional concerns. I have four years of experience providing individual, group, and family counseling to juvenile offenders. In addition, I have experience providing music therapy to children, adults, and older adults in group settings. I have worked with adolescents in a residential treatment facility and adults in a psychiatric facility using an integrated music therapy-counseling approach. I have also obtained specialized training in dreamwork through graduate-level coursework. My training allows me to utilize two different models of dream interpretation, which rely on either a cognitive-experiential approach or a focus on bodily sensation and awareness. If you are interested in utilizing dreamwork within your sessions, we can do so within the course of our regularly scheduled sessions or focus independently on your dreams.

*Nature of Counseling*

I believe that counseling requires a mutual engagement by both the client and the therapist in an effort to create a facilitative, open, and genuine therapeutic relationship. I work from a Person-Centered theoretical approach and believe in an individual’s inherent ability to grow and change in positive directions toward reaching their true potential. I believe that although everyone has this innate capacity, our external environments, as well as our own internal struggles, can inhibit our potential to fully realize this ability. It is my belief that clients provide the most knowledgeable source of information about their own experience. Therefore, it is of the utmost importance for the client to take a leadership role in deciding the direction and goals of therapy. My role as a counselor is to create a supportive environment through a therapeutic relationship characterized by warmth, genuineness, empathy, and acceptance in which the client can feel safe in engaging in self-exploration and working toward reaching their therapeutic goals. I believe that the counseling process is a journey that the therapist and client embark upon together in an effort to help the client to gain insight into patterns of behavior and underlying emotions, to achieve greater self-awareness and understanding, to live more authentically, and to lead more enriching lives.

**Informed Consent**

*Length of Sessions and Number of Visits*

For the initial intake session we will meet for 60-75 minutes to allow for time for reviewing the paperwork. Following the initial intake session, we will meet at a scheduled time for 60-minute counseling sessions for adults and 45-minute counseling sessions for adolescents. The number of sessions needed by clients depends on many different factors; therefore, the duration of counseling cannot be accurately predicted at the outset.

*Counseling Relationship*

Although the counseling relationship may feel psychologically close at times, it is professional in nature, as opposed to a social relationship. As such, I do not engage in social activities or contact outside of our scheduled appointment times, including Internet-based social media outlets such as Facebook or Twitter. Please do not offer me gifts, invite me to social activities, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. Any use of electronic media such as e-mail or text messages is strictly for scheduling purposes and are subject to the risks inherent in using this type of media. You will be best served if your needs and concerns are the sole focus of our work together.

*Goals*

I believe that it is important for you to take a leadership role in developing goals for your counseling sessions. I will help guide this process, but this will require you to take an active role in deciding what you would like to work on during your time in counseling. Goals that are initially developed at the beginning of counseling may change over time and should be discussed within your counseling sessions.

*Potential Effects of Counseling*

It is important to note that although counseling is a process that can result in a great deal of personal growth and change, no specific outcomes or benefits can be guaranteed. Some potential benefits of counseling include: gaining a better understanding of yourself, improving your relationships, and improving your ability to cope with stress. Because counseling involves some level of self-reflection, some clients may experience both positive and negative emotions in reaction to this self-exploration. Furthermore, this process may lead to new ways of understanding yourself, which may also affect your self-perception, your relationships, your career endeavors, or other significant areas of your life. Counseling may also result in experiencing unexpected feelings or changes related to the growth process, which may impact you or your personal relationships in unanticipated ways. Although such changes are unforeseeable at the outset of therapy, we will work together toward your best interest.

*Client’s Rights*

While some clients need only a few sessions to reach their goals, others may require several months or even years of counseling to achieve their desired outcomes. You have the right to decide whether or not to enter into counseling. You have the freedom to decline or discuss changes to any specific treatments or techniques that you do not feel will benefit you. You have the right to end our counseling relationship at any time, though I do request that you meet with me for a final termination session if you choose to discontinue counseling. If at any point during our work together, you have questions or concerns about the process, please bring this up during our sessions. I am open to discussing alternative treatments other than counseling to address your concerns, should you request such a discussion.

You can expect that I will provide services in accordance with the standard of care established by the profession of counseling and in accordance with the ethical standards of the American Counseling Association and the expectations of the Texas State Board of Examiners of Professional Counselors. In addition, you can expect that I will provide music-based expressive arts techniques and music therapy services in accordance with the code of ethics and standards of practice set forth by the American Music Therapy Association. If you become concerned about the quality of my services at any point, please let me know so that I may attempt to address your concerns directly. If you have concerns that cannot be resolved, or you wish to issue a formal complaint about services rendered, you may contact the Texas State Board of Examiners of Professional Counselors at 1-800-942-5540 or write to Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369.

*Emergency Procedures*

Emergencies are urgent issues that require immediate attention. If you experience a life-threatening crisis or psychological event outside of our regularly scheduled session times, you are advised to go to the nearest emergency room, call 911, or contact the Denton County MHMR Crisis Hotline at 1-800-762-0157 or the national crisis hotline at 1-800-273-8255. I do not provide emergency or crisis counseling services outside of normal business hours and I cannot guarantee availability outside of our scheduled appointment time.

*Requirements for Counseling Services*

If you have received counseling services within the past seven years, you will need to complete release forms allowing me to obtain records from and/or communicate with those mental health providers. In order for me to ethically engage in a professional counseling relationship with you, you may not receive counseling services from another mental health professional without consulting with me and providing me a release to speak to that mental health provider. I reserve the right to terminate counseling if you continue receiving counseling from another mental health provider.

I may choose to reschedule sessions or terminate counseling with clients who appear to be under the influence of drugs or alcohol. Counseling may be discontinued at the counselor’s discretion for clients who are not complying with their psychiatrist’s or physician’s medication recommendations or for clients with addiction problems who are not actively working in an appropriate addiction treatment program.

*Referrals*

You have the right to request referrals for mental health treatment at any time during the course of our working relationship. If either you or I believe a referral is in your best interest, I will provide you with appropriate mental health providers and/or programs. If you wish to discuss alternatives to counseling, we can do so at your request. I cannot vouch for the quality of any particular provider or program, and responsibility for contacting and evaluating referrals rests with you. In those rare instances where I may be unavailable to provide counseling services for an extended period of time, I will provide you with a referral for use in crisis situations.

*Appointments, Cancellations, and No Show Policy*

Appointments are scheduled by calling (940) 783-0870 Monday through Friday between the hours of 9:00am and 5:00pm. If you are unable to keep a scheduled appointment, please notify me via phone at least 24 hours prior to your scheduled appointment. If you are late to your appointment, the session will end 60 minutes after the originally scheduled appointment time and the full fee of $100 will be charged for session. I request that you notify me at least 24 hours in advance if you need to cancel or reschedule your appointment.

Clients who do not provide 24 hours advanced notice for session cancellations will be required to pay a $50 rescheduling fee in order to schedule another appointment after the missed appointment.

*Fees*

I agree to provide counseling services for a fee of $120 for the initial intake session and $100 for each session thereafter. All fees must be paid in full by cash or check at the conclusion of each counseling session. No subsequent sessions will be scheduled if an outstanding balance exists, unless other payment arrangements have been made. If a check is returned, you will be charged a processing fee of $25 and you will need to make a payment by cash or money order for the returned check plus the $25 processing fee. After two returned checks, payment may be required in cash for subsequent sessions. If the fees for counseling sessions create a hardship for you, please inquire about payment arrangements to temporarily adjust fees in times of financial hardship.

If I am subpoenaed or otherwise required by law to testify, provide a deposition, or complete administrative paperwork due to a lawsuit involving you, you will be responsible to pay for costs involved in producing records and for the therapist’s normal fee of $100 per 60 minutes for time engaged in preparing for and giving testimony (including travel and wait time, report/note preparation, phone calls, etc.). Payment is due at the time or prior to the time that these services are provided.

*Confidentiality*

The content of our counseling sessions is confidential. No information will be released without your consent except in situations where such disclosure is required by law. It is my goal as a therapist to protect the confidentiality of your records and our communications. In order to protect your confidentiality, I will not approach you in public and will only acknowledge you if you approach me first.

Any communication (including e-mail and text correspondence) becomes part of your permanent clinical record. You have the right to request your records, but will be required to attend a separate session specifically for the purpose of obtaining these records. All clinical records are retained for seven years, at which time they are destroyed. For clients under 18 years of age, records are retained until seven years following the client’s 18th birthday.

In most instances, communication between client and therapist remains confidential and is considered privileged communication. However, possible exceptions to confidentiality include, but are not limited to, the following situations:

* Suspected abuse, exploitation, or neglect of a child, elderly person, disabled person, or patient in a mental health facility
* Threat of harm to yourself or someone else
* HIV infection and possible transmission
* Sexual misconduct by another mental health professional
* Required by law or a court to release information
* Fee disputes between client and therapist
* Negligence suit brought by the client against the therapist
* Filing of a complaint with the licensing board or other state or federal regulatory authority

If you decide to file for reimbursement through your insurance company, be aware that the insurance company will require confidential information such as a mental health diagnosis and possible treatment information in order to reimburse for counseling services. By filing with your insurance company, you are authorizing me to disclose the confidential information required in order for counseling services to be reimbursed.

For further information, review the notice of privacy practices provided to you along with this Professional Disclosure and Informed Consent document. By signing this Professional Disclosure and Informed Consent Document, you are giving me permission to share confidential material with individuals as mandated by law.

*Duty to Warn*

In the event that Amanda Sehr, LPC, MT-BC reasonably believes that I am a danger, physically or emotionally, to myself for another person, I specifically consent for Amanda Sehr, LPC, MT-BC to warn the person in danger and to contact any person in a position to prevent harm to myself or another person including medical and law enforcement personnel. I understand that I may revoke this consent at any time in writing to the extent that Amanda Sehr, LPC, MT-BC has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices of Amanda Sehr, LPC, MT-BC that I have received and reviewed.

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Client’s Initials

*Counseling Children and Adolescents*

In the state of Texas, a child or adolescent under the age of eighteen is still considered a minor; therefore the minor’s parent/guardian holds legal rights to his/her confidentiality. Nevertheless, minors will be best served when confidentiality is maintained within the counseling relationship. I will, however, share information with you if I find it to be in the best interest of your child. You have the right to request a parent consultation to discuss questions or concerns regarding your child’s progress in counseling.

*Therapist Incapacity or Death*

In the event that I, Amanda Sehr, am no longer able to provide counseling services, it will be necessary for another mental health counselor to take possession of your file and records. By signing this consent form, you are giving permission for me to select another counselor to take possession of your files and records or deliver them to a therapist of your choice. It is your responsibility as the client to select a new therapist within a reasonable amount of time and to notify my successor of the new therapist’s contact information.

*Consent to Treatment*

Your signature below acknowledges that you are voluntarily consenting to receive mental health assessment, care, treatment, and related services and authorize Amanda Sehr, MS, MA, LPC, MT-BC to provide such care, treatment, or services considered necessary or advisable in her professional judgment. Your signature further acknowledges your agreement with the conditions specified within this document related to the provision of counseling services.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services received from Amanda Sehr, MS, MA, LPC, MT-BC at any time. By signing this Professional Disclosure and Informed Consent document, I acknowledge that I have read and understood this document and all the terms and information it contains. I further acknowledge that I have had the opportunity to ask questions about this document and its contents, that any questions I had have been addressed to my satisfaction, and that I have received a copy of this document on this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

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Client’s/Parent’s Signature Date Counselor’s Signature Date

*Consent for Treatment of a Minor*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the parent or legal guardian of the minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for this minor to receive therapy services provided by Amanda Sehr, MS, MA, LPC, MT-BC. I have read, understood, and signed the informed consent related to this child’s therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services for both the minor and his/her family. Furthermore, I understand that I am expected to participate in this process by meeting with Amanda Sehr, MS, MA, LPC, MT-BC at least once per month.

Minor’s Parent/Legal Guardian

By signing this I acknowledge that I have read and received a copy of the HIPAA Notice of Privacy Practices and Client’s Rights Document.

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Client’s/Parent’s Signature Date Counselor’s Signature Date

*Parental Waiver of Right to Child’s Records*

I hereby waive my rights as parent/guardian to obtain information from and copies of any records from Amanda Sehr, MS, MA, LPC, MT-BC pertaining to the assessment, evaluation, and treatment of the following child: , age . I understand that Amanda Sehr may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child’s mental health evaluation and treatment, if disclosure in the opinion of Amanda Sehr, MS, MA, LPC, MT-BC would negatively impact the child or the child’s evaluation and treatment. I hereby release Amanda Sehr, MS, MA, LPC, MT-BC from any and all liability for good-faith refusal to disclose the child’s information or records.

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Parent/Legal Guardian Signature Date Counselor’s Signature Date