**Professional Disclosure Statement**

*Qualifications*

I, Noelle R. St. Germain, am a National Certified Counselor and Licensed Professional Counselor and Supervisor in the state of Texas. I am in private practice providing mental health services to adults and adolescents at Shambhala Wellness Center. I earned a Ph.D. in Counselor Education and Supervision at St. Mary’s University in San Antonio and a master’s degree in Counseling at the University of New Orleans.

*Experience*

I have over 20 years of experience providing individual and group counseling to adults, adolescents, and children. My counseling practice is primarily geared toward adults dealing with a variety of personal and emotional concerns. In addition to my part-time private practice, I am a full-time Assistant Professor and Director of Clinical Training at Argosy University in Dallas, Texas. My specializations and areas of interest include lesbian, gay, bisexual, transgender issues, women’s issues, Sensory Processing Disorder (SPD), mindfulness meditation, adult survivors of sexual abuse, grief and loss counseling, and transpersonal experiences. I have obtained specialized training in dreamwork through graduate-level coursework, which has prepared me to utilize two different methods of working with dreams in therapy: A cognitive-experiential approach and an approach that uses body awareness to work with dreams. For clients interested in gaining a deeper understanding of their dreams, we can incorporate dreamwork into our regular counseling sessions or we can schedule additional sessions specifically focused on dreamwork.

*Nature of Counseling*

I believe that counseling is a mutual endeavor involving a genuine relationship between client and therapist. I take a holistic approach to counseling that focuses on the client as a whole person, integrating body, mind, and spirit. I include humanistic and existential perspectives coupled with aspects of Eastern philosophy in my practice. I work from an integrated theoretical approach based in a relational-cultural perspective that is focused on empowering individuals to increase awareness of their authentic selves, gain insight into their patterns of relating and underlying needs, while taking into account the cultural and environmental factors that may be impacting the individual’s experience. I believe that clients have within them what they need to lead more fulfilling lives and that challenges and difficulties in life afford opportunities for gaining insight and personal growth. I believe that counseling can assist clients in sorting through confusion and deepening their understanding and acceptance of themselves so that they can make more informed choices about their lives. My focus is on providing a safe and supportive environment to promote clients' self-exploration. I strive to help clients focus on attending to their instinctual knowing, increase self-awareness, and live in ways that are congruent with their true selves.

**Informed Consent**

*Length of Sessions and Number of Visits*

For the initial intake session we will meet for 60-75 minutes to provide adequate time for paperwork and questions. After that, we will meet for one hour counseling sessions, typically each week. The number of sessions needed by clients depends on many different factors and, therefore, the duration of counseling cannot be accurately predicted. Since my availability for clinical practice is limited, clients requiring more intensive treatment may be referred to other mental health professionals if it is determined to be in the best interest of the client based on my assessment of the client’s clinical needs.

*Counseling Relationship*

Although the counseling relationship may feel psychologically close at times, it is a professional therapeutic relationship as opposed to a social relationship or friendship. 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 focus of our work together.

*Goals*

It is important that you take part in developing goals for your counseling. Goals developed at the outset of counseling may change over time and should be discussed within your counseling sessions.

*Potential Effects of Counseling*

Counseling is a process that can involve a great deal of personal growth and change, however, no specific outcomes or benefits can be guaranteed. Because counseling involves some level of self-reflection, some clients may experience both positive and negative emotions in reaction to this self-exploration. In addition, self-reflection and exploration may lead to new ways of understanding yourself, which may lead to changes in your self-perception, your relationships, your career endeavors and other significant areas of life. Although such changes are unforeseeable at the outset of therapy, we will work together toward your best interest.

*Client’s Rights*

Counseling is a very individualized process. Some clients benefit from very few sessions, while others may need months or 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. 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 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) 765-2297 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 the 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 $120 will be charged for session. 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 $130 for the initial intake session and $120 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. I will submit billing to your insurance carrier upon request. However, I cannot guarantee payment by the insurance company and you remain responsible for any fees that are not paid in full by the insurance company. 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 $120 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 Noelle St. Germain, Ph.D. reasonably believes that I am a danger, physically or emotionally, to myself for another person, I specifically consent for Noelle St. Germain, Ph.D. 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 Dr. St. Germain 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 Noelle St. Germain, Ph.D. that I have received and reviewed.

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Client’s Initials

*Therapist Incapacity or Death*

In the event that I 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.

Your signature below acknowledges that you are voluntarily consenting to receive mental health assessment, care, treatment, and related services and authorize Noelle St. Germain, Ph.D. 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 Noelle St. Germain, Ph.D. 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 Signature Date Counselor’s Signature Date

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 Signature Date Counselor’s Signature Date