Professional Disclosure Statement

Qualifications

I earned a bachelor's degree in Sociology from West Virginia State College located in Institute, WV in May 1997. In August 1999 I earned a Master of Arts degree in Sociology from Marshall University in Huntington, WV. In August 2009 I graduated with a Master of Education in Rehabilitation Counseling. I am a Licensed Clinical Mental Health Counselor my license number is 12758.

Counseling Background

I have 15 years of counseling experience. My areas of focus include working with individuals diagnosed with DSM diagnoses, couples, and youth ages 14 to 21. I also have extensive experience working with our veteran population as well as individuals living with disabilities. My approach to counseling is eclectic, I use a blend of cognitive behavioral therapy, emotion focused therapy, solution focused therapy, and mindfulness training.

Session Fees and Length of Service

I accept all major credit cards and cash only. All deductibles and copayments are expected at the time of service. Upon request I will provide documentation to submit to client's insurance carrier for reimbursement purposes. I encourage my clients when possible, to leverage their Flexible Spending Accounts. While I understand that on occasion circumstances arise that are out of client's control, any session cancelled without a 24-hour notice will be charged a no-show fee that is charge to your card on file, or before your next session.

- Initial Consultation/intake session 140.00
- Individual sessions 115.00 per 50-minute session
- Couples or Family therapy sessions 130.00 per 50-minute session
- Pre-marital Counseling 75.00 per session or 200.00 for 5 sessions
- Late Cancellation, no show fee is 45.00

Insurance

I am an in-network provider for Aetna, Cigna, Blue Cross Blue Shield North Carolina, Optum, and United Healthcare.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some may not. If a health insurance company decides to reimburse their member, most will require that they have a mental-health condition before they agree to reimburse their member. Not all conditions qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you. Lastly, any diagnosis made will become part of your permanent insurance records

Confidentiality

Client's application data, diagnosis, mental/emotional condition, and case progress notes maintained throughout the therapeutic process, becomes a permanent part of the client's record. This information is considered private and will be kept strictly confidential. Moreover, this private information will not be released to other parties without a client's written permission, and only the information a client agrees to disclose will be released.

Exceptions to Confidentiality clause

The client has signed a release form giving me permission to disclose information

There is reason to believe that a client may harm themselves, and or others

Medical Emergencies

Judge issues a court order directing that your records be released

I suspect that you or a family member is a victim of child or elder abuse I am obligated by law to file a report with the proper authorities.

Complaints

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx).

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

Client: _____ Date: _____

Counselor: _____ Date: _____

TICS No Show, and Late Cancellation Policy

1. I understand that my credit/debit card on file will be charged a LATE CANCELLATION fee of $55.00 if I do not to give at least 24-hour notice prior to canceling my appointment.

2. I understand that my credit/debit card on file will be charged a NO-SHOW fee of $55.00 if I do not show for my scheduled appointments.

3. I understand that after the initial session, therapy sessions will last 50 minutes. I understand that if I am late to my appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive.

_____

Print full name

_____

Signature of Responsible Party

_____

Date

_____

Counselor's Signature and Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and North Carolina State law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your Protected Health Information, or PHI. I must follow the privacy practices described in this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Notes and Reports, as described in Section II, for certain purposes described below.

1. Treatment:

I may use and disclose PHI to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This may include referrals to other clinicians that are bound by the same mental health confidentiality laws.

2. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may seriously harm yourself.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect.

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so.

e) Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon due date.

B. Uses and Disclosures Requiring Your Written Authorization

1. Counseling Notes:

Notes recorded by me documenting the contents of a counseling sessions will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. Marketing communications:

I will not use your health information for marketing communications without your written authorization.

3. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.
4. Other Uses and Disclosures:
Uses and disclosures other than those described in Section I, will only be made with your written authorization. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. You have the right to Inspect and Copy:
You may request access to your medical and/or billing records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.
B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
C. Right to Request Restrictions:
You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer, "as indicated below. I am not required to agree to any such restriction you may request.
D. Right to Accounting of Disclosures:
Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. It is my obligation to you to inform you if there are any unauthorized releases of your PHI by me. If a breach of your PHI has been made I will explain the possible scope of the disclosure, the risks associated, and the steps I have taken/will take to deal with the breach.
E. Right to Request Amendment:
You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (15) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement" based upon your proposed amendment, must be added to your record.
F. Right to Obtain Notice:
You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.
G. Questions and Complaints:

If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Travis E. Williams M.Ed., LPC, CRC by telephone at (984) 664-4105 or in writing at 5300 Atlantic Ave. Suite 106-B Raleigh NC 27609.

You may also file written complaints with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you if you file a complaint with me or the Department of Health.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date:
This Notice is effective on _____

B. Changes to this Notice: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I (print your name) _____, acknowledge that I received a copy of the Notice of Privacy Practices for Travis E. Williams M.Ed., LPC, CRC. This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations. The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of Travis E. Williams M.Ed., LPC, CRC with respect to my protected health information.

Client's signature and date:

Counselor's signature and date:

This form will be retained in the mental health record.
FOR OFFICE USE ONLY
I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

□Individual refused to sign
□Communications barriers prohibited obtaining the Acknowledgment
□An emergency prevented me from obtaining Acknowledgment
□Other:
_____
_____
_____
_____

TICS Counseling Intake Form

Today's Date: _____

Last Name: _____First Name: _____

M.I._____Age: _____DOB: _____Sex: _____Gender_____

Race_____

Current address: _____City_____ Zip _____

Phone Number: _____Alternate Phone Number: _____

Email:_____

Will you be filing with your insurance? Yes or No

Primary insurance company _____

Member ID Number _____

Secondary Insurance company _____

Member ID number _____

What would like to accomplish during your counseling sessions?

_____

Do you have any reservations about participating in counseling? If yes, please explain?

_____

Please check any of the following that apply to you?

Anxiety
Difficulty Communicating with others
Depression
Marital Problems
Lack of Focus
Sexual Addiction/Pornography
Panic Attacks
General and consistent feelings of unhappiness
Irritability
Fatigue
Anger Issues
Hallucinations
Issues with High School or College Transition
Trauma
Issues in School
Crying Spells
Substance Use
Persistent Overwhelming Guilt
Avoidance of Others
Problems with adjusting to a significant life event

Physical Health History

Describe any previous medical diagnoses.

_____

Current medications?

_____

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often _____

Mental Health History

Previous mental health diagnoses?

_____

Dates treated?

_____

Name of your previous therapist? _____

His or her telephone? _____

Previous Therapist address?

_____

_____

Have you ever had feelings or thoughts that you didn't want to live? ☐Yes ☐ No.

If YES, please answer the following. If NO, you may skip to the next section.

Do you currently feel that you don't want to live? ☐Yes ☐ No

How often do you have these thoughts?

_____

Has anything happened recently to make you feel this way?

_____

Have you ever tried to kill or harm yourself before?

_____

Do you have access to guns? If yes, please explain.

_____

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances?

_____

If yes, where were you treated and when?

_____

Do you think you may have a problem with alcohol or drug use? ☐Yes ☐No

Have you used any street drugs in the past 3 months? ☐Yes ☐No

If yes, please describe?

_____

Have you ever abused prescription medication? ☐ Yes ☐ No
If yes, please describe?

_____

Tobacco History:
Have you ever smoked cigarettes? ☐ Yes ☐ No
Currently? ☐Yes ☐ No How many packs per day on average? _____ How many years? _____
In the past? ☐Yes ☐ No How many years did you smoke? _____When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ☐Yes ☐ No In the past? ☐ Yes ☐ No

Relationship History

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
How long? _____
If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? _____
Describe your relationship with your spouse or significant other?

_____

Have you had any prior marriages? ☐ Yes ☐ No If yes, how many? _____
How would you identify your sexual orientation? _____
Are you sexually active? ☐ Yes ☐ No
Do you struggle with persistent urges to view Pornography? ☐ Yes ☐ No
Has your spouse criticized you for viewing Pornography? ☐ Yes ☐ No
If yes, please explain?

_____

Do you struggle with having intimacy with your spouse? If yes, please explain,

_____

Family History

Is there any family history of mental health diagnoses or mental health treatment in your family?

_____

Any history of suicide or suicide attempts in your family?

_____

If yes, please describe their relationship to you?

_____

Do you have a history of being abused- emotionally, sexually, or physically? ☐ Yes ☐ No. If yes, please describe when, where and by whom?

_____

Has anyone in your immediate family died recently, if yes please describe?

_____

Social

Highest education completed?

_____

Have you ever served in the military? If yes, provide dates of Service and branch

_____

Highest rank?

_____

Honorable discharge ☐ Yes ☐ No If No, please explain?

_____

Are you currently: ☐Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

How long in present position?

_____

What is/was your occupation?

_____

Where do you work?

_____

How satisfied are you with your currently employment situation?

_____

Legal History

Have you ever been arrested? ☐ Yes ☐ No

If yes, please explain circumstances and dates?

_____

Do you have any pending charges, please describe?

_____

_____

_____

Spiritual Life:

Please describe your faith.

_____

Are you satisfied with this aspect of your life?

_____

_____

Client Signature and Date

_____

If under 18years of age Parent/Guardian Signature and Date

_____

Counselor's Signature and Date

Credit Card Authorization

Your provider requires you to provide your credit/debit card information on file with us so we can automatically charge any co-pays, co-insurance, deductible amounts, and professional service charges such as late cancelation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site. Payment is required at the time of service. If balance accrues and no payment is received, we reserve the right to seek payment by any means, including using the credit/debit information we have on file, retaining the collection agency, and taking legal action in court. We may be willing to work out a client payment plan that includes a reasonable period for resolving the balance. If the client's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full.

Name on Card: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Credit Card # _____ Exp: _____/_____ Security Code: _____

Signature of card holder: _____ Date: _____