Brooke Carr, MA, LPCA, NCC

Professional Disclosure Statement

Clinical Background

I am a Licensed Professional Counselor Associate (LPCA, License # A13373) and a National Certified Counselor (NCC, License # 870996). I received a Masters of Arts in Clinical Mental Health Counseling from Wheaton College, Wheaton, Illinois in May 2017 and also received a Bachelors of Science in Psychology from The College of William and Mary, Williamsburg, VA in May 2014.

Restricted Licensure

I am a Licensed Professional Counselor Associate (LPCA, License # A13373) in North Carolina and work under the supervision of a Licensed Professional Counselor Supervisor (LPCS). I review and staff all cases with my supervisor with the goal of providing you with better care. To protect your privacy, any staffing with my supervisor remains confidential. I hope that you can bring me any concerns about treatment so we can resolve any questions. If you continue to have a concern, you can contact my supervisor:

Wendy Skenderi, LPCS, RPT-S
Carmel Counseling Center
Phone: (704) 839-1134
wendys@carmelbaptist.org

Counseling Background

I have experience counseling men, women, parents, adolescents, children and families. My clients have had diverse cultural backgrounds, meaning I have experience working with a wide variety of religions, ethnicities, sexual orientations and races. I am able to counsel general areas, such as trauma recovery, depression, anxiety/panic, adjustment issues, psychological aspects of bi-polar disorder, self-esteem, spirituality, substance abuse, grief, job stress, violence, codependency, family of origin issues and life transitions. My experience as a counselor consists of one year as a counseling intern at Warrenville Youth and Family Services in Warrenville, Illinois where I helped children, adolescents, adults and families with a wide variety of concerns. I also had four months of experience co-leading a Women's Anxiety and Depression group at Susan Myket, Ph.D & Associates in Naperville, Illinois. Additionally, I have four months of counseling experience co-leading a GriefShare support group at Wheaton Bible Church in West Chicago, Illinois. After graduation, I worked at Phoenix Counseling Center in Gastonia, NC for eight months where I served clients who had substance abuse disorders or a dual diagnosis.

Services Offered

I believe the strength and power of the therapeutic relationship is the most important aspect of the counseling experience. Therefore, therapy is best provided in an atmosphere of safety and trust, which I will do my best to provide for you. Additionally, it is crucial we discuss things openly and honestly, as communication and collaboration are important in a therapeutic relationship. For this reason, I will work with you to formulate clear goals and work towards achieving those goals. I want to empower clients to make changes and to work towards overall health and well-being. I work from a strengths-based approach, meaning that I believe that everyone has strengths and skills that can help them solve problems and handle life circumstances. I work to help individuals and families discover those strengths and apply them to their circumstances in a way that encourages growth in relationships and functioning. I will also discuss different techniques and modalities of therapy as appropriate to make sure we are on the same page in terms of treatment.

In terms of my approach to counseling, I take a bio-psycho-social-spiritual approach to conceptualizing cases. This means that I often take a holistic view of seeing how lots of complex factors are contributing to the problems bringing individuals and families into counseling. I honor my clients' personal spiritual values and strive to incorporate their spirituality into the counseling process at their request. I have an integrative and client-centered orientation to counseling. This means that I view each case on an individual basis and tailor my modality of treatment to what will best serve the client.

I am not trained to treat medical issues and cannot prescribe or provide medication. If medical treatment is indicated, you will be encouraged to seek that attention. If needed, I will work closely with a psychiatrist or other physician if medication is warranted. Furthermore, I encourage you to have a routine physical health exam if you have not had one in the past year. This helps to rule out any medical complication that might be contributing to your mental health needs.

Referrals

If at any time for any reason you are dissatisfied with my services, please let me know. If there are any issues or concerns beyond my scope of competence, I will make every effort to refer you to the appropriate professional specializing in that area. A verbal exploration of alternatives to counseling will also be made available upon your request.

Possible Side Effects

It is possible therapy will bring up unpleasant emotions, memories or thoughts, thus causing some discomfort. We might also talk about making changes that might interrupt family dynamics or relationships. If you feel yourself experiencing these side effects, it can be helpful to let me know so that we can discuss the side effects you are experiencing. It is important to consider the risks of therapy while also considering the potential benefits such as gaining insight into yourself, developing coping strategies and tools, and growing emotionally to deal in the healthiest way with the challenges life presents to us.

Complaints about Service

If you ever have complaints or reservations about therapy, please feel free to let me know. This information and communication can often help me to best tailor therapy to what would be most beneficial to you. However, if you ever do not feel comfortable coming to me but would still like to make a complaint about our time together, you can contact my supervisor, Wendy Skendari (see information above). If, however, you do not feel your concerns are being addressed appropriately, feel free to contact the board:

North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
Email: Complaints@ncblpc.org

Therapist and Crisis Availability

Counseling sessions are conducted within the counseling office only. In case of an emergency, please call 911 or go to the nearest emergency room or call the Mecklenburg Crisis Line at 704-566-3410 and select Option 1. If you or I think it would be beneficial, we can discuss crisis plans during our time in therapy.

Fees and Billing Practice

Sessions fees are outlined below:

$125.00	Initial session
$100.00	Individual Therapy (adult, adolescent or child)
$115.00	Couples or Family Therapy
$100.00	Consultation or Report writing (per hour)
$100.00	Case Management (per hour)
$100.00	Phone Calls per hour (any call over 10 min.)
$ 15.00	Emails requiring 15 min. or more (billed in 15 min increments)

Payment of services is expected at the time of each session and a receipt will be provided upon request. If we have made arrangements to file insurance directly you are responsible for any co-pays due and ultimately responsible for payment in full if your insurance company does not pay within 90 days for any reason. It is your responsibility to file with your insurance unless other arrangements have been made with me. If payment for services is not made at that time and it is not a matter of special arrangement agreed upon by you and me, such payment must be made within 10 working days of the session in question AND before a new appointment can be made. If payment is not made within this time period, I have the option of informing you in writing, that future services might be jeopardized and even discontinued. In this instance, I will provide you with names of other practitioners if requested.

If you fail to cancel scheduled therapy appointments at least 24 hours in advance, an automatic charge of $70 will be made for the missed appointment. Please understand, that insurance companies do not reimburse for charges resulting from missed appointments. If you fail to attend two consecutively scheduled sessions without notifying me, I will assume that you wish to terminate services and I will notify you in writing, that services have been terminated. Two

consecutively cancelled sessions without prior notice may result in loss of an established appointment time. You may terminate services at any time by notifying me.

If a check is returned due to insufficient funds, there will be a $50.00 charge to cover bank fees. Payment of the session fee and $50 charge must then be made at or before your next scheduled appointment.

Phone Calls

I am happy to speak with you by phone if a pre-arranged time is scheduled to do so. If you need to communicate with me, you may contact me by email (brookecarr@ptgcounseling.com) or by phone ((704) 448-3684). Should you prefer to speak with me by phone for any reason, please only contact me during business hours and keep in mind that any phone calls lasting over 10 minutes will be billed at my normal hourly rate. This fee is not covered by insurance and will be due at your subsequent therapy session or billed and due within 14 days.

Records and Confidentiality

If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this, it is suggested you contact your insurance company so that you know what access they are allowed to have as part of your policy agreement. Additionally, in order to file through insurance, it is required that I give you a diagnosis. It is important that you understand that not all diagnoses are covered under any given insurance plan and that when a diagnosis is given it becomes part of your records with the insurance company.

Your counseling sessions, and the discussions therein, remain confidential unless I obtain a signed release from you for me to discuss your case with another professional. Case records are confidential and will not be released without written permission from you.

However, in certain circumstances it is required that confidential information is disclosed without your consent which include, but are not limited to the following: 1) If you are evaluated to be a danger to yourself or others; 2) If you are a minor, elderly or disabled, and the counselor believes you are the victim of abuse or if you divulge information about such abuse; 3) if a court order or other legal proceedings or statute require disclosure; 4) Your insurance company requires information in order to pay claims; 5) As stated above, at your request.

By signing below, I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality. I have also discussed the goals of therapy with Brooke and understand that therapy is a joint effort between the counselor, caregivers and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates.

By signing below, you are indicating that you have read and understand the information contained in this statement, that you have been given a copy of this form for your records, and that any questions you have about this statement have been answered to your satisfaction.

_____

Client Name (Printed)

_____ _____

Client /Legal Guardian Signature Date

_____ _____

Legal Guardian (2nd Parent) Date

_____ _____

Counselor's Signature Date

Brooke Carr, MA, LPCA, NCC
5200 Park Road Suites 223, 236
Charlotte, NC 28209
704-612-4148

I, _____ as the legal custodial guardian of _____,
(parent/legal guardian) (minor child)
hereby give my permission for _____ to be seen by Brooke Carr, MA, LPCA, NCC
(minor child name)
for counseling services. I understand that all information shared in these counseling sessions will remain

confidential with the exceptions of the following:

1. Your child is evaluated to be a danger to themselves or others
2. Your child is believed to be the victim of abuse or your child reports such abuse.
3. A court order or other legal proceedings or statute require disclosure
4. Your insurance company requires information in order to pay claims.

I understand that Brooke may contact me in order to discuss issues related to my child and that I am able to contact her in regard to any questions I may have, with the understanding that she will share only what she believes to be in the best interest of your child. I will not request access to my child's records or have them subpoenaed for any reason now or in the future, and understand that to do so would jeopardize the therapeutic relationship and violate my child's confidentiality. I also understand and agree to the terms and fees outlined in the Professional disclosure statement related to fees associated with involving Brooke Carr, MA, LPCA, NCC in any legal issues. I understand that these fees include any and all time, including phone calls, report writing, etc. related in any way to any type of legal actions.

By signing below I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality and that I have read and signed the Professional Disclosure provided to me as well.

_____ _____
Parent/Legal Guardian Signature Parent/Legal Guardian Signature (2nd Parent)

_____ _____
Parent/Legal Guardian Name Printed Parent/Legal Guardian Name Printed (2nd Parent)

_____ _____
Address Date

_____
City State Zip

_____ _____
Home Phone Work Phone

_____
Cell Phone

_____ _____
Therapist Signature Date

Pathways to Growth Counseling
Brooke Carr, MA, LPCA, NCC
5200 Park Rd. Suites 223, 236

Notice of Privacy Practices
HIPPA (Health Information Portability & Accountability Act) **Law**

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health information (PHI). I am required by law, as well as by professional standards, to keep your health information private, to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form," stating that you have received and reviewed this notice, give me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections). For treatment, health care operations and other cases, I will ask for you authorization for use and/or disclosure of your PHI. I may not disclose you PHI without your informed and voluntary written consent or authorization. (See also, Professional Disclosure).

Disclosure of Information

Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics. These include:

- Emergencies
- Reporting of abuse or neglect
- Disclosures required by court order
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public

Your Rights Regarding Privacy

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

-The right to inspect and obtain a copy of your medical record
- The right to request an amendment of any section of your medical record
- The right to request restriction of disclosure of your PHI for the purpose of treatment, payment, and health care operations.
- The right to request accounting of the disclosures that we make of your health care information
- The right to request confidential communication
-The right to a copy of this notice
-The right to refuse to acknowledge receipt of this notice

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about his notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot, and will not make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice. THIS NOTICE IS EFFECTIVE OCTOBER 1, 2011.

PLEASE KEEP THIS FOR YOUR RECORDS

Brooke Carr, MA, LPCA, NCC
5200 Park Rd. Suite 236
Charlotte, NC 28209

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Brooke Carr, MA, LPCA, NCC at brookec.pathwaystogrowth@gmail.com or at 704-612-4148.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative ∗ Date

_____

Signature of Second Parent, Guardian or Personal Representative ∗ Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parentetc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member & Date

_____

Brooke Carr, MA, LPCA, NCC
Pathways to Growth Counseling
5200 Park Road Suites 223, 236 Charlotte, NC 28209
704-612-4148

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Brooke Carr, MA, LPCA, NCC, through Pathways to Growth Counseling to provide counseling services to:

_____ _____
Client Name Date of Birth

I understand that Brooke Carr, MA, LPCA, NCC will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

Intake/Initial Session	$125	Phone Consultation (per hour)	$100
Individual Therapy	$100	Case Management (per hour)	$100
Marriage/Couples/Family Therapy	$115	Consultation or Report Writing (per hour)	$100
Emails Requiring More than 15 mins or more (Billed in 15 min increments)			$15

I understand that payment for services are expected at the conclusion of each session unless previous arrangements have been made (as indicated below) and agreed upon with Brooke Carr, MA, LPCA, NCC. If insurance arrangements have been made prior to the session and a co-pay is applicable, it is due at the time of my session. If for any reason your insurance does not agree to pay your fee (co-pay or percentage), you are ultimately responsible for payment in full.

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Brooke Carr for a missed or unpaid appointment.

Credit Card #_____ **Exp.**_____ 3 digit code:_____

Billing Address Zip Code_____ **VISA** **MASTERCARD**

Name as it appears on Card_____

Your insurance company has informed me that your benefits are as follows:

Insurance Company:_____ **Deductible:**_____ **Co-pay:** _____

Max. # of sessions/Amount_____ **Per Calendar Year/Benefit Period:**_____

I agree to allow Brooke Carr, MA, LPCA, NCC, to bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Brooke Carr, MA, LPCA, NCC, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Brooke Carr, MA, LPCA, NCC has the option of informing me, in writing, that future services might be

jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an ***automatic*** charge of the full session fee will be made for the missed appointment. I understand that I will be responsible for this fee as insurance does not pay for missed appointments. You can call me at 704-448-3684 to notify me or leave a message. If I fail to attend two consecutively scheduled sessions without notifying Brooke, she may assume that I wish to terminate services and she will notify me, in writing, that services have been terminated. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Brooke Carr, MA, LPCA, NCC

Parents of minor children attest by their signature that they will not demand session content from Brooke Carr, MA, LPCA, NCC and will uphold the confidentiality of the child's treatment with the understanding that the counselor, by law, has to report if the child threatens harm to self or others or if he/she discloses that he/she has been harmed.

Children whose parents are involved in divorce/custody proceedings agree to allow my work with their child to remain therapeutic and not to involve me, or the treatment I do with minor clients in legal proceedings. My role is to remain as an advocate/safe person for your child and subjecting the treatment process to legal proceedings prohibits the efficacy of treatment and can potentially cause your child undue emotional harm.

Custody evaluations are done by trained professionals that are specifically involved in making recommendations related to custody. This includes standardized testing and evaluations. This is **NOT** a service I provide, nor is it the role I take as your child's therapist. I will, however, make recommendations should I have concerns through my work with your child related to parenting.

If for any reason I am requested to testify in court regarding your case my fee is $500.00/hour. This includes travel and waiting time. I require a $1000.00 retainer fee in advance. You will be responsible for payment of this fee in full. I will also no longer be able to see your child in therapy, as testifying in court breaches the client/therapist relationship.

_____
Client Name (Printed)

_____ _____
Client /Legal Guardian Signature Date

_____ _____
Legal Guardian (2nd Parent) Date

_____ _____
Counselor's Signature Date

Brooke Carr, MA, LPCA, NCC
Pathways to Growth Counseling
5200 Park Road Suites 223, 236
Charlotte, NC 28209
704-612-4148

Pathways to Growth Counseling (hereafter referred to as "We") will be enforcing a strict "No Show" and "Cancellation" policy from this point forward. Please be aware that you are responsible for any missed appointments and must give 24 hour advance notice of cancellation. When you schedule an appointment, you are paying for an hour of counseling time. If you fail to provide 24 hour notice or do not show for an appointment, you will still have to pay for the hour because that hour cannot be filled and insurance cannot be billed. This is a standard procedure for counseling practices.

We allow a 10 minute grace period for late arrivals and ask that you or the party transporting the client to the appointment call or text the therapist if running late. Please keep in mind that this time will be taken out of the session as we are usually scheduled back to back.

We understand that emergencies and unforeseen circumstances may arise that impact your ability to attend a scheduled appointment. If this is the case, please call to discuss with your therapist as soon as possible. We have the right to waive or reduce the cancellation fee in case of a true emergency, as long as this is not a pattern and we work together.

Please read the below statement and sign to confirm that you have been notified of and understand the policy:

If I fail to cancel a scheduled appointment at least 24 hours in advance or no show to an appointment, I understand that an *automatic charge of $70* will be made for the missed appointment to the credit card on file with Pathways to Growth Counseling. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time.

_____ _____

Signature of Card Holder Date

_____

Parent/Legal guardian

Pathways to Growth Counseling

Brooke Carr, MA, LPCA, NCC
5200 Park Road Suites 223, 236
Charlotte, NC 28209

Important information in order for me to work with you:

Child's Legal Name: _____ DOB:_____ Age:_____

Child's Preferred Name: _____

Parent/guardian Name: _____DOB:_____

Address: _____

City/ State: _____Zip Code: _____

Home Phone: _____ May we leave a message? Yes No
Cell Phone: _____ May we leave a message? Yes No

Email Address _____May we email you? Yes No

Insurance Provider: _____ Name of Plan: _____

Member ID: _____ Insurance Phone #: _____

Name of Insured: _____ DOB of insured: _____

Name of Primary Care Physician or Pediatrician: _____

Phone Number: _____

Name of emergency contact: _____ Phone #: _____

Referral Source: _____

Has your child ever received any type of mental health services (counseling, hospitalization, psychiatric services, etc.)? Yes No
Explain:

Are you or any family members in therapy now? Yes No

Previously? If so, when, with whom, and for what reasons?

Do you consider yourself or any family members to be spiritual or religious? Yes No

Please describe any spiritual/religious concerns:_____

Family Information

Siblings (including step-siblings and half-siblings):
Include Name, Age, and Gender

1._____
2. _____
3. _____
4._____

Others in the home (parents, grandparents, cousins, family friends):
Include Name, Age, and Gender

1._____
2._____
3. _____
4. _____

Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

Are you or any family members taking prescribed medications? What are they and what are they being taken for?

Are you, or is anyone in your family experiencing thoughts of harming oneself or someone else?

Have you or anyone in your family experienced instances of physical violence now or in the past?

Have you had problems with natural disasters (i.e.; flood, hurricane) or another traumatic event?

Do you have any special needs regarding therapy, such as a physical disability?

In general, what is your reason for seeking counseling at this time?