



“Make Living Your Priority”

2031 66th Avenue Unit #14176

Philadelphia, PA 19138

(267)598-5433

hnsawyer@lifefirsttherapy.com

www.lifefirsttherapy.com

Professional Disclosure Statement

Introduction

This document is provided to inform you of your rights and responsibilities as a client and to answer general questions you may have about your therapeutic treatment. I encourage you to express any concerns or questions you may have at any time.

My Philosophy and Approach to Counseling

Therapy is a collaborative work that considers the life experiences, patterns, relationships, and beliefs that have shaped and currently influence your ways of being in the world. I am committed to identifying and exploring challenges that currently bring you to therapy and the innate strengths and resources that will allow you to make the changes you desire. I am committed to provide a safe and accepting therapeutic environment that facilitates growth, insight, and change. I am trained within a variety of treatment models and will work with you to determine the approach that best fits your needs.

At our initial meeting, we will assess your current needs and concerns to collaboratively decide if we can work together. We will evaluate the results of our work together periodically to determine the need for additional sessions, termination, or an outside referral for further assistance. Ultimately, you must decide to use what you gain from the therapeutic process and incorporate it into your daily life.

I may challenge some assumptions or perceptions as well as propose difference ways to view, think or manage situations you present during your session. During the course of therapy, I will use therapeutic approaches based on the problems you present, your choices and feedback as well as my assessment of what may benefit you.

If I initiate terminating therapy with you, it will be because I feel that I am not able to be helpful or a higher level of care is needed. Ending therapy well is important. If you feel ready to terminate counseling, please inform me so that we can have 1-2 wrap-up sessions to discuss recommendations to maintain your progress.

Formal Education and Training

Dr. Holly N. Sawyer, PhD, MS, LPC, CAADC, NCC
Licensed Psychotherapist



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I hold a Master of Science (MS) in Professional Counseling from Grand Canyon University. I also hold a Doctor of Philosophy in Higher Education, a Master of Public Administration in Nonprofit Management, and a Bachelor of Arts (BA) in Mass Communication.

Code of Ethics

I am a Licensed Professional Counselor (LPC) through the Pennsylvania Department of State Board and Licensing. I also am a Certified Advanced Alcohol and Drug Counselor (CAADC) through the Pennsylvania Certification Board, and a National Certified Counselor (NCC) through the National Board of Certified Counselors. I regularly attend workshops and trainings to expand my competence, knowledge, and skills in areas that will best serve the needs of my clients.

Confidentiality

Whatever you say or do during a counseling session cannot be shared with anyone else without your written permission. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

1. You report that you are currently perpetrator or victim of child abuse or molestation. I am obligated to report it to the appropriate authorities.
2. You indicate you intend to injure or kill yourself or someone else. I must act to notify potential helpers or victims.
3. Under certain conditions, your written records of your treatment process may be subpoenaed. I may be obliged to surrender them. I may be obliged to report information required in court proceedings or by your EAP or other relevant agencies. If you have been referred for evaluation or treatment by a certain agency, I may be required to furnish information to that agency. However, you will be informed.
4. In situations of suspected child, spouse, or elder abuse, I must notify medical, legal, or other authorities.
5. You disclose sexual contact with another mental health professional.
6. You directly sign a consent to release your records.



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Counseling may involve your family members and/or other persons known to you. I cannot guarantee confidentiality among participants in therapy, although I will use professional discretion in disclosing communications related to me. Whenever possible, you will be consulted before confidential information is released to a third party.

You are welcome to greet me in public or social settings, but please aware your choice to do so may compromise your confidentiality if other people are present. I do not initiate contact.

Risks and Benefits

Therapy work can vary in duration. Most clients come bi-weekly and occasionally people attend therapy more often. Others may reduce frequency once things improve. Longer sessions are an option for those needing more intensive work for a set period of time, is determined by information provided during intake and agreed upon between client and therapist.

It is not uncommon to experience periods in which you may experience seemingly new challenges and struggles prior to noticing positive growth and progress towards goals. Counseling can improve and upset the equilibrium in any person. Counseling is a personal exploration and may lead to changes in life perspectives and decisions. These changes could be temporarily distressing. You are free to discontinue therapy at any time. If you are no longer benefiting from our work together, we can discuss alternatives and appropriate referrals to best meet your needs.

PLEASE INITIAL EACH ITEM:

____ I understand Holly Sawyer, PhD, LPC, CAADC, NCC does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1, crisis hotline, National Suicide Hotline 800-784-2433 or go to an emergency room.

____ I understand during the time we work together we will meet for approximately 1 hour. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

____ I understand our contact will be limited to counseling sessions except, only in case of emergency, you may call/text Holly Sawyer, PhD, LPC, CAADC, NCC at (267)598-5433.



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____ I understand email/text correspondence is not a guaranteed, confidential method of communication, shall be limited and not serve as a venue for delivery of therapeutic services.

____ I understand Holly Sawyer, PhD, LPC, CAADC, NCC does not accept invitations from current or former clients via social networking sites (LinkedIn, Twitter, FB, Instagram, etc.) for ethical reasons.

____ I understand our paths may cross in social situations, but our therapeutic relationship comes first, along with protection of your confidentiality and privacy.

____ I understand the rate for 1 hour sessions (individual \$150.00).

____ I understand the rate for 1.5 hour sessions (individual \$200.00).

____ I understand the rate for 2 hour sessions (individual \$290).

____ I understand all fees for counseling are due after each session.

____ I understand sessions can be paid by cash, credit, or debit card – **credit or debit cards will be charged a \$5 transaction fee.**

____ I understand I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the EXCEPTION OF AN EMERGENCY. I understand if I do not show up for an appointment and cancel without 24 hours’ notice, it will result in my being charged the full fee for the full missed session.

____ I will not dispute legitimate charges for sessions I have received, appointments missed or without confirmation of 24 hours’ notice.

____ I understand Holly Sawyer, PhD, LPC, CAADC, NCC does not accept insurance to ensure clients have choice, control and confidentiality of a premium counseling service that is not under contract with managed care.

____ I understand conducting expert witness and testimonial services is not an area of interest of Holly Sawyer, PhD, LPC, CAADC, NCC and should she be subpoenaed as a factual case witness or involvement in any court-related processes, Holly Sawyer, PhD, LPC, CAADC, NCC charges a

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retainer fee of \$1,000.00 with an additional \$500.00 every hour she is involved in legal depositions, case preparation, travel, and witness time.

____ I understand (see above) and a bill will be rendered to me for immediate retainer fee payment.

____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Holly Sawyer, PhD, LPC, CAADC, NCC. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of counseling services and the limits of confidentiality outlined above. I understand the risks and benefits of receiving these services. My signature below means that I understand and agree with all of the points above.

Client Signature

Date

HEALTH PROVIDER'S STATEMENT

I have inquired to insure that the patient understood the above description of services and the limits on confidentiality.

Health Provider's Signature

Date

HIPPA Notice of Privacy Practices

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, licensing, marketing and conducting or arranging for other business activities. For example, we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization:



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communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge I have received and understood the HIPPA Notice of Privacy Practices for this office:

Client signature

Date