"Make Living Your Priority"
6703 Germantown Avenue #210-B2
Philadelphia, PA 19119
(267)245-6146
hnsawyer@lifefirsttherapy.com
www.lifefirsttherapy.com

Professional Disclosure Statement

Introduction

As my client, you have the right to know my qualifications, methods, and mutual expectations of our professional relationship. The information presented here is provided to help you decide if my services are suitable for your needs at this time. I am a professional counselor and under the supervision of Robert Tierney, M.Ed., LPC Lic. PC00455 while completing my 3,000 hours needed to become a Licensed Professional Counselor (LPC) through the Pennsylvania Department of State Board and Licensing. I may need to consult with my licensed supervisor regarding my clients to improve the outcome for the client. The client's name or other identifying information is never disclosed and remains anonymous as confidentiality is maintained.

The Process

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.

Most clients come 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.

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.

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PLEASE INITIAL EACH ITEM:

_____ I understand Holly Sawyer, PhD, MS is a Pre-Licensed Professional Counselor in the state of Pennsylvania.

_____ I understand Holly Sawyer, PhD, MS 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 weekly 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 Holly Sawyer, PhD, MS at (267)245-6146.

_____ I understand email/text correspondence is not a guaranteed, confidential method of communication and I will reserve using these methods for details like scheduling/cancelation.

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

_____ I understand at any time I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and specific results are not guaranteed although benefits are expected from counseling.

_____ I understand counseling can improve and upset the equilibrium in any person. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing.

_____ I understand I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

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_____ I understand our paths may cross in social situations, but our therapeutic relationship comes first, along with protection of my confidentiality, and Holly Sawyer, PhD, MS does not initiate the greetings.

_____ Should I believe that a referral is needed, Holly Sawyer, PhD, MS will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand the rate for 1 hour sessions (individual $120.00).

_____ I understand the rate for 1.5 hour sessions (individual $170.00).

_____ I understand the rate for 2 hour sessions (individual $250).

_____ 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 $3 surcharge**.

_____ 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. If I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is $100.00.

_____ 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 hr notice.

_____ I understand Holly Sawyer, PhD, MS 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.

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_____ I understand conducting expert witness and testimonial services is not an area of interest of Holly Sawyer, PhD, MS and should I subpoena Holly Sawyer, PhD, MS as a factual case witness or involve her in any court-related processes, Holly Sawyer, PhD, MS charges a retainer fee of $1,500.00 with an additional $240.00 every hour she is involved in legal depositions, case preparation, travel, and witness time.

_____ I understand if I do issue Holly Sawyer, PhD, MS a subpoena without her approval (see above) my subpoena will be directly turned over to her attorney 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, MS. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

_____ I understand while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Holly Sawyer, PhD, MS is ordered by a court to disclose information.
- You direct Holly Sawyer, PhD, MS in writing to release your records.
- Holly Sawyer, PhD, MS is otherwise required by law to disclose information.

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STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

_____

Client Signature **Date**

HEALTH PROVIDER'S STATEMENT

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

_____

Health Provider's Signature

AGREEMENT FOR THERAPY

I,_____

Client Name (Print)

❏ Agree to receive therapeutic services provided by Holly Sawyer, PhD, MS.

❏ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services for myself.

❏ Furthermore, I understand I am expected to be an active and cooperative participant in this process to the best of my ability.

❏ My signature below means that I understand and agree with all of the points above.

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I understand my rights as a client or as the client's responsible party. I consent to receive counseling for myself. My signature below demonstrates that I have reviewed the information as outlined above.

_____

Client's Name (Print)

_____ _____

Client's Signature **Date**

Holly N. Sawyer, PhD, MS
Counselor

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HIPPA Notice of Privacy Practices

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, employee review activities, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may

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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: 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