



PROFESSIONAL DISCLOSURE STATEMENT

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COUNSELING CENTER OF CONCORD

THIS CLIENT INFORMATION SHEET HAS BEEN PREPARED FOR YOU SO THAT YOU MAY BE WELL INFORMED ABOUT BEGINNING YOUR THERAPY PROCESS WITH ME, INCLUDING A DESCRIPTION OF MY QUALIFICATIONS, MY VIEW OF THE THERAPEUTIC PROCESS, AND WHAT YOU CAN EXPECT FROM ME AS YOUR COUNSELOR.

MY QUALIFICATIONS

I RECEIVED MY MASTERS DEGREE IN COUNSELING FROM GORDON CONWELL THEOLOGICAL SEMINARY IN MAY 2001. I ALSO HOLD A M.DIV., DEGREE FROM SOUTHEASTERN BAPTIST THEOLOGICAL SEMINARY, WHICH I EARNED IN DECEMBER 1989. I AM A LICENSED CLINICAL MENTAL HEALTH COUNSELOR (#4S573).

DURING MY COUNSELING CAREER I HAVE WORKED PRIMARILY WITH CHILDREN, ADOLESCENTS, ADULTS AND COUPLES ADDRESSING A VARIETY OF CONCERNS AND ISSUES RANGING FROM PROBLEMS INCLUDING DEPRESSION, ANXIETY, ABUSE, ADDICTION, SELF-ESTEEM ISSUES, ANGER, COMMUNICATION PROBLEMS, FAMILY OF ORIGIN ISSUES, MARRIAGE, GRIEF, STRESS MANAGEMENT, PERSONALITY DISORDERS, BEHAVIORAL PROBLEMS, AND SPIRITUAL CONCERNS. PRIOR TO MY TRAINING AS A LICENSED CLINICAL MENTAL HEALTH C, I HAD OVER TEN YEARS EXPERIENCE AS A MINISTER OF YOUTH, CHILDREN, AND CHRISTIAN EDUCATION.

COUNSELING PROCESS AND THEORETICAL ORIENTATION

DURING THE COUNSELING PROCESS I WILL MAKE EVERY EFFORT TO BRING MY SKILLS AND RESOURCES TO EACH SESSION TO ASSIST YOU IN FINDING SOLUTIONS TO YOUR CONCERNS. WE WILL WORK TOGETHER TO BUILD A THERAPEUTIC RELATIONSHIP THAT IS SAFE AND CONFIDENTIAL. I SEEK TO MAKE AN INITIAL ASSESSMENT IDENTIFYING PROBLEMATIC SYMPTOMS AND POTENTIAL UNDERLYING CAUSES. TOGETHER WE WILL IDENTIFY DESIRED OUTCOMES OF THE COUNSELING AND GROWTH PROCESS AND I WILL ATTEMPT TO CHOOSE THE BEST THERAPEUTIC PROCESS TO MEET YOUR NEEDS. WE WILL CREATE GOALS IN THERAPY AND PERSONAL GOALS IN YOUR LIFE, WITH THE REALIZATION THAT COUNSELING IS NOT A "QUICK FIX" AND THAT CHANGE REQUIRES A COMMITMENT OF TIME AND DEDICATION ON THE PART OF THE CLIENT AND COUNSELOR. I WILL FREQUENTLY USE HOMEWORK ASSIGNMENTS TO FACILITATE THE PROCESS. I OFTEN USE A COGNITIVE BEHAVIORAL APPROACH IN COUNSELING, WHICH HELPS YOU IDENTIFY YOUR CURRENT THOUGHT PROCESSES AND HOW THEY CREATE CERTAIN FEELINGS AND BEHAVIORS. I GENERALLY FOCUS ON THE PRESENT AND ON SOLUTIONS, AND EXAMINE THE PAST WHEN IT HAS A RELATIVE IMPACT ON THE PRESENT. WE WILL IMPLEMENT METHODS FOR ACHIEVING THE DESIRED GOALS, EVALUATE PROGRESS TOWARD THOSE OUTCOMES AND MAKE MODIFICATIONS WHEN NECESSARY.

I BELIEVE HEALING, BOTH PHYSICALLY AND EMOTIONALLY, BEGINS WITH AN UNDERSTANDING AND RECOGNITION OF THE SPIRITUAL DIMENSIONS FOUND IN A CHRISTIAN PERSPECTIVE THAT GOD IS ULTIMATELY THE SOURCE OF HEALING THROUGH HIS LOVE, TRUTH, AND GRACE. I ATTEMPT TO INTEGRATE A FOUNDATION OF BIBLICAL PRINCIPLES WITH A VARIETY OF THEORIES, USING AN ECLECTIC APPROACH AND BORROWING FROM SEVERAL THEORETICAL FRAMEWORKS INCLUDING FAMILY SYSTEMS, SOLUTION FOCUSED, STRUCTURAL, COMMUNICATION, CLIENT CENTERED, COGNITIVE BEHAVIORAL, AND OTHERS WHEN APPROPRIATE. OTHER TECHNIQUES UTILIZED MAY INCLUDE ROLE-PLAYING, EXPOSURE AND REVERSALS OF DISTORTED COGNITIONS, PROBLEM SOLVING, STORY-TELLING, FEEDBACK ON COMMUNICATION STYLES, AND INTEGRATION OF THERAPEUTIC GAMES. PERSONALITY AND CAREER INVENTORIES MAY ALSO BE USED.

SESSION INFORMATION: FEES, PAYMENT POLICY, AND CANCELLATION POLICY

COUNSELING SESSIONS WILL LAST 60 MINUTES. THE FEE FOR THE INITIAL VISIT IS \$140 AND EACH SUBSEQUENT SESSION IS \$135.00. **PAYMENT IS DUE WHEN SERVICES ARE RENDERED IN THE FORM OF CASH, CHECK, CREDIT/DEBIT CARD.** I REALIZE SOME PERSONS ARE UNABLE TO PAY THAT FULL FEE; THEREFORE, I WILL PROVIDE CONSULTATION WITH EACH CLIENT IN ORDER TO DETERMINE A FEE USING SUBSIDY WHEN THE NEED IS PRESENT. IF I AM A PROVIDER FOR YOUR INSURANCE COMPANY, YOU WILL BE ASKED TO PAY YOUR CO-PAY AT THE TIME OF YOUR VISIT AND WE WILL FILE YOUR INSURANCE CLAIM.



PLEASE NOTE THAT A FEE WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT A 24 HOUR NOTICE, AS THIS APPOINTMENT TIME HAS BEEN RESERVED EXCLUSIVELY FOR YOU.

CONFIDENTIALITY

UNDER NORMAL CIRCUMSTANCES WHATEVER IS REVEALED IN SESSIONS WILL BE KEPT CONFIDENTIAL. INFORMATION ABOUT YOU WILL NOT BE DISCLOSED WITHOUT YOUR KNOWLEDGE AND CONSENT, NOR WILL YOUR RECORDS BE SENT OR SHOWN TO OTHERS WITHOUT A SIGNED RELEASE FROM YOU. HOWEVER, YOU SHOULD BE AWARE THAT THERE ARE SOME SITUATIONS IN WHICH I MAY BE REQUIRED BY LAW TO REPORT INFORMATION TO THE PROPER AUTHORITIES WITHOUT YOUR CONSENT OR KNOWLEDGE. THESE SITUATIONS INCLUDE:

- 1. DANGER TO YOURSELF OR OTHERS.** IF YOU THREATEN TO HARM YOURSELF OR SOMEONE ELSE, OR TO COMMIT A FELONY, I AM BOUND BY LAW TO TAKE THE NECESSARY ACTIONS TO PROTECT THE INVOLVED PERSONS FROM PHYSICAL HARM. THIS INCLUDES AN OBLIGATION TO WARN ANY PERSON WHO MAY BE HARMED BY YOUR BEHAVIOR.
- 2. CHILD OR ELDER ABUSE.** IF I HAVE REASON TO BELIEVE THAT A CHILD OR AN ELDERLY PERSON IS BEING ABUSED OR NEGLECTED BY YOU OR A FAMILY MEMBER, I AM OBLIGATED BY LAW TO REPORT THAT TO THE DEPARTMENT OF SOCIAL SERVICES.
- 3. LITIGATION AND LEGAL PROCEEDINGS.** IF YOU ARE INVOLVED IN ANY COURT CASE OR LEGAL PROCEEDINGS, I MAY BE REQUIRED BY THE COURT TO TESTIFY ABOUT YOUR COUNSELING REGARDLESS OF WHETHER YOU GIVE YOUR PERMISSION.

THE BENEFITS AND RISKS OF THERAPY

THE THERAPEUTIC PROCESS INVOLVES BOTH BENEFITS AND RISKS. THE DESIRED OUTCOME OF COUNSELING IS TO PROMOTE HEALING, BUT THE RESULTS DEPEND ON MANY FACTORS THAT CANNOT BE GUARANTEED. THERE ARE POSSIBLE RISKS, SUCH AS UNCOMFORTABLE LEVELS OF SADNESS, ANGER, GUILT, ANXIETY, PAINFUL MEMORIES, OR DIFFICULTY WITH RELATIONSHIPS THAT MAY OCCUR AS YOU ENGAGE IN THE THERAPEUTIC PROCESS. YOUR PERSEVERANCE THROUGH THE COUNSELING PROCESS MAY HELP YOU TO REALIZE THE BENEFITS AND GOALS THAT YOU SEEK TO ATTAIN.

COUNSELING CAN LAST ANYWHERE FROM A FEW WEEKS TO SEVERAL MONTHS, OR YEARS, DEPENDING ON THE COMPLEXITY OF THE ISSUE(S) WHICH ARE ADDRESSED. MOST PEOPLE REMAIN IN COUNSELING UNTIL THEY HAVE LEARNED BETTER METHODS OF MANAGING THEIR DIFFICULTIES AND THE THOUGHTS, FEELINGS, AND THE ACTIONS RELATED TO THEM. OCCASIONALLY, COUNSELORS MAY, FOR YOUR BENEFIT, ELECT TO DISCONTINUE THERAPY BASED ON FACTORS THAT ARE INTERFERING WITH YOUR ABILITY TO WORK TOGETHER FOR PROGRESS. SHOULD THIS TAKE PLACE, I WILL DISCUSS THE ISSUE WITH YOU AND ASSIST YOU IN FINDING QUALIFIED HELP ELSEWHERE, IF APPROPRIATE AND DESIRED.

IF YOU HAVE QUESTIONS REGARDING THE COUNSELING PROCESS, ABOUT ME OR MY QUALIFICATIONS, OR ANY OTHER ISSUE NOT PROVIDED IN THIS INFORMATION SHEET, PLEASE FEEL FREE TO DISCUSS THEM WITH ME. YOU MAY ALSO CHOOSE TO WORK WITH ME ON A PROCESS OF TERMINATION AS YOU FEEL YOU ARE ACHIEVING YOUR COUNSELING GOALS OR FOR ANY OTHER REASONS YOU DEEM AS NECESSARY. YOU ARE FREE TO WITHDRAW FROM COUNSELING AT ANY TIME WITHOUT ANY PREJUDICE TO YOU. IF AT ANY TIME YOU FEEL YOU HAVE BEEN TREATED BY ME IN AN UNETHICAL OR DISRESPECTFUL MANNER YOU MAY ALSO REPORT YOUR CONCERNS TO THE STATE BOARD OF PROFESSIONAL COUNSELORS AT THE FOLLOWING ADDRESS:

NORTH CAROLINA BOARD OF LICENSED CLINICAL MENTAL HEALTH COUNSELORS
PO Box 77819
GREENSBORO, NC 27417
336-217-6007

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND ACCEPT THE PROVISIONS OF THIS CLIENT INFORMATION SHEET.

CLIENT SIGNATURE

DATE



COUNSELOR SIGNATURE

DATE