**Professional Disclosure Statement**

 Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. Please read this form carefully and sign in the appropriate places. Feel free to ask questions or discuss this information with me at any time.

**Philosophy and Approach to Therapy:**

My philosophy of therapy is holistic, meaning that I believe that people are made up of many parts —mind, body, soul and spirit. I believe that brokenness can occur if when any part is out of balance, causing pain, which signals the need for help, forgiveness and healing.

My main focus is on the importance of emotional balance and well-being. I believe that everyone experiences difficulties in their lives and see therapy as a space for clients to explore express feelings, receive validation and support. I believe that people have all of the components for a happy and healthy life but sometimes need help processing their feelings through the various stages of life and learning effective ways to cope.

**Code of Ethics & Supervision:**

As a clinical social worker, I am bound to the Social Work Code of Ethics and the laws of the state of Michigan. My license number is 6801087687. I have completed my Master’s Degree in Social Work at Eastern Michigan University, and an undergrad degree in Psychology from the University of Dayton.

**Professional Boundaries:**

In an intentional manner out of respect for the unique aspects of the therapeutic relationship, I will not acknowledge the existence of the therapeutic relationship outside of the therapy session unless initiated by the client. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at any time. Such a relationship, in my view, would be detrimental to our purposes of therapy. Because of this, any effort to interact via social media or in any social setting will be discouraged or refused.

**Your rights as a client:**

1. You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy. If you desire, I will explain my usual approach as well as my qualifications.
2. You have the right to decide not to receive therapeutic assistance from me or to seek a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. You have the right to expect confidentiality within the limits described under #6 below.
5. If you request in writing, any records can be released to any person or agency you designate (note that consent from all clients in the treatment unit is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.
6. There are certain situations in which I am required by law to reveal information obtained during therapy without your permission. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if a court of law issues a legitimate court order (signed by a judge); (c) if you reveal information relative to physical abuse, sexual abuse, or neglect of a child or the elderly (in the past as well as the present); (d) if you are in therapy by order of a court of law; or, (e) if you are involved in a criminal or delinquency proceeding.

**Consent to Treatment**

**I affirm that prior to becoming a client of Michelle T Warren, LMSW, she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits of therapy, and the nature of confidentiality. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. My signature below affirms my informed and voluntary consent to receive therapy. With the understanding of the above information and conditions, I agree to participate in therapy.**

**——————————————————— ————————**

**Signature Date**

**Financial Considerations:**

1. If you are not going through insurance my standard sliding fee for private pay is $**165 per 60 minute session**. If we agree to longer or shorter sessions, you will be charged accordingly. Payment in full is expected at the end of each session.
2. There may be a charge for other services, including consultation with other professionals, preparing reports or correspondence, any necessary court appearances, phone calls lasting over 10 minutes, and missed appointments.
3. Therapists have the right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.
4. I understand that I will be charged a LATE CANCELLATION fee of $100 if I fail to give at least 24 hour notice prior to cancelling my appointment unless I am sick.
5. I understand that I will be charged a NO-SHOW fee of $100 if I fail to show for my appointment.
6. If therapist is asked to appear in court, the client is responsible to pay $100 per hour.

**Health Insurance Claims:** I give my authorization to release medical records to assist in the processing of my insurance claims to biller. I also authorize payments of my Claims to be mailed directly to Michelle T Warren, LMSW, for providing my services. I understand that I am completely responsible for any charges incurred and that billing my insurance does not guarantee payment of the claim(s). If the provider of service does not receive payment in a timely fashion, I understand that I may receive a bill for services rendered. I also understand HIPAA policies and practices

**I have read the above and understand the financial considerations as they have been described to me.**

**Signature ————————————————————— Date——————————-**

**Insurance & Payment**

**(co-pays/late cancels/no shows/workshops/lectures)**

**Name of Insurance Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurer’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurer’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Enrollee’s ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-Pay (If applies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment Preferred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Exp Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CVC (back of card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\* I give permission for Michelle Warren Therapy to submit for billing purposes for therapeutic services provided, to my insurance provider.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature) (date)**

**\*\*\*\* I give permission to Michelle Warren Therapy to utilize my card on file for payments for co-pays, late cancel/no show fees (if applies), and for workshops/lectures if registered (in paper form).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Signature) (date)**