Alicia G. McArthur, MA, LCMHC
Seeds Counseling & Collaboration, PLLC

Professional Disclosure Statement

This professional disclosure statement provides information about my education and experience relevant to my work as a professional counselor in the state of North Carolina. If you have any questions, please ask.

Education and Professional Affiliations

I received my MA in Counseling in 2004 from Gordon-Conwell Theological Seminary in South Hamilton, MA. I have been a licensed clinical mental health counselor in the state of North Carolina since August 26, 2005 (License #5019). I became a LCMHC Supervisor in August 2013 (License #S5019). I am currently working on becoming certified in EMDR through the EMDR International Association.

Professional Experience

Most of my career has been spent providing individual and group psychotherapy in an outpatient setting to adult clients who have a variety of diagnoses. I also have experience working in both emergency services settings and the jail, evaluating adults and children experiencing psychiatric crises, and providing crisis counseling.

My expertise is in working with adults and older adolescents (age 16 and older) around the following issues or symptoms: anger management, depression, anxiety, mood disorders, grief and loss, life changes, relationship difficulties, coping skills, and past trauma or abuse. I particularly enjoy helping clients explore how their values and spiritual beliefs can help them improve their mental health.

Theoretical Orientation and Counseling Techniques

I believe that all individuals are unique and valuable, and I endeavor to treat all of my clients with compassion, respect, and acceptance. I believe that it is a privilege to walk alongside individuals during difficult seasons in their lives as they seek to grow and heal.

My approach is grounded in the beliefs that:

- The relationship between the counselor and the client should be a safe, confidential place where the client can enact change, grow, and heal.
- Good mental health involves the whole person: body, mind, emotions, and spirit.
- The counseling experience is a **process** towards growth and healing that requires an investment of time and energy from both the client and the counselor.
- Collaborating to identify reasonable goals is important to the therapeutic process - this includes examining your hopes and desires for the counseling process to establish realistic objectives.

My counseling approach integrates a variety of theories including elements of cognitive-behavioral therapy, existential therapy, systems theory, dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT). I also offer EMDR. The techniques I may use include personal story-telling, exercises to improve communication skills, skills training, defusion exercises and experiential mindfulness practice. I often give worksheets or handouts to help clients translate the work done in the counseling office into their real world experience.

Responsibilities and Risks

My responsibility as your counselor is to provide an environment that is safe and confidential, and to help you work towards your goals in a caring, ethical and professional manner. I also agree to respond promptly to your calls (within one business day, unless otherwise indicated on my voicemail), be prepared for our sessions, and generally work in your best interest. Your responsibility is to identify your hopes and desires for the counseling process, set appropriate goals in collaboration with me, and to work towards achieving your goals by participating in therapy and completing any assignments given. Engaging in the counseling process is an investment. The length of therapy and the results vary depending on the situation and your goals. Typically, most clients see improvement within 6-20 sessions but this is not a firm time limit or guarantee. If you have any questions or concerns about the risks of therapy or the counseling process, please feel free to discuss them with me.

Termination of Treatment
If at any time you wish to discontinue therapy, I will provide you with referrals to other therapists at your request. If you feel you are achieving your goals in therapy, or desire to end therapy for some other reason at your discretion, please let me know so we can work together towards termination. You may also terminate counseling without consulting me.

Session information: Length, Fees, Financial Policy, and Cancellation Policy
Length, Fees and Payment Options. Initial sessions are scheduled for 90 minutes at rate of $225.00, which ensures adequate time for the necessary paperwork and an initial assessment of the presenting problem(s). Additional sessions are typically 55-60 minutes at a rate of $150.00. Occasionally a shorter session may be required at 45 minutes at a rate of $110, or if doing EMDR a longer 90 minute session may be scheduled. Payment is due at the end of the session. I ask all my clients to provide a credit card on file (for no shows, see below) and will automatically charge it at the end of the session. You may also pay with cash or check. I am glad to provide a receipt for services at your request. As of January 1, 2023, I no longer contract with any insurance companies and am considered "out-of-network." Many insurance companies provide out-of-network benefits for psychotherapy services; I am glad to provide you with documentation so that you can file for your out-of-network benefits – in this case, if you have any, the insurance company would reimburse you directly. I have a limited number of reduced-rate therapy (50% of the regular fee) slots per week. If you feel that you cannot pay the full rate, please consult with me about possible arrangements to secure a reduced-rate slot; proof of your income may be required to determine if you are eligible for a reduced fee. Please note that if you choose to file claims with your insurance provider, I will be required to submit a mental health diagnosis for your claim, which will become part of your health records. For returned checks, you will be charged a $30.00 fee. *Clients may schedule appointments only if their account is in good standing*. The "No Surprises in Billing Act" passed in December 2020 requires that I provide you with a "Good Faith Estimate" for the total cost of your services if you request it. Transparency in cost/fees has been important to me since I started in private practice, and I have attempted my best to communicate my fees here clearly. Therapy is highly individualized and I am unable to accurately predict how many sessions each client will need but should you desire a separate estimate, I am glad to clearly articulate my fees on a separate estimate.

Late Cancellation/No Show Policy. A fee of $150.00 (or the corresponding reduced-rate session fee, if applicable) will be charged for appointments cancelled without 24-hour (1 day) notice. This fee is not reimbursable by insurance. I require that you provide a credit card for me to hold on file, and the card will be automatically charged in the case of no shows/late cancellations. Cancellations must be made via email or phone call. Please initial here that you have read and understand this policy: _____

Phone Calls. Phone calls that last longer than 10 minutes and/or for the purpose of consultation or support, will be billed at a pro-rated hourly rate in 15 minute increments (i.e., $37.50 per 15 minutes, or the appropriate reduced rate amount).

Past Due Accounts. If an account is past due by 90 days, unless you have made payment arrangements with me, the account may be sent for collection and/or small claims court. You will be responsible for a 40% collections fee that will be added to your past due balance for any collection agency fees, court costs or other expenses incurred in the collection of the account.

Legal Proceedings. I believe that it is in my clients' best interests to keep the therapeutic relationship out of the court setting, and I will resist any efforts to involve me in litigation. Should I be compelled to appear in court, I will be largely unable to offer any opinions that will be of assistance in any imminent legal proceedings. Additionally, you will be responsible for the cost of all service rendered in response to legal proceedings, including a minimum retainer to be held in escrow of $1500, a travel fee of $300 and an hourly rate of $280.

Technology and Communication
Please be aware that **I do not text with clients** or connect with clients on social media outlets (such as Facebook or LinkedIn). Also, please be aware that while I am glad to correspond via email regarding appointment times and/or sending handouts, I cannot guarantee that my email service is secure and meets the standards of HIPPA compliance; if you consent to receive emails or initiate email contact with

me, you are indicating your awareness of this fact. Under no circumstances will I discuss clinical concerns over email.

Virtual Sessions/Teletherapy
Virtual sessions are available upon request. Should you choose to engage in therapy virtually, there is an additional consent for you will need to read and sign.

Confidentiality
I am dedicated to maintaining the privacy of your personal health information as part of providing professional care in compliance with the law. I will use the information I collect about you mainly to provide you with treatment, to arrange payment for services, and for some other business activities that are called, in the law, health care operations. By signing the additional "consent for treatment form" provided along with this document, you are consenting to let me use and share your information in this way. If you do not consent and sign the form, I cannot treat you.

Information about you will not be disclosed without your knowledge or consent, nor will your records be sent or shown to others without a signed release from you. Phone calls or emails will not be accepted as permission to release information, regardless of the situation. If you would like a comprehensive notice of my privacy practices, please let me know and I would be glad to provide that to you. Below is a summary of the few exceptions to your right of privacy.

1. Danger to yourself and others. If you threaten to harm yourself or someone else, and I believe that you may do this, I am obligated to take whatever actions seem necessary to protect you or any other involved people from physical harm. This includes the obligation to warn any person who may be harmed by your behavior.
2. Child abuse. If I have reason to believe that a child is being abused or neglected by you or one of your family members, I am obligated by law to report that to the Department of Social Services (DSS). Child abuse includes, but may not be limited to, severe physical punishment, sexual molestation, neglect and abandonment. I will inform you if I make a report to DSS about a child in your care.
3. Elder abuse. If I have reason to believe that a disabled adult is being abused or neglected or you or one of your family members, I am obligated by law to report that to the North Carolina Department of Health and Human Services (NCDHHS). Elder abuse includes, but may not be limited to, physical or emotional abuse, exploitation, neglect or abandonment. I will inform you if I make a report to NCDHHS about an elderly person in your care.
4. 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. If you have any questions about this, consult me or your attorney.
5. Insurance claims. Your insurance company may require information about your treatment to pay a claim. Similar to a medical visit, it is usually limited to a diagnosis based on certain symptoms, and does not include details. A diagnosis or diagnoses may be assigned to you for treatment purposes and provided to your insurance company. If a diagnosis is given, it will become part of your record here. If an insurance company requires more information beyond a diagnosis based on specific symptoms and treatment modalities, it will be brought to your attention.

Registration of Complaints
If at any time you feel you have been treated by me in an unethical or disrespectful manner, I welcome the opportunity to hear and discuss your concerns, and hope that you can approach me directly. Regardless of your choice in discussing the matter with me, you may 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

I look forward to working with you, and feel privileged to serve as your counselor.

Consent to Treatment
I acknowledge that I have received, have read (or have had read to me), and understand the "Professional Disclosure Statement" and/or other information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by Alicia McArthur, LCMHC/Seeds Counseling.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged a fee for that appointment. I understand that this fee is not reimbursable by insurance.

I am aware that my therapist is out-of-network with all insurance companies at this time, and that I am responsible for paying the full fee at the time of service and for filing any claims for reimbursement directly with my insurance company. I understand that, at my written request, the therapist may disclose information about my treatment to my insurance company to assist in the processing of my claims. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) *Date*

_____
Printed name /Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist *Date*