

KENNETH J. SMITH MA, LPC – GROUP DISCLOSURE AND CONSENT

This document is to inform you of the professional expectations, risks, fees, and policies of our counseling relationship.

I. I am approved by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board (CSWMFT) as a Licensed Professional Counselor (LPC), license number: C.1500587 effective 9/29/16 through 9/29/18 and am governed by its regulations. I am a member of American Counselors Association and the Ohio Counselors Association. My faith-based Christian practice includes counseling adolescents and adults in the individual, family, and group settings, including the diagnosis and treatment of mental, behavioral, and emotional disorders under supervision. My relevant degree is a M.A. in Clinical Mental Health Counseling from Union Institute and University. Ken will be assisted by Miya Thomas.

II. Clients are accepted into Group therapy who I believe have the capacity to resolve their issues with my assistance. If counseling is successful, you should feel better able to face life's challenges without my continued therapeutic support. If I do not feel I have the training, scope, or capacity to appropriately help you, I will inform you and may refer you to someone better equipped to help you. There is a risk that therapy will expose issues that the client was unaware of, which may cause unintended consequences. You have the right to second opinion and to end treatment at any time. It is recommended that we discuss this decision to make sure you have considered all the options and potential results of ending treatment. Clients who choose to leave therapy with unresolved issues may experience unintended negative consequences.

III. Our relationship is exclusively a professional one. Although our sessions may be very intimate psychologically and you may learn a great deal about me, it is important for you to realize that we have a professional relationship rather than a personal one. Thank you for not inviting me to social gatherings, offering gifts, or asking me to relate to you in any way other than in the professional relationship: *this includes personal friendship and connection requests on social media (such as Facebook and LinkedIn)*. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Due to client request, I often communicate/send reminders via email, which may be subject to unauthorized access despite precautions being taken. If you wish to limit use of email or reminders, please inform me.

IV. I will keep confidential anything you say/information you provide, with the following exceptions: (1) meeting with/billing under my supervisor(s), Michele A. Melaragno LPCC-S/Joseph Geig LPCC, license number E.0500951-SUPV/E.1100215, licensed by the Ohio CSWMFT, and other professional staff during individual and group supervision, (2) if I determine you are a danger to yourself or others, (3) on the rare occasion that child or elder abuse is discovered, (4) demographic/diagnostic information directly necessary for billing/collection of fees, (5) when you request in writing that we communicate information to someone else, and (6) if you are a mental/health professional and unethical practice/client harm is exposed. If during treatment, you have any questions about the goals, procedures, or nature of your treatment, about office procedures or fees, please feel free to ask. If you desire, you have the right to have, M. Melaragno, present during this discussion or you can meet with her directly. You can contact M. Melaragno/J. Geig at 614-442- 7650, Ext. 3/Ext. 2. M. Melaragno /J. Geig are required to have direct knowledge of your counseling needs through supervisory meetings, direct observation, and/or audio taping of our sessions. If I do audio/videotape any session, I will inform you before the session begins. In addition, you can contact the CSWMFT at 614-466-0912. Please be advised that if you are involved with the judicial system, i.e., but not limited to: court ordered evaluation, personal injury lawsuit, divorce, child custody, etc. it is my policy that I do not go to court as your advocate. If you are looking for a clinician for forensic reasons, I can refer to another provider. If I am forced to go to court in regard to you/your counseling, you agree to pay full hourly rates which include travel, waiting, and testimony times and any other expenses incurred, regardless of outcome. It is my policy to take temporary notes in session which are destroyed after making the permanent clinical note. Please note that it is impossible to fully control confidentiality and there may be breaches in confidentiality by other Group members. I cannot be held responsible for confidentiality disclosures made outside my control by other Group members.

V. In return for a fee of \$400, OR the rate negotiated by an applicable insurance company/EAP I agree to be your therapy Group leader. It is your responsibility to inform me immediately if you have an insurance change and realize that you remain responsible for payment if you fail inform me about the change. If using insurance, your services may be billed under a supervisor's name. Ohio regulations forbid bartering for services. If you fail to pay any amount owed, the balance is eligible to be forwarded to a collections company to be collected from you. By signing this disclosure, you understand that outstanding balances and your personal information pertinent to collection of fees may be shared with a collections company. There is an expectation that you will attend all the Group meetings. You agree that you will be charged \$40 for every session you do not attend.

VI. Please note that it is impossible to guarantee any specific results regarding your counseling goals. We work on the issues you wish to work on: together we will work to achieve the best possible results for you. My services will be rendered in a professional manner consistent with accepted ethical standards. If you have any questions, please feel free to ask. You also agree to abide by the Group rules.

By signing below, you acknowledge that you have read, understand, and agree to all the provisions of this disclosure.

Printed Client Name

Client Signature

Date

Client DOB

Kenneth J. Smith, MA, LPC

Date