

Meghan O'Malley Doubraski, M.S.
Licensed Professional Counselor

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I have a Masters degree in Community Counseling from Western Carolina University and am licensed by the NC Board of Licensed Professional Counselors. When working with clients I most often use a Person-centered Cognitive Behavioral approach, although I may often integrate various other theoretical approaches based on the needs of each client. I feel strongly that each of my clients is unique and I will work with each to form a collaborative relationship in which these needs can be met successfully.

I believe that people come to counseling in order to create positive change in their lives. This may take the form of desired improvement of relationships, personal growth, improved ability to deal with challenges of the past or present or to seek a more fulfilling and balanced life. The counseling process can be energizing and exciting at times and may also be very challenging and at times painful. All of these aspects are a necessary part of the process for many people. Even when therapy feels difficult, the goal of bringing about the desired positive change remains in focus.

Client Rights and Important Information:

While working with Meghan Doubraski, LPC I, _____, understand that:
Client Full name

Because I have chosen to make therapy and positive change a priority in my life I am expected to arrive for all scheduled appointments or give 24 hours notice if I am unable to attend (*see attendance policy for detail*). If I have an appointment and I have not arrived 15 minutes after the scheduled appointment time, the therapist will assume that I was unable to make the appointment and she will be unavailable for the remainder of the hour. I know that I may call to inform her if I am running late to determine if there is flexibility in the schedule that day.

If I am a parent or guardian seeking services for my child I understand that I am responsible for remaining in the office while my child receives services.

The length of sessions will be a clinical hour (45-50 minutes). Meghan Doubraski, LPC accepts Medicaid, Health Choice, and Blue Cross Blue Shield insurance. If I choose to pursue services and do not have insurance coverage by these companies I can create a cash agreement for services. The hourly rate for therapy is \$75/ clinical hour. A sliding scale may be used for cash agreements. The number of sessions authorized is based on reimbursement agreements with insurance companies as well as my/ my family's therapeutic needs. If my insurance company does not cover services provided I will be responsible for covering fees. Services may be put on hold until outstanding balances are paid or a financial agreement has been made.

If services are being billed to insurance a diagnosis will be determined during the initial appointment. Insurance companies require this information to reimburse for services. If I have questions about my diagnosis or treatment I can ask the therapist at any time. If my child has Medicaid insurance I also understand that in order to obtain authorization for services Meghan Doubraski, LPC must obtain a signed service order from a doctor. I understand that she will obtain this order from Dr. Pamela Lowe and will need to share limited client information with Dr. Lowe in order to complete this process.

I understand that this therapist only provides non-emergency therapeutic services and does not provide 24/7 crisis coverage. If I have an emergency outside of session I am responsible for calling 911 or going to the hospital for necessary services. If at any time this therapist feels that my therapeutic needs are greater than the level of services she provides, she is legally obligated to consult, refer, or terminate services with me so that I can pursue the appropriate level and type of care.

I understand that I can terminate therapy at any time or seek a second opinion from another therapist. If I choose to pursue services with another therapist I must terminate services with Meghan Doubraski at that time due to ethical considerations.

Confidentiality is necessary for a positive therapeutic relationship.

I understand that all information shared in session will be kept *confidential* with the following *exceptions*;

- a) If the therapist believes I am a *danger* to myself or someone else
- b) If I give the therapist *written permission* to disclose information
- c) In the case of *abuse* to a child or an elderly person confidentiality will be waived
- d) If the information is court ordered
- e) If I desire to seek reimbursement from an insurance company, the disclosure of confidential information may be required for reimbursement
- f) In case of a *Medical Emergency*
- g) These rights are waived if accusations of misconduct are brought

I understand that there may be times when my therapist needs to consult with a colleague or another professional based on issues raised in therapy in order to provide the most effective care. My confidentiality is still protected during consultation by my therapist and the professional consulted. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services.

All records are the property of this therapist; however they are kept for my benefit and are available to me at my request, if deemed therapeutically valuable by the therapist.

If for any reason I have concerns about the services I am receiving I can address them directly with my therapist. If I do not feel that I am able to resolve them with my therapist I may contact the NC Board of Licensed Professional Counselors at: P.O. Box 1369, Garner, NC, 27529, Ph: 919-661-0820.

This therapist adheres to the code of ethics of the American Counseling Association. This statement is required by the Professional Occupations Licensure Act: Licensed Professional Counselors (N.C.G.S. 90-24).

Client Signature, Agreement and Consent:

I have read all of the preceding information and understand my rights and responsibilities as a client and have discussed any questions or concerns about this information with the therapist.

By signing below I acknowledge this understanding and agree to all terms discussed in this disclosure statement. I also affirm, by signing this form, that I am the legal guardian/ custodial parent with legal right to consent to treatment for any minor child or children for whom I am seeking therapy services.

Client/ Guardian Signature

Date

Meghan Doubraski, LPC

Date

