BreakThrough Counseling

1616 East 19th Street, Suite 1, Cheyenne, WY 82001, 307-514-2781
Sonjia Serda, LPC, NBCC

Professional Disclosure Statement and Office Policies — Form G

As a client of BreakThrough Counseling, you are entitled to the following information regarding my license disclosure, your rights as a client, confidentiality, and office policies. Please read this information carefully before signing. A copy is available upon request. Feel free to discuss this information with me at any time.

Professional Education

Master of Arts, Counseling, Marriage & Family Therapy emphasis, Assemblies of God Theological Seminary, Springfield, MO
Bachelor of Arts, Administration of Justice, University of WY, Laramie, WY

Licensure

Licensed Professional Counselor, WY #2077
Licensed Mental Health Practitioner NE #1472

Nationally Known Certifications

National Board of Certified Counselors #95616
Circle of Security Parenting
EMDR (Eye Movement Desensitization & Reprocessing)
ICF (International Coaching Federation) Certified Coach, ACC in-process

Professional Membership

National Board of Certified Counselors

Areas of Specialization

Relationship Specialist (marriage, family, individual) adolescent-adult, groups,
Circle of Security Parenting (parenting program),
Christian Counseling,
Trauma and Stressor-Related Disorders (i.e., Posttraumatic Stress Disorder),
Anxiety Disorders, Depressive Disorders (i.e., grief).
Conflict Management Specialist/Mediator
Certified Coach, individual and business/corporate leadership communication

Client Rights

As a licensed professional, I adhere to the American Counseling Association "Code of Ethics" as prescribed by the Wyoming Mental Health Professions Licensing Board and to the laws of the State of Wyoming. According to the Code of Ethics, no information about you is to be released without your explicit consent in the form of a signed release or authorization with the following exceptions:

1. When disclosure is required to prevent clear and imminent danger to the client or others. In instances in which it is confirmed that the client has a disease commonly known to be both communicable and fatal, I am duty bound to warn an identifiable party, who by his or her relationship with the client is at risk of contracting the disease.
2. When there is knowledge of or suspicion of abuse or neglect of a minor or elder, I am duty bound to report such information to proper authorities.
3. When court ordered to release confidential information without a client's permission. When circumstances require the disclosure of confidential information, only essential

information is revealed. To the extent possible, clients are informed before confidential information is disclosed.

4. In order to provide comprehensive and consistent treatment practices, information may be shared with treatment team members regarding the client's progress, to coordinate treatment efforts, or to consult for supervisory purposes. In addition, dual relationships and sexual intimacies between a therapist and a client are not appropriate.
5. You have the right to ask questions about my credentials and therapeutic approach. You have the right to report complaints. If you have any questions, please do not hesitate to ask. Your rights are promulgated by authority under the Wyoming Mental Health Professions Licensing Board, 2001 Capitol Avenue, Room 104, Cheyenne, WY, 82002, 307-777-3628.

Coordinating Care with other providers can be important for you to receive comprehensive care. I am willing to coordinate care with your physician or any other health care provider at your request or I may ask you to consider signing a Release of Information (ROI) to attain pertinent information; however, you have the right to refuse.

Your Rights are to receive:

- Helpful and respectful treatment and information about any treatment techniques used.
- A safe treatment setting, free from sexual, physical, and emotional abuse.

Confidentiality is important; however, I cannot guarantee 100% confidentiality. I cannot guarantee that others will not see you enter or leave the office. At times, I utilize a 3rd party billing service and a supervising consultant. Basic identifying information, service dates, type of service, diagnosis and fees will be shared with those persons as well as your insurance company for billing purposes only. **Please read the Notice of Privacy Policy.**

Appointment Times: Appointments are scheduled for time and frequency that will best suit you and your therapy goals. Fees are based on the amount of time in session. I usually begin on time and try to avoid late starts. If your appointment is shortened, the billing code/time will be adjusted. If you late cancel or do not show for your appointment, you will need to confirm your next session with me prior to attending your next appointment. Missing an appointment can be a concern to be addressed in session or may result in discontinuation of services. Missed appointments are subject to a $50 fee that is not reimbursed by insurance. Missed appointment fees are due at or before the next appointment after confirming the next appointment after a late cancel or missed appointment.

Costs: The charge for each session is listed on the fee schedule on **Informed Consent Policies: Office Practices, Consent to Treatment, and Fee Schedule, Form E.** Payments are expected at the end of the session unless other specific billing arrangements have been made. If you do not pay any fees/balances as required, I will utilize a collection agency or small claims court. Your signature below acknowledges you received notice of the potential risk to your confidential information to collect fees for service. Late fees may incur a daily interest fee.

Health Insurance Claims: I will bill your insurance as a courtesy. However, you are ultimately responsible to know how your insurance operates. If your insurance company has not paid the balance within 30 days, you are required to pay the balance due or discuss payment arrangements within 30 days after each appointment. Late fees and collection fees will apply.

Special Notice: It is against my clinical judgement to appear in any legal proceedings related to a client's care. If you anticipate this need, please tell me before starting counseling since I will not

appear in court or give a deposition. I will not appear or give testimony under any circumstances. If you need any type of report related to any aspect of your treatment, a flat charge of $125-$300 will be charged, due before transcription. Many reports take 2-3 hours to type. I provide a summary of your counseling, not your records.

Availability: Typically, I am not available after business hours during the week, and not at all on the weekends, except for emergencies. If you feel you need a therapy service with more after-hours availability I may be able to refer you to other sources for those services. My practice is covered by a 24-hour voicemail and I frequently check messages. I try to return calls within 24 hours. **I will not check my voice mail on weekends**. If you need assistance before I return your call or on the weekends, please call 911 or go to the emergency room. Both sources are trained to handle emergencies.

Emergency: I provide 24 hours voice mail coverage and cannot always be reached. If you have an emergency, please call 911 first and/or go to the Cheyenne Regional Medical Center Emergency Center, 214 E. 23rd Street, Cheyenne, WY. You may then contact me.

Right Of Therapist To Discontinue Treatment: I may at my professional discretion, discontinue treatment due to failure of client to comply with an agreed treatment plan or right to refuse because I am not qualified in the area of expertise needed by the client. I may refer the client to someone more qualified.

In the event of an extended illness or death, I will work with you to coordinate services with another provider.

By signing below, I state I read the above information, and agree to the conditions contained herein.

Print Client Name: ____

Print Your Name (if different than client): ____

Signature: ______________________________________ Date:___________________________

Relationship to Client: self _____ parent ______ guardian _____

I have read and understand the information in this document.

____ _________________________________

Signature of Client or Representative Date