A Talk with John Counseling and Consulting, PLLC

John W. Goodwin III., MA, LCMHC

Professional Disclosure Statement

My name is John W. Goodwin III., MA, LCMHC- a Licensed Clinical Mental Health Counselor (License #15374) in North Carolina. I am pleased that you have chosen me as your counselor. The purpose of this document is to provide you with information about my background, our professional relationship, and the counseling process. This information is intended to inform you about my background, business policies, and to describe certain issues regarding our therapeutic relationship. Please read it carefully and feel free to ask any questions you may have. Under HIPAA and the American Counseling Association Code of Ethics (ACA), I am legally and ethically responsible to provide you with informed consent. When you sign this document, it will represent an agreement between us.

My Qualifications

I received my master's degree in Marriage and Family Therapy from Liberty University in 2018. I also received a Bachelor of Arts in Religion and Associate of Arts in Christian Counseling all from Liberty University. I am a National Certified Counselor – NCC- 1140403 endorsed by the National Board of Certified Counselors. I completed my practicum and internship through New Options for Violent Actions (NOVA), one year of professional experience with Colonial Management Group (CMG), along with Behavioral Health Intervention Center (BHIC) and completed my provisional licensed supervision under Anderson Counseling and Consulting group for 2 years. I started my own private practice, A Talk with John Counseling and Consulting, PLLC in 2020.

Counseling Background

My education and background have prepared me to conduct individual, couple and group counseling sessions with both children and adults. I have had the privilege to work with people of all ages, genders, ethnicities, religions, sexual orientations, and races. I work primarily from a person-centered, solution orientation while also drawing techniques from cognitive-behavioral approaches, motivational interviewing and other theoretical orientations to meet the specific needs of my clients. I view counseling as a collaborative process in which I provide clients with a space to be open and honest while helping them to identify goals for change. Upon entering a professional counseling relationship, we will reexamine and evaluate identified therapeutic goals periodically. When necessary, we will adjust counseling goals to ensure that you are getting the most out of the counseling sessions. Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who fully engage. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress but there are no guarantees of what you will experience.

CONTRACT

This is a contract for services with A Talk with John Counseling and Consulting, PLLC to begin therapy, you must agree to the following:

***Emergencies:** I do not provide any emergency therapeutic services. In the case of an emergency, please contact 911, or contact your primary care physician. You can also go to the local emergency room and request the psychiatrist on call.

Session Fees, Length of Service and Billing Practice

My services will be rendered in a professional manner consistent with accepted ethical standards of care. Payment of services are expected at the time of each session or as early as 24 hours in advance; a receipt will be provided by request. Payable by cash or credit card prior to each session. If we planned to file insurance directly, you are responsible for any co-pays due and ultimately responsible for payment in full if your insurance company does not pay within 90 days for any reason. It is your responsibility to file with your insurance unless other arrangements have been made with me. If payment for services is not made at that

time and it is not a matter of special arrangement agreed upon by you and myself, such payment must be made within 10 working days of the session in question AND before a new appointment can be made.

There is a 4% charge per transaction when paying for services with a credit card. This will show as a separate charge.

-Initial/ session for Individual/Couples:	$175 (60 minutes) session
	$150 per session (60 minutes) afterward initial
-Initial/ session for Families:	$225 (60 minutes) session
	$175 per session (60 minutes) afterward initial

If you fail to cancel scheduled therapy appointments at least 24 hours in advance, an automatic charge of the full session fee will be made for the missed appointment and payment is required prior to scheduling your next session.

COURT APPEARANCES, SUBPOENAS AND EXPERT WITNESS TESTIMONY

-Preparation:	$150 per hour; billed in 15-minute increments
-Travel:	$500/day flat rate for out-of-town travel not including lodge expenses
-Time in court:	$200 per hour
-Supervised Therapeutic Visitation:	$200 per hour (includes court summary)

Phone Calls

I am happy to speak with you by phone if a pre-arranged time is scheduled to do so. It is often easier to reach me and communicate with me by e-mail (my e-mail address is atalkwithjohn@gmail.com). However, should you prefer to speak with me by phone for any reason any phone calls lasting over 10 minutes will be billed at my normal hourly rate and payment due at the next scheduled session or within 7 business days of the phone consultation, whichever comes first.

Emails

E-mail communications requiring 15 minutes or more, between myself as your counselor and you regarding matters of ongoing therapy will be charged in 15-minute increments $38 per 15-minutes. There is no charge for emails concerning administrative and scheduling matters.

Seeing Each Other in Public

If the counselor were to see you outside of therapy (e.g., the grocery store), they will protect your confidentiality by not acknowledging that they know you, however, you are free to initiate communication if you choose to do so.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services, and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. Any diagnosis made will become a part of your permanent record.

Records and Confidentiality

If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this, it is suggested that you contact your insurance company concerning what access they can have as part of your policy agreement. Additionally, to file through insurance, it is required that I give you a diagnosis. It is important that you understand that not all diagnoses are covered under any given insurance

plan and that when a diagnosis is given it becomes part of your records with the insurance company. Should you choose to forgo use of your insurance and pay out of pocket, the insurance company does not have any rights to information from our work together. Your counseling sessions, and the discussions therein, remain confidential unless I obtain a signed release from you for me to discuss your case with another professional. Case records are confidential and will not be released without written permission from you. However, In accordance with my professional code of ethics with the American Counseling Association, in certain circumstances it is required that confidential information is disclosed without your consent which includes, but are not limited to the following: 1) If you are evaluated to be a danger to yourself or others; 2) If you are a minor, elderly or disabled and the counselor believes you are the victim of abuse or if you divulge information about such abuse; 3) if a court order or other legal proceedings or statute requires disclosure; 4) Your insurance company requires information in order to pay claims; 5) As stated above, at your request.

Termination of Service

I may terminate therapy with you in the following situations: 1) You are not cooperating with the appropriate treatment recommendations. 2)There is a discovered conflict of interest. 3)You fail to pay the negotiated fee. 4)The practice is closing.

Referral and Complaint Procedures

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics. If at any time for any reason you are dissatisfied with my services, please let me know. Should you and/or I believe that a referral is needed, I will provide you with some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon your request.

The North Carolina Board of Licensed Clinical Mental Health Counselors Phone: (844) 622-3572
Email: complaints@ncblcmhc.org

By signing below, I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality. I have also discussed the goals of therapy with John and understand that therapy is a joint effort between the counselor and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as my interactions with family, friends, and other associates. By signing below, you are indicating that you have read and understand the information contained in this contract, that you have been given a copy of this form for your records, and that any questions you have about this statement have been answered to your satisfaction.

Client Name: _____ DOB: _____

Acceptance of Terms *We agree to these terms and will abide by these guidelines.*

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

Counselor: _____ Date: _____
John W. Goodwin III., MA, LCMHC

A Talk with John Counseling and Consulting, PLLC

John W. Goodwin III., MA, LCMHC

Notice of Privacy Practices HIPPA (Health Information Portability & Accountability Act) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also, Professional Disclosure.)

Disclosure of Information

Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics.

These include:

- Emergencies.
- Reporting of abuse or neglect.
- Disclosures required by court order.
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Your Rights Regarding Privacy

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record.
- The right to request restriction of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
- The right to request an accounting of the disclosures that we make of your health care information.
- The right to request confidential communication.
- The right to a copy of this notice.
- The right to refuse to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about this notice, please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to:

The Secretary of Health and Human Services

200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-(800) 368-1019
Email: OCRprivacy@hhs.gov

I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

A Talk with John Counseling and Consulting, PLLC
John W. Goodwin III., MA, LCMHC
Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: _____ DOB: _____

I hereby acknowledge that I received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact John W. Goodwin III., MA, LCMHC at atalkwithjohn@gmail.com or at 704-412-1407.

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Parent or Guardian's Signature _____ Date: _____

***Client/Guardian Refuses to Acknowledge Receipt:**

Signature of Staff Member: Date:

A Talk with John Counseling and Consulting, PLLC retains this signed document.

A Talk with John Counseling and Consulting, PLLC

John W. Goodwin III., MA, LCMHC

Notice of Privacy Practices HIPPA (Health Information Portability & Accountability Act) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also, Professional Disclosure.)

Disclosure of Information: Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics.

These include:

- Emergencies.
- Reporting of abuse or neglect.
- Disclosures required by court order.
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Your Rights Regarding Privacy

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record.
- The right to request restriction of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
- The right to request an accounting of the disclosures that we make of your health care information.
- The right to request confidential communication.
- The right to a copy of this notice.
- The right to refuse to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about this notice, please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800 368-1019; or by sending an email to OCRprivacy@hhs.gov.

I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

PLEASE KEEP THIS FOR YOUR RECORDS

A Talk with John Counseling and Consulting, PLLC
John W. Goodwin III., MA, LCMHC

CLIENT INFORMATION SHEET

Important information **PLEASE PRINT**:

NAME(1) :_____

ADDRESS:_____

CITY:_____ST:_____ZIP:_____

PHONE: DAY (_____) _____ EVE(_____)_____

E-MAIL: _____

DATE OF BIRTH: _____

Instructions regarding contacting you concerning scheduling and other matters: _____

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A MESSAGE IDENTIFYING COUNSELORS NAME AND NUMBER: HOME_____WORK_____CELL_____

NAME (2):_____

ADDRESS:_____

CITY:_____ST:_____ZIP:_____

PHONE: DAY (_____)_____ EVE(_____)_____

E-MAIL: _____

DATE OF BIRTH: _____

Instructions regarding contacting you concerning scheduling and other matters: _____

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A MESSAGE IDENTIFYING COUNSELORS NAME AND NUMBER: HOME_____WORK_____CELL_____

A CONTACT PERSON IN CASE OF EMERGENCY:

NAME:_____Relationship:_____

PHONE: DAY(_____)_____ EVE (_____)_____

Insurance Information:

WILL YOU BE USING YOUR INSURANCE? YES ___ NO ____ INSURANCE COMPANY:_____

MEMBER ID NUMBER: _____ DOB OF INSURED:_____

NAME OF INSURED:_____ INSURANCE PHONE: _____

FAMILY INFORMATION:

Start with all family members, and nonmembers, who live in the household and then include those outside the household that may also participate in the therapy.

• Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

_____

_____

_____

_____

_____

• Are any of those who will be coming for therapy involved in divorce proceedings? If so, who has sole custody or is there joint custody of the minor children?

_____

_____

_____

• Are you, or is anyone else in your family, experiencing thoughts of harming oneself or someone else?

_____

_____

_____

• Have you or anyone in your family experienced instances of physical violence now or in the past?

_____

_____

_____

• Have you had problems with a natural disaster (i.e., flood, hurricane) or another traumatic event?

_____

_____

_____

• Do you have any special needs regarding therapy, such as a physical disability?

_____

_____

_____

A Talk with John Counseling and Consulting, PLLC
John W. Goodwin III., MA, LCMHC
Teletherapy Informed Consent Form

Definition of Services:
Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data using interactive audio, video or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks and Responsibilities:

- I, the client, have the right to withhold or withdraw consent at any time without affecting my rights to future care or treatment.

- The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with A Talk with John Counseling and Consulting, PLLC.

- I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my counselor; that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Client Name: _____ DOB: _____

I hereby acknowledge that I received and have been given an opportunity to read a copy of the Teletherapy Informed Consent form. I understand that if I have any questions regarding the form, I may contact John W. Goodwin III., MA, LCMHC at atalkwithjohn@gmail.com or at 704-412-1407.

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Parent or Guardian's Signature _____ Date: _____