

**Professional Disclosure Statement and Consent for Treatment with Shelly Smith**

The majority of this document is mandated by both South Carolina State law and Public Law 104-191; it is provided for your protection. Shelly Smith has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with her.

**Contact Information:** Shelly Smith is located in Pickens, SC. Her mailing address is P.O. Box 1233, Pickens, SC, 29671. Clients are seen by appointment only and special appointments for evenings, weekends, and other selected times will be considered. Her telephone number is 864/933-8000. The voicemail is confidential.

**In Case of Emergency:** Shelly Smith does not provide on-call or emergency service. If you have an emergency, please call 911 or your local crisis hotline.

**Personal Qualifications:** Shelly Smith is a:

South Carolina Licensed Marriage and Family Therapist

South Carolina Licensed Professional Counselor

**Fees:** It is customary to pay for professional services at the time that they are rendered. The fee for individual, couple, and family therapy is $120.00. She does not accept any form of insurance and will not provide any information to an insurance company.

**Confidentiality:** The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. Shelly Smith is mandated by standards – through Duties to Warn – to breach confidentiality if she discovers: 1) you are threatening self-harm or suicide, 2) you are threatening to harm another or homicide, 3) a child has been or is being abused, neglected, and/or 4) a vulnerable adult has been or is being abused or neglected. Finally, if you wish to have your health information released to another party, you must sign a specific Release of Information.

**Ethics:** Shelly Smith follows the Code of Ethics for the South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists.

Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.

**Informed Consent:** You will be asked to sign the last page of this document. Your signature verifies that you have been given this document and the HIPPA document that follows; that you have read and understood these documents, and that you consent to treatment. Further, you need to be aware that treatment isn’t always successful and may open unexpected emotionally sensitive areas.

* Shelly Smith is not a physician and cannot prescribe medications.
* Shelly Smith may need to consult with your physician, attorney, or other counselor.
* Shelly Smith is not available 24 hours a day.
* Appointments may be successfully cancelled as late as 24 hours prior to the scheduled time. If this is not done, you will be charged the full fee for the missed session.
* Shelly Smith is licensed through the South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-education Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803/896-4652. The mailing address is P.O. Box 11329, Columbia, SC 29211-1329).

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I acknowledge that I have received and read the Professional Disclosure Statement and Consent for Treatment and the HIPPA Client’s Rights. I further acknowledge that I seek and consent to treatment with Shelly Smith. My signature below confirms that I understand and accept all the information contained in the Professional Disclosure Statement and Consent for Treatment, and the HIPPA Client’s Rights.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the others sign below. Signatures below confirms that each understands and accepts all the information contained in the Professional Disclosure Statement and Consent for Treatment and the HIPPA Client’s Rights, and that each seeks and consents to treatment. We will provide additional copies of the Professional Disclosure Statement and Consent for Treatment and the HIPPA Client’s Rights upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client #2

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