Charlie Rao, LPC-A / TX License #91345

Supervised by Angie Smith, PH.D., LPC-S

PROFESSIONAL DISCLOSURE STATEMENT

First 4 pages of this document are yours to keep

If you would like a copy of the signature page, I will provide one for you.

This document is designed to provide information concerning my competency, philosophy, chosen techniques, and to ensure you understand the professional counselor/client relationship.

My name is Charlie Rao (Charu Thammavaram), and I am licensed by the State of Texas as a Licensed Professional Counselor-Associate. I have a Master of Science degree in Counseling Psychology from University of St. Thomas in Houston, TX. I also have a MS in Cellular Biology, and taught Biochemistry for 10 years at the undergraduate level.

AREAS OF COMPETENCE

As an LPC-A, my areas of competence include individual and group counseling, geared towards caregivers and senior citizens. I will be

able to see young adults too, 14yo and above. **However, I am not able to prescribe medications to clients.**

I believe that clients have the ability to choose how to resolve their own problems, can make their own decisions with my assistance as a facilitator, and are responsible for their own behaviors, thoughts, and feelings.

As a counselor, I encourage my clients to develop greater self-awareness and mental health through their life experiences, building increased confidence and self-esteem. Some clients need only a few counseling sessions to achieve these goals, while others may require more therapeutic sessions. As a client, you maintain control and you may end our counseling relationship at any point, and I will be supportive of that position. If you are dissatisfied with my work, I will help you find another counselor with whom you might be able to work with effectively.

TECHNIQUES

Because I believe that a client's self-awareness and choices are key to developing self-direction and independence, my techniques will be drawn from an Existentialist manner, Cognitive-Behavioral Model, Dialectical Behavioral Therapy with Mindfulness, Solution-Focused Brief Therapy and other therapy disciplines as needed, in collaboration with clients. These techniques will provide methods to solve problems utilizing the client's own strengths and experiential learning to meet their needs. Occasionally other approaches will be used such as role- playing, work to be done at home, and guided imagery when deemed appropriate for the client(s).

PROFESSIONAL RELATIONSHIP

While our sessions might be very intimate psychologically, it is important for you to understand that we have a professional relationship rather than a social relationship. Our contacts, other than chance meetings, will be limited to appointments you arrange with me. Understand that I will not attend your social gatherings, accept gifts from you, or relate to you in any other way than in the professional context of our counseling sessions. You will be best served if our relationship remains strictly professional, and our sessions concentrate exclusively on your concerns. While you might learn much about me as we work together, it is important for you to remember that you are experiencing my professional role.

CONFIDENTIALITY

Information you share with me may be entered into records in written form. Additionally, I will keep confidential the things you tell me, with the following **exceptions**: (a) thorough written consent you direct me to share information with someone else; (b) if you are a danger to yourself or others (TX Health and Safety Code); (c) I am ordered by a court to disclose information; (d) you disclose abuse of a child, a disabled person, or an elderly person (TX Family Code); (e) you disclose that a previous therapist sexually exploited you (LPC, LMFT Rules); or, (f) other reasons as specified in laws of this state. Confidentiality also does not extend to criminal proceedings or to legitimate subpoenas in a civil proceeding. My responsibility to you is to maintain all identifiable information about you in confidence and to not release it to any person or facility without your written permission **except** in the instances noted above.

INDIVIDUAL, COUPLE, AND FAMILY CONFIDENTIALITY

When collaborating with individuals, the individual holds the right to confidentiality. When working with couples, I am obligated to preserve confidentiality on behalf of the couple. This means that I will not release information about either member of the couple without the consent of **both**. This also means that I will not hold individual confidences of either party that will jeopardize my allegiance to both parties in the couple.

EMERGENCY PHONE CALLS

I shall always try to return your call within 24 hours if not sooner. I am not an emergency mental health service, so if you need to talk with me immediately and cannot reach me, call **911/ 988**, or go to your nearest hospital emergency room.

TEXT MESSAGE AND EMAIL DISCLAIMER

Any text messages/email sent to you will be for informational purposes only. No private protected health information should be included in your emails, and they will not be replied to via email. If you do not want your information viewed by anyone else, you must make sure that no one else can access your text messages/email. I cannot be responsible for who views your messages once I have submitted correspondence to the private mobile#/address you provided. By providing your private and secure mobile#/email

address, you are giving me consent to text/email you at any time. I recommend you do not use your work mobile#/email address because your employer may be able to view your texts/emails.

TERMINATION AND FOLLOWUP

You are free to work on a specific problem, not return for a period of time, and then resume therapy later. On the rare occasion that you have achieved your treatment goals but want to continue to see me anyway, I may make the decision to terminate your treatment based on my ethical obligation not to prolong therapy when it is no longer necessary. I will not become your friend, client, customer, supervisor, teacher, or have any relationship with you after termination. I may also terminate with you if I cannot provide therapy that fits your specialized treatment needs, if you do not comply with the mutually developed treatment goals and procedures, if you are not benefitting from therapy, if you do not pay your bill, if you become violent, abusive, or litigious, or if the therapy relationship is compromised in any way due to unforeseen circumstances. Any non-voluntary termination will be accompanied by an appropriate referral.

RECORDS

A file is maintained containing information, session notes, reports from other professionals, any correspondence, or materials you send to me, copies of correspondence you authorize me in writing to send to others, and forms you complete. On occasion, we may review the case folder as part of your therapy. It is meant to be a working document to both reflect and guide your therapeutic work and is stored in a locked file or protected electronic medium. After two years of inactivity, it is moved to a remote storage and held for seven years after the last entry.

FEE POLICIES

Sixty (60) minutes constitutes a therapy hour for which I charge $100.00 for each session for individual therapy. Occasionally, you may need some extra time to complete the session, in which case either you or I may request this, preferably prior to the scheduled session. You will be charged for these contacts at my discretion and most often when the contact is lengthy.

INSURANCE

I **do not** accept insurance. But I can provide a receipt if you wish to file a claim for out-of-network benefits.

PAYMENT AND COLLECTION POLICIES

A statement of fees will be provided to you at the appointment conclusion or mailed to you as they occur. Please do not ignore these statements as any unpaid fees may be referred for collection after 45 days. If a collection agency is necessary, a charge of $45.00 will be added to your account. There is a $45 charge for all returned checks.

If you need to reschedule an appointment, please contact the office at **281-241-9990** soon as you become aware of the situation. Not doing so takes away the opportunity to give that appointment to another client. (Emergency situations will be taken into account.)

Appointment reminder calls are only made when time allows. DO NOT rely on this courtesy to keep from missing appointments. You are responsible for your attendance.

OTHER

It is my intention to render my services in a professional manner consistent with accepted standards of practice. Usually, our sessions will be 60 minutes in duration for individual, couple, marital or family counseling, and 90 minutes in duration for group counseling, unless otherwise arranged. It is impossible for any counselor to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

CLIENT RIGHTS

You have the right to be treated by me in a competent, ethical, and respectful manner.

You have the right to a personal, individualized assessment of your treatment needs in which your expertise about yourself is as important as is my professional opinion about you.

You have the right to referrals to other competent professions and services when this is indicated by your treatment needs.

You have the right to ask questions about the approach and methods we use and to decline the use of certain therapeutic techniques.

You have the right to confidential treatment except in the circumstances already described. This means that you determine the amount of information to be released to anyone outside this setting by signing a permission form that is specific to each situation that determines the length of time in which the information may be released, and that may be canceled by you at any time.

You have the right to stop receiving therapy from me without any obligation other than to pay for the services you have already received unless you are a danger to yourself or to someone else. You have the right to resume service following termination with my expressed agreement. You have the right to discuss your treatment, concerns, questions, complaints, or any other matter with me.

Authorization for Use/Disclosure of Protected Health Information (HIPAA)

I, _____, do hereby authorize

_____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information:

_____

Phone: _____

Address: _____

Date of Authorization: ____ / ____ / _____

Authorization to expire on: ____ / ____ / _____

Or upon the happening of the following event:

_____

Information to be Released:

☐ My entire mental health record

☐ Only those portions pertaining to:

_____

(Specific provider name and/or dates of treatment)

☐ Authorization for Psychotherapy Notes ONLY

☐ Other: _____

Purpose of Information Release:

☐ Further mental health care ☐ Insurance claim ☐ Legal case

☐ Applying for ins ☐ Vocational rehab/ eval ☐ Disability eval

☐ At the request of the individual ☐ Other (specify):

_____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature: _____ **Date:** _____

If signed by a personal representative:

Print your name: _____

Indicate your relationship to the client and/or reason and legal authority for signing:

☐ Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

☐ Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased

CONSENT

I hereby state that I have read or had read to me and understand the elements of the Professional Disclosure Statement. I hereby consent to and agree to receive counseling services and acknowledge that I have received a copy of the Professional Disclosure Statement for Rao Counseling, Charlie Rao, MS, LPC-A.

_____

Client's or Responsible party signature Date

Please include the name and phone number of any and all persons you wish for me to contact in case of an emergency or crisis.

Name: _____

Phone No.: _____