

## **LCMHC Professional Disclosure Statement**

Live Oak Counseling and Associates, PLLC #PC15854  
Wendy W. Laursen, MA, LCMHC #10857  
3806 Park Avenue, Unit D  
Wilmington, NC 28403  
910-636-5100  
Fax: 910-636-5101  
wendy@liveoak-counseling.com

### **Education:**

Master of Arts in Professional Counseling received December 13, 2013 from Liberty University in Lynchburg, VA. Bachelor of Arts in Psychology received in May 1992 from the University of North Carolina at Chapel Hill.

### **Counseling Background:**

After graduating from the University of North Carolina at Chapel Hill in May of 1992, I worked for 5 years as a Social Worker with the New Hanover County Department of Social Services gaining experience in working with at risk youth and families. During my graduate program with Liberty University, I gained a year's supervised experience working with adults suffering from addiction as well as significant mental health issues. I co-facilitated Substance Abuse Intensive Outpatient (SAIOP) groups and an Emotional Regulation groups, as well as individual sessions. As of December 2, 2013, I became employed with Coastal Horizons Center, Inc. as a Substance Abuse Intensive Outpatient (SAIOP) Co-occurring Group facilitator and therapist until March 2016. From July 2014 until March 2016, I also worked part-time with Hope Counseling Center providing individual and couple therapy. In March 2016, I joined Agape Counseling Associates, Inc where I am a group facilitator and therapist for individuals, couples and families.

I enjoy working with adults, couples, and families. I view every client as a unique individual and will treat each client as such. I believe in a collaborative approach while working with clients and will help each client develop their own individual counseling goals and plan to achieve those goals. I believe that counseling should provide a safe and productive place to share and I take every effort to make each counseling session this way. There is not one counseling approach/theory that works for every client and for this reason I take a holistic approach to working with my clients. I honor my clients' personal spiritual values and strive to incorporate their spirituality into the counseling process at their request. I will adjust counseling techniques to help best meet the needs of each individual client. I do align myself most with the following theoretical approaches: Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Cognitive Processing Therapy (CPT), as well as person-centered individualized approaches. I will at times assign homework that is designed to help improve and reinforce work done during counseling sessions and progress towards achieving counseling goals. I am also a trained and certified PREPARE/ENRICH Premarital/Marriage Facilitator.

### **Session Fees/Length of Sessions & Cancellation Policy:**

It is my policy to hold an active credit card on file at all times. The appointment you have scheduled with me is reserved for you and I never overbook appointments. I have blocked this time for you, and I respect your commitment to therapy. Your credit card will be charged for no shows to appointments or late cancellations. Holding the card on file provides an additional accountability to your commitment to therapy. **If you are unable to keep your appointment, please call or reschedule at least 24 hours in advance in order to avoid being charged a \$75 cancellation or no-show fee.** In turn, should I have to cancel your appointment in less than 24 hours, I will provide you with a \$50 credit towards your next session. Please note that insurance does not cover no show or late cancellation fees.

Sessions are **50 minutes** in length unless we agree together to have an extended session. My fees are as follows:

	<b>Insurance Rate</b>	<b>Private Pay Rate</b>
Initial Assessment	\$175.00	\$135
Counseling Session	\$165.00	\$130
Phone Consult	\$30.00 per extended consult (over 10 minutes) *	
	<i>(Insurance will <b>not</b> cover phone consults)</i>	

Other fees will only be charged after being discussed and agreed upon by you, the client (i.e. counseling material used within the session). Payments may be made by cash, check, or credit card, and full payment is expected at the conclusion of each session.

Currently, I accept insurance through **Blue Cross Blue Shield, Aetna and Humana Military (formerly Tricare)**. Please come to your session prepared with your insurance card and co-pay. Any changes to insurance should be provided as soon as available. It is my policy that payment is due at the time of service unless other financial arrangements are made in advance. I require all patients to pay their deductible, co-pay and/or coinsurance payment at the date of service. You may also be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly. It is your responsibility to be aware of your insurance policy's coverage for mental health and substance use disorder services. Some insurance companies require prior authorization and it is your responsibility to obtain this prior authorization. You will be responsible for any charges your insurance does not pay.

If yours is another insurance company, I can provide you a receipt so that you may file an individual claim. It is possible that your insurance company may reimburse you for counseling sessions; however, you will need to verify this with your insurance company.

If I am requested by you, your attorney, or someone from the court on a matter regarding you or your family to participate in, I charge **\$450** per hour, with a **\$900 retainer fee** for any court appearance, to cover my attorney fees, preparation of documentation, and time lost from work. I will charge you this fee for any legal matter I am requested to attend, including but not limited to meeting with lawyers, deposition hearing, and court appearances. This fee is due immediately

upon receipt of my bill. If requested by you or a third party that you have signed a release to send information regarding your treatment file or write a letter, I will charge a **\$15.00 fee each time.**

### **Use of Diagnosis:**

Diagnosis as recognized by the DSM-5 will only be used when it is beneficial for the purpose and intent of counseling. In addition, most insurance companies will require 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. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. **Please be aware that any diagnosis provided will become a part of your permanent insurance records.**

### **Confidentiality:**

Everything that you discuss in session is held in strict confidence. All our communication becomes part of your clinical record which is kept in a secured location which is HIPAA compliant. I am legally and ethically bound to obtain a signed authorization from you to release any information or before I communicate with other service providers such as medical or mental health professionals, family members, or anyone else. *The only exception to this is if I believe that: (a) you may harm yourself or someone else, and (b) if I believe that a child or elder adult has been, or may be at risk for abuse or neglect, then I am legally and ethically obligated to notify the proper authorities.* Also, in rare instances, therapists can be legally ordered by a Judge to release your personal information to the court. Other than these exceptions, I am legally and ethically obligated not to disclose to anyone- anything regarding your treatment, diagnosis, history, or that you are a client receiving services. This cannot be done without your full knowledge and a signed release of information.

When providing **couples counseling**, I approach confidentiality by an *accountability with discretion* position. I maintain all information that you tell me through whatever means in confidence. *However*, if you tell me something in an individual session, or through some other means, that I think will impede the progress of you couple therapy, I will ask you to take responsibility for it. This might mean individual sessions for one or both of you and a limited time period during which certain problems are stopped. You may or may not wish to tell me secrets and I will tell you whether it is important for your partner to know. If I think your partner should know, then I will suggest you tell them and coach you about how to do it. If there is an ongoing secret behavior, I will help you to stop it in a given period of time before asking you to tell your partner. I will never reveal the nature of the secret, *but* if it interferes with your stated goal of doing couple therapy, I may terminate therapy by saying you have not fulfilled this agreement. I will remind you of this policy before beginning such individual sessions.

### **Other Rights:**

Because I have a limited practice, I **do not** have 24-hour emergency or “on call” coverage. If you believe you will need a therapist with 24-hour coverage I will be happy to make a referral. **If you experience a psychiatric emergency, you should do one of the following recommendations:**

- **Call 911**
- **Take yourself, family member or friend to the nearest emergency room.** For New Hanover County residents this would be New Hanover Regional Memorial located at 2131 S.17th Street or Cape Fear Hospital located at 5301 Wrightsville Avenue.
- **Contact the local mobile crisis line.** Teams are made up of experienced clinical staff who are trained to respond in a behavioral crisis and help provide stabilization techniques. They will come to the person who is in crisis wherever they may be - school, home, or work. For *New Hanover, Brunswick, Pender, Onslow, Carteret, Jones, Pamlico and Craven* counties, please call **1-844-709-4097**.

**Complaints:**

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

(<http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>).

North Carolina Board of Licensed Clinical Mental Health Counselors  
 PO Box 77819  
 Greensboro, NC 27417  
 Phone: 844-622-3572 or 336-217-6007  
 Fax: 336-217-9450  
 E-mail: [complaints@ncblcmhc.org](mailto:complaints@ncblcmhc.org)

**Acceptance of Terms:**

We agree to these terms and will abide by these guidelines. Please sign and write today’s date for evaluation and counseling services to be provided by Wendy W. Laursen. I understand that I can withdraw myself at any time from treatment and refuse any treatment offered.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor \_\_\_\_\_ Date: \_\_\_\_\_

Wendy W. Laursen, MA, LCMHC

## Authorization for Credit Card Use

Name Printed on Card: \_\_\_\_\_

Type of Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CVC 3 Digit Code on back of the Card: \_\_\_\_\_

Zip Code for Billing Address: \_\_\_\_\_

I authorize Wendy Laursen, MA, LCMHC to charge my credit/debit/health account card for professional services at the time of service. If I do not cancel before 24 hours, I recognize that Wendy Laursen, MA, LCMHC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the no show/late cancellation fee.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. I certify that I am the authorized holder and signer of the credit card referenced above. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist's Signature \_\_\_\_\_ Date \_\_\_\_\_