Professional Disclosure Statement

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My name is Dana B. Foster and I am a Licensed Clinical Mental Health Counselor working as a sole proprietor in Midland, North Carolina.

EDUCATION:

Bachelor's degree in Sociology/S.W. from UNC Charlotte (May, 1981)
Masters' of Education in Counseling from UNC Charlotte (May, 1995)
Licensed as a school counselor (K-12) from the state of N.C. of Public Instruction (Issued April, 1995, classification #005)
Licensed Professional Counselor (Issued March 7, 2008, #6906) (Name changed to: Licensed Clinical Mental Health Counselor, Jan., 2020)
National Certified Counselor (Issued May 2, 2008, #243033)

EXPERIENCE/CLIENTELE SERVED:

My experience involves serving as a counselor for thirty years in the following capacities: a Licensed Clinical Mental Health Counselor (formerly licensed professional counselor), as a sole proprietor, as well as contracted with The Bridge of the Carolinas in Albemarle, N.C. and at New Directions Psychiatric Services in Albemarle, N.C. At these locations, I implemented individual, group and family counseling. I also served as a school counselor in the Stanly County Schools as well as Union County Schools. The services I have offered in the school system involved individual counseling with students, group counseling, career counseling as well as counseling adults, as needed. The clientele that I have served involved elementary, middle and high school students and their families as well as staff members. I have worked in the alternative high school setting with high risk adolescents also. The various groups that I have facilitated are: children of alcoholics/drug abusers, social skills groups, children of divorce, single parent family, study skills, and grief groups. There are many times I have worked very closely with agencies/schools in the community to meet the needs of clients.

DESCRIPTION OF SERVICES/COUNSELING PHILOSOPHY:

I believe all individuals, regardless of age, ethnic or cultural background has the right to receive treatment. In working with these populations, I have predominately used a cognitive behavioral approach, which is a problem-focused approach designed to help clients identify and change their dysfunctional beliefs, thoughts and patterns of behavior that contribute to their problems. Techniques I have used to promote change include modeling, reframing, and behavioral training, thought stopping and self-talk strategies. I often use didactic presentations and homework is sometimes assigned. I work hard to help clients gain insight into the connection between how their thoughts affect their feelings and actions. Counseling is both a helping relationship and a process of change. It is a joint effort between the counselor and the client which takes a lot of hard work and energy. I order to be successful, it is highly important to establish trust and empathy with clients in a work environment where they may feel comfortable expressing themselves and issues of concern.

BENEFITS/RISKS:
While the effects of counseling have proven to be beneficial, there are some risks to consider. Some clients may experience uncomfortable feelings for a time as they begin to work on sensitive areas in their lives and/or unpleasant memories. These feelings can also affect clients' lives outside of the counseling office-having an impact on current relationships. Any doubts or concerns should be discussed prior to therapy and if possible, alleviated in order to minimize potential risk and maximize the benefits of therapy.

CONFIDENTIALITY:
All information shared is considered confidential and private. All client records are stored in a secure location and only authorized persons have access to them. If records are transported, they will be transported by secure means by authorized personnel also. All correspondences are highly confidential and only executed by secure means (ex. confidential fax, certified mail).
There are exceptions where I must breach confidentiality in order to protect the clients or others. All information shared will be kept confidential with the following exceptions:

-When disclosure is required to prevent clear and imminent danger to yourself or others. This includes sexual or physical abuse to you or someone else (child or elderly). If in doubt of a decision, I will consult with another professional as to the validity of the exception.
-When a court orders to release information without client consent.
-If I have knowledge of someone having intentions on hurting the client.
-At times, when I have a small group, I can't guarantee all group members will keep all information confidential.

OFFICE HOURS:
Monday- Friday 11:00am – 7:00pm
After hours, we provide 24/7/365 coverage as all calls are monitored. Please note if you find yourself in an emergency you need to call 911 or go to your nearest emergency room for assistance.

LENGTH OF SESSIONS/FEES:
Counseling sessions usually last 45-60 minutes in length and are usually held weekly, bi-weekly and sometimes monthly. (There are instances where a longer session may be needed and agreed upon by all parties involved.) Each client will be billed individually, based on insurance or self-pay. The method of payment will be discussed and agreed upon during the first session. We except credit cards, cash, checks as well as health savings/flex cards. There will be a $25.00 service charge of all returned checks. The initial evaluation fee is $200.00. Thereafter, the fee for an individual session is $180.00 per session. The fee for a family session with the individual or a couple's session is $180.00. If cost is a barrier for services, there are sliding scale appointments available. Fees will be adjusted in accordance to need. Therefore, please do not allow finances to be the reason you do not seek mental health services. I will do my best to find a compromise that is tenable for your circumstances.

I accept a number of insurances where the fees will be adjusted in accordance to the insurance's negotiated rate for services provided. Please inquire regarding specific costs associated with each insurance provider as costs vary.

MISSED APPOINTMENTS/FEES:
Each client is asked to call at least 24 hours prior to the scheduled appointment, if for some reason they are not able to attend. Remember, there are others that may need your slot if you are not able to arrive at your appointment time. So please do call if you cannot make it.

INSURANCE: If you are covered by a participating insurance carrier, our office will be happy to submit your claim form to the insurance company. Co-payments (the portion of your bill not covered by your insurance), are required at the time of service.

USE OF DIAGNOSIS/REPORTS:
All clients have the right to be informed of any diagnosis or reports being made. Any personal information or diagnosis provided to an insurance company can no longer be held to the same standard of confidentiality and become part of your permanent insurance record. All procedures will be explained to each client.

CLIENT COMPLAINTS/GRIEVANCE PROCESS:
The client has the right to disclose any complaints or concerns either in person, by phone or in writing to the following:

Dana B. Foster, M.Ed., LCMHC, NCC
P.O. Box 487
Locust, NC 28097
Office: 704-888-1616
Fax: 704-888-1670
Email: dana.b.foster@gmail.com

Complaints/grievances in writing will be reviewed and client will be contacted by phone within 10 days by above stated to discuss and/or set up a meeting to address clients concerns. If client concerns are not addressed to client satisfaction, client has the right to report complaints to the following address:

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417

For Overnight and Special Delivery:
7D Terrace Way
Greensboro, N.C. 27403

Phone: 844-622-3572
Fax: 336-217-9450
E-mail: LCMHCinfo@ncblcmhc.org

I abide by the ACA Code of Ethics
(http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx).

We agree to these terms and will abide by these guidelines. I may ask questions pertaining to this document at any time.

Client signature _____ Date _____

Parent/Guardian _____ Date _____

Counselor's signature _____ Date _____