

Lake Mead WELLNESS CENTER

522 E. Lake Mead Parkway, Suite 2, Henderson, NV 89015
702.900.5040
www.lakemeadwellnesscenter.org

Disclosure Statement

Welcome to the Lake Mead Wellness Center! This paperwork has been prepared for you to inform you of our qualifications and what you can expect from us as a therapist. It explains our therapeutic approach, services, fees, policies and your rights as a client. Additionally, this disclosure statement provides you with information about our education, training, and experience. After you have read this statement, you will be asked to sign a statement of acknowledgement stating that you have received it and you will be provided a copy for your records. Our desire is that your first visit is a pleasant one and that you leave glad you came.

First, check the box next to the therapist you are scheduled with and take a minute to read about them.

 **Michelle Blakeley, M.A., LCPC (#5066), LMFT (#4154)**
Direct: 702.907.8306

I am a CPC and MFT in the state of Nevada. I hold a Bachelor of Arts in Workforce Post-Secondary Math and Business Education from the University of Nevada Las Vegas, a Master of Arts in Human Services with an emphasis on Marriage and Family Therapy from Liberty University, a Master of Arts in Clinical Professional Counseling and a Master of Arts in Marriage and Family Therapy (MFT) from Lincoln Christian University.

I am certified licensed instructor in the Myers-Briggs Type Indicator, Prepare/Enrich Couple Assessment, am an Enneagram coach, and am a member of the American Association of Marriage and Family (AAMFT) and the American Association of Christian Counselors (AACC). I am Level 2 EMDR (Eye Movement Desensitization and Reprocessing) certified.

 **Mariano Codarini, B.A., M.A., LMFT Intern (#MI0811)**
Direct: 702.834.9380

I hold a Bachelor of Science in Computer Science from the University of Nevada Las Vegas, and a Master of Arts in Marriage and Family Therapy (MFT) from Lincoln Christian University. In addition to my professional experience I also speak some Spanish and have volunteered with adolescents in both a discipleship and recovery church setting. I am a member of the American Association of Marriage and Family (AAMFT) and the Nevada Association of Marriage and Family Therapy (NAMFT).

 **Keith Stark, B.S., M.A., LMFT Intern (#MI0925)**
Direct: 702.608.5514

I hold a Bachelor of Science in Business Management from the University of Phoenix and a Master of Arts in Marriage and Family Therapy (MFT) from Lincoln Christian University. I am certified licensed instructor in Anger Management and a member of the American Association of Marriage and Family Therapy (AAMFT).

Therapeutic Approach

As a marriage and family therapist intern, my training has come from a systems perspective. Systems therapy works with the relationship and cycles of interaction between persons. Within the context of systems that may be affecting one's life, issues such as gender, culture, and spirituality are considered. During our first couple of sessions, we will set specific goals to accomplish based on your presenting problem. I will gather data on your presenting problem and we will work together to find solutions. I always attempt to work within the structure of brief therapy therefore goals are usually met within eight to ten weeks. I believe that therapy not only takes place in the therapy room, but also between sessions. Therefore, a part of your therapeutic process may include assignments outside the therapy room. I work with individuals, couples, adolescents, families and groups. The approaches that I use in treatment vary. I believe the relationship between the therapist and the client is paramount for productive treatment and ultimately for healing to occur. Typically, treatment consists of:

1. An assessment, which may include any or all of the following: interviews, observation, review of records, behavior rating scales, biological, psychological and social history, and/or mental health evaluation.
2. Development of a treatment plan, which includes goals and objectives, therapeutic interventions and estimated length of treatment.
3. Implementation of treatment plan.
4. Ongoing assessment, discussion of progress, and revisions to the treatment plan as appropriate.
5. Completion or termination of treatment when satisfactory progress has been made or treatment goals are achieved.
6. Aftercare planning for follow-up care to maintain gains and prevent relapse if needed or desired by the client.

Appointments, Fees, Payment

Sessions are 50 minutes in length and your arranged fee is due before the end of each session. Any time incurred due to court proceedings, which includes court preparation time, travel time, providing written documentation, and testifying will also be billed at the same session rate/ per 50 minutes. Partial hours will be prorated. Please note that I do not bill insurance. I understand that financially you may be struggling and on that point I am willing to work on a sliding scale down that may be more affordable for you.

Your appointment is reserved particularly for you. If you are unable to make your appointment, please provide 24 hours notice of cancellation to me directly by calling or texting your therapist directly. Failure to give 24 hours notice of cancellation or failure to show up for a scheduled appointment may result in you being charged your full session rate. You will be expected to pay this fee at the start of your next session. If you do not book another session within 10 days you will be billed at the address listed on the front of the intake form. Any outstanding fees owed will need to be paid before a future session may be booked.

Request for Additional Reports/Letters/Documentation/Legal Issues

Completing assessment paperwork, treatment plans, progress/psychotherapy case notes, brief phone calls (less than 15 minutes) and/or letters are included in your fee. The Lake Mead Wellness Center is unable to provide documents for court, however, you may request a letter verifying attendance and with proper signatures, it will be released.

Other Fees/Charges

You are responsible for all fees/charges incurred and will be billed for all charges not previously paid by you.

Insurance

I do not bill insurance.

Refunds

No refunds are provided for services already rendered.

Dual Relationships

My professional code of AAMFT ethics and the Nevada statutes are very strict in terms of dual relationships. Due to this code, all social networking sites would be considered a dual relationship.

Technology

All communication with my client is either done in the therapy room, except for communications that needs to take place in reference to appointment scheduling. Please note that my phone number is a cellular phone with a voice mail. My number is private as is my voicemail; however, I cannot guarantee the confidentiality of technology beyond my control. Some clients prefer to communicate via text and email and if you choose to do this, please know privacy cannot be guaranteed.

Telehealth

Teletherapy is a non-acute service. Internet-based therapy services are not emergency services. During our first session we will discuss an emergency response plan, and as such, your therapist will be taking down the address of your current location at the beginning of each session. If you find yourself in an emergency situation, please call 911 or proceed to the nearest emergency room for help. You have the right to withhold or withdraw consent for online treatment at any time without affecting my right to future care or treatment.

The laws that protect the confidentiality of my medical information also apply to Telehealth. The information disclosed by me during the course of my therapy is generally confidential. There are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where you make my mental or emotional state an issue in a legal proceeding.

There are risks and consequences from Telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of LMWC and my therapist, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur.

Misunderstandings are possible with telephone, email and real-time internet chat because non-verbal cues are typically lacking. Even with video software, misunderstandings may occur because bandwidth is always limited and the image quality could be poor. If you have never engaged in online therapy before, please be patient with the process and clarify any information that you think I have not understood or heard properly. Telehealth based services and care may or may not yield the same results nor be as complete as face-to-face service.

If you are accessing our sessions from a public setting, you should also consider the visibility of your screen to the people around you, which can compromise your confidentiality. Be mindful of those that can hear you while using headphones. Your therapist will always conduct therapy in a confidential place.

You are also responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping your email and chat IDs and passwords secret and maintaining the security of your wireless internet access points. If we have a connection issue we will continue our session over the phone. If somehow the phone call fails we will reschedule the session for the following available time for the both of us.

By signing below, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Telehealth facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in Telehealth Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in Telehealth.
5. To maintain confidentiality, I will not share my Telehealth appointment link with anyone unauthorized to attend the appointment.
6. There is no recording of sessions by LMWC or the Telehealth service without written consent of the client.

Emergencies

If I will be out of town for a significant length of time, another therapist may be available for interim treatment. I will discuss this possibility with you before a prolonged absence I might have. On some occasions I may leave contact information on my voicemail for another therapist who will be available in my absence. I do not operate a crisis center and therefore I am not available 24 hours a day, 7 days a week. Should you need this kind of therapy, please let me know upon reading this and I will provide you a referral to this kind of clinic. Should you have a crisis arise during off campus hours, please call 911.

Confidentiality

My professional code of American Association of Marriage and Family Therapist ethics and the Nevada statutes prevent me from disclosing information that is shared in therapy or releasing information without your written consent. If you are here for couples of family therapy, all persons involved in the therapy process are required to provide written consent before information can be released; however, I cannot guarantee the confidentiality of other participants who are involved in your therapy process. The only exceptions to confidentiality are stated in the family therapy section of this disclosure statement. Sessions may be videotaped and/or observed through a computer on a regular basis for the purpose of quality care of your case, training for the therapist, and supervision. These videos are put on a USB drive and securely locked in a file cabinet that is behind a locked door. Only therapists have access to this room. Once the supervisor has reviewed the session, it will be deleted from the USB drive. The Center conducts group supervision and works from a systemic model. All therapists in your case will potentially discuss it. If there is anything you do not want discussed, please let me know.

Your rights as a family therapy consumer

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure provided.
2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without moral, legal, or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy between the therapist and client is never appropriate.
5. To know that our therapeutic relationship is confidential except under the following conditions:
 - a. If you threaten bodily harm or death to yourself or another person
 - b. If you reveal information about physical abuse, sexual abuse or neglect in regard to a child or elderly person.
 - c. If you are in court-ordered therapy
 - d. If a court of law issues a legitimate subpoena or a judge breaks your confidentiality
 - e. If you are under the age of 18, in the State of Nevada, parents have access to information in regards to their child's medical records.
 - f. If you request, any part of your records can be released to any person or agency if you have signed an authorization for me to do so.

The following is a list of therapists and supervisors potentially involved in supervision with the Lake Mead Wellness Center. Please let us know if you know any of these individuals and we will ensure that that they will not be a part of the supervision of your case.

Supervisors:
Merelynn Harris
Sherri Collier
Isabelle Parker

Therapists:
Michelle Blakeley
Mariano Codarini
Keith Stark

Couples

Please be advised if you are attending couples counseling there may be a time where I request to see one or each of you individually, please know I am not the keeper of any secrets and whatever is exposed in an individual session, will be shared, at some point, in your couple's session.

Both initials required here: _____

The Nevada Board of Family Therapist Examiners regulates all marriage and family therapy services in Nevada. Questions or complaints may be addressed to P.O. Box 370130, Las Vegas, NV 89134. The phone number is (702) 486-7388.

Acknowledgement

By signing below, I acknowledge that I have received a copy of my therapist’s disclosure statement.

As well as agree that:

1. I have read and understood the above policies.
2. I have read and understand the financial obligations and cancellation policies.
3. I have been informed of my therapist’s credentials and my rights as a client.
4. I have read the section specific to cancellation of appointments.
5. I have read and understand that if I have a crisis after hours, I am to call 911.

Signed: _____
 Client or parent/guardian Printed Date

Signed: _____
 Client or parent/guardian Printed Date

Consent to Treatment

As a client, I understand that:

1. I have the right to refuse any or all parts of the treatment plan, with the exception of emergency treatment.
2. Consent to any or all parts of the treatment plan may be withdrawn at any time.
3. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.
4. All counseling/therapy sessions are confidential other than the situations outlined in the disclosure statement.
5. As a client, I have read my rights and acknowledge receipt of a copy of her disclosure statement.
6. I have been fully informed of the above, understood the process, and agree to accept such treatment and to cooperate in its implementation.

Signed: _____
 Client or parent/guardian Printed Date

Signed: _____
 Client or parent/guardian Printed Date

 Signature of Therapist Date

 Printed Name of Therapist Date