****

Valerie Allen, MEd, LPCC

Professional Clinical Counselor & Couples Therapist

License # E.1700025

Address: Contact:

Gracetree Studio 513-317-8113

8933 Cincinnati-Dayton Road valallencounseling@gmail.com

West Chester, OH 45069 www.valallencounseling.com

**Professional Policy and Disclosure Statement**

I am pleased that you have selected me as your therapist and I look forward to working with you. This document is designed to inform you about the counseling process, the relationship between client and therapist, and the ethical standards by which my services will be rendered. Please don’t hesitate to ask any questions about the therapy process throughout the course of our professional relationship.

Professional Profile as Required by State of Ohio

I am licensed by the State of Ohio as a Professional Clinical Counselor and hold a Master’s Degree in Community Counseling from The University of Dayton (2010). In my counseling practice, I work with adults, adolescents, and couples. My areas of competence include mental health counseling, personal and social counseling, couples and family counseling, adolescent counseling, chemical dependency counseling, addictions counseling, career counseling, and the independent diagnosis and treatment of mental and emotional disorders.

**This information is required by the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board, which regulates all licensed and registered counselors, social workers, and marriage and family therapists. If you have complaints about professional services from a counselor, social worker, and/or marriage and family therapist, contact:**

**State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board**

**50 West Broad Street, Suite 1075**

**Columbus, OH 43215**

**Telephone: 614-466-0912 Fax: 614-728-7790**

**www.cswmft.ohio.gov**

Confidentiality

I take the issue of confidentiality very seriously. As mandated by the American Counseling Association Code of Ethics, it is your right as a client, and my responsibility as a professional counselor, that anything discussed in our sessions be kept private, with the following exceptions: (1) you release me, in writing, to exchange information with a third party, (2) you reveal to me that you may harm yourself or others, (3) I have reason to suspect child or elder abuse, (4) I am court-ordered to disclose information regarding your case, or (5) I need to consult with a colleague regarding diagnosis, treatment, or ethical issues. In these instances, only the minimal information necessary will be shared and “every effort will be made to protect your identity and avoid undue invasion of privacy,” as stated in the American Counseling Association Code of Ethics.

Emails and texts are not guaranteed confidential methods of communication. If you choose to email or text me, please limit details to appointment issues. For reasons of confidentiality and ethical considerations, it is my policy to not use social media to connect or communicate with clients.

All confidential client information and files are kept in a secure location. Documentation is stored in an encrypted Electronic Medical Records database.

Page 1 of 3

**Valerie Allen, MEd, LPCC**

Professional Clinical Counselor & Couples Therapist

The Counseling Process

Counseling is a collaborative relationship between client and therapist. Together, we will discuss issues that you feel are relevant to your health and wellness. At times, the therapy process may bring about painful feelings and your situation may “feel worse before it gets better.” This is especially common in the early stages of therapy. However, seeing the process through can culminate in a greater understanding of yourself and your interpersonal relationships and create an opportunity to find a resolution or sense of peace.

Please note that therapy results cannot be guaranteed. Each individual experiences the therapeutic process in a unique way. As a client, you can facilitate the counseling process by being open and honest, willing to try new ways of thinking and behaving, and attending regularly scheduled appointments. As a counselor, I will provide my services in a professional manner and adhere to the ethical standards defined by my licensure. In a combined effort, we will strive to achieve the best results possible.

It is my belief that the counseling relationship is most successful when the client feels at ease with the counselor’s professional and personal style. If at any time in our professional relationship you feel that I am unable to meet your counseling needs, please don’t hesitate to bring your concerns to my attention. If together we cannot amend the situation, I am willing to refer you to another counselor or counseling agency better suited to your needs.

Treatment Termination

When you feel that sufficient progress has been made, goals have been met, and you are ready to end treatment, this process is most effective when a plan for closure is agreed upon between client and therapist. Together, we can debrief about your time in therapy, discuss progress and insights that you will carry forward, and bring closure to the therapy process. After all, this is what you are working toward!

Sometimes when a client stops coming to therapy for a while, I will reach out by phone or email to check in. This is not meant as pressure to return, but true interest in your wellbeing. If you do not return for counseling after more than 6 months without explanation, I will officially close your file. If your file is closed, you are welcome to return to therapy at any time! New intake paperwork will be required, and new rates may apply.

Emergency Situations

If an emergency arises and a client or their guardian feels immediate attention is necessary, the client or guardian will contact emergency services **(Dial 911).** As a Professional Counselor, I cannot be available for emergency situations, but I will follow up with appropriate counseling and support to the client or the client’s family.

HIPAA Notice of Privacy Practices

A copy of my official Notice of Privacy Practices as required by the federal government can be obtained from my website [www.valallencounseling.com](http://www.valallencounseling.com) under the New Client Forms tab. If you would like a copy of this form, please download the document and print for your records.

\*\*Signature required on Page 3\*\*

Page 2 of 3

**Valerie Allen, MEd, LPCC**

Professional Clinical Counselor & Couples Therapist

Rates and Payment

50-minute session:  $150.00

90-minute session:  $225.00

Phone and video sessions are available and will be charged at the same hourly rate.

Shorter consultation calls will be prorated in 15-minute increments.

Rates are reviewed each year and are subject to increase with 30 days notice.

Payment is due at time of services rendered. You may pay by cash, check, credit card, or HSA. Returned checks are subject to a $20.00 fee.

All clients are required to keep a credit card and signature on file authorizing charges for services rendered and/or late cancellation fees as agreed upon in this document. Please see Financial Agreement and Credit Card Authorization Form.

I do not accept “In Network” insurance.  This is preferable to many clients, as health insurance companies require that a diagnosis of your mental condition be reported before they will reimburse for mental health care services. This diagnosis will become part of your permanent insurance record.

If you would like to use “Out of Network” insurance benefits, I will provide a receipt for reimbursement.

Appointment Cancellation

**If it is necessary to cancel a scheduled appointment, please give 24 hour advance notice.**

**No shows and same day cancellations will be charged FULL FEE.**

**----------------------------------------------------------------------------------------------------------------------------------------------**

**Informed Consent**

I have read the Professional Policy and Disclosure Statement and understand my rights and responsibilities

in the counseling relationship. I agree to abide by these guidelines and hereby consent to participate in counseling provided by Valerie Allen, MEd, LPCC. I understand that this consent will be valid until treatment is terminated and I have the right to refuse or withdraw consent at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature Date Client signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (If applicable) Date

Page 3 of 3