



Description of our practice:

Psychotherapy involves assessment, treatment and counseling through a professional relationship to assist individuals, couples or families to alleviate issues with personal life, relationships and conflicts. We strive to help modify thoughts and/or behaviors that interfere with effective emotional, social or intellectual functioning. Psychotherapy follows a planned procedure of intervention that takes place on a regular basis over a period of time.

Description of Education and Experience:

Elizabeth Nuismer, MA, LPC, CHAIS

Bachelor of Arts in Psychology- Trinity Christian College

Master of Arts (MA) in Professional Counseling- Colorado Christian University

Licensed Professional Counselor (LPC) # 6401015656

Certified Facilitator of Prepare/Enrich

Certified Human Animal Intervention Specialist (CHAIS)

Scott Nuismer, LPC, CAADC

Bachelor of Arts in Theology and Psychology – Trinity Christian College

Master of Arts (MA) in Professional Counseling – Colorado Christian University

Certified Facilitator of Prepare/Enrich

Licensed Professional Counselor (LPC) – # 6401015796

Certified Advanced Alcohol and Drug Counselor (CAADC) - C-03253

If any issues, concerns or complaints arise, please contact:

Michigan Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing

Legal Affairs Division, Allegations Section

P.O. Box 30670

Lansing, MI 48909

(517) 373-9196

1. You are entitled to receive information from me about my therapeutic methods or techniques, the duration of your therapy (if it can be determined), and my fee(s). Please ask if you'd like to receive this information.
2. At any time, you may seek a second opinion from another therapist or terminate therapy.
3. In a professional relationship (such as ours) sexual intimacy between a therapist and client is never appropriate. If sexual intimacy occurs, it must be reported to the Board that licenses, certifies or registers the therapist.
4. Generally speaking, the information provided by the client during therapy sessions is legally confidential. This confidential information cannot be divulged without your consent except for certain legal exceptions and instances which include: (1) any suspected child abuse or neglect – as



such I must report this to the appropriate law enforcement agency, (2) a threat of imminent physical violence or harm against a specific person or group of people – as such I must inform the person or people of the threat and inform law enforcement authorities, (3) an individual who is a serious or feasible threat of harm to themselves or someone else as a result of a mental disorder, (4) any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

5. At all times, I reserve the right to consult with other therapists as needed, and to brief therapists covering for me while I am out of town or during a personal emergency. In general, the information divulged would not identify you personally, except in co-therapy agreements. In a case of a personal emergency, it might be necessary to divulge your name and phone number if it became necessary to contact you on my behalf. Such information will be given only in extreme or dire circumstances.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION:

If you are involved in divorce or custody litigation, my role as a therapist is **not to make recommendations to the court** concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, and also to make recommendations concerning custody. If a Subpoena is required, we require a \$1,500 retainer.

Administrative Fees:

Requested documentation and/or services not otherwise included in a standard therapeutic relationship (such as phone calls over 10 minutes outside of regularly scheduled therapy) are eligible to incur an additional charge based on your regular hourly rate.

Exceptions to Confidentiality (Release of Information):

For all clients who are receiving treatment from our team, it is understood that by signing this disclosure statement the client agrees to a *release of information* to staff members of Hope Heals Counseling, LLC so that we may better serve the individual/couple/family as a therapeutic team.

Services & Billing:

Standard therapy appointments may be billed the business day previous to the appointment. Retreats, intensives, and workshops require a 50% deposit (non-refundable) before confirmation of any such services will be given. Until the deposit is received, such services will be subject to rescheduling and/or cancellation. A credit/debit card is required to be kept on file and will be charged within a 7-14 day period prior to these scheduled services.

Appointment Changes and Weather:

Any changes to an appointment require 48 business hours notice. There are no refunds for appointments not kept or not rescheduled more than 48 hours in advance. You are responsible for scheduling a new appointment if there has been a missed or cancelled meeting. You may reschedule within the same week of your appointment if there is an opening for a \$25 fee. **In**



cases of couples' sessions, the couples' rate will be charged unless your therapist is given 48 hours or more notice that only one person will attend.

Inclement weather policy is that all sessions are still held, but will be conducted via phone, Facetime or Skype. (You acknowledge that remote counseling via phone or Skype is not a secure/confidential form of therapy and you agree to receiving this form of therapy in the circumstances previously described and any other which your therapist and you verbally agree upon.)

Insurance:

We accept Blue Cross Blue Shield and Priority Health insurances. If you have Medicaid or Medicare as primary or secondary, we are not a provider and are unable to provide services. (Exception includes Priority Health Medicaid). By signing this form, you agree that you do not carry Medicaid/Medicare. ***It is your responsibility to know your benefits.*** If your insurance does not reimburse for mental health appointments, *you will be responsible to pay the full insurance amount.* We require co-pay at the time of services. If you have a different insurance, we provide our clients upon written request with coded insurance receipts that clients may submit to their respective insurance company for potential reimbursement. You will be charged at the regular hourly rate.

In order to bill your insurance (if you are using this benefit), we are required to disclose certain information to your insurance company. By signing this document, you authorize Hope Heals Counseling, LLC to release the necessary information for transactions and assignments of benefits for claims.

Treatment/Progress Notes:

These are available upon written request only. Hope Heals Counseling, LLC reserves the right to deny these requests if your therapist determines that the information requested would be harmful to the client or others involved.

Current Rates:

Sessions are approximately 50 minutes (scheduled as 1 hour) or 75 minutes (scheduled as 1.5 hours) depending on service purchased.

Cash Pay: Cost for cash payers per 50 min session is \$90 for individuals, \$130 for couples, and \$170 for families (3-5 individuals). Co-therapy (Two therapists working with one client) rate is \$200/hr for couples and \$240/hr for families.

Insurance Pay: See above for accepted insurances. Direct charge to the client will vary depending on both the insurance plan (Co-pays are different depending on your plan) and the billing code submitted (depending on service provided and duration of session). Each client is responsible for understanding their insurance benefits before initiating therapy and paying the difference of what insurance does not cover.

Experiential Intensives: Details and rates vary. Please speak with HHC staff for more information.



Phone Contact/Emergencies:

Your therapist provides non-emergency psychotherapeutic services by scheduled appointment. If, for any reason, you are unable to contact your therapist by telephone and are having a true emergency, you may call the 24-hour crisis hotline in your area (Ottawa County Crisis: (616) 396-4357). You may also call 911 or check yourself into the nearest hospital emergency room. Be aware that you may leave a confidential voice mail with your therapist (ask your therapist directly for this information) for non-emergencies as well.

Risks and Safety Concerns: Participating in our outdoor services may be a potential risk to your health and well-being. These activities have an element of danger and risk. We cannot assure the safety of clients in all circumstances. You participate at your own risk, and by signing this document you agree to not indemnify Hope Heals Counseling, LLC in any way. For more information about the associated risks and safety concerns of any of our services, please ask your therapist.

“I have read the preceding information and understand my rights as a client/patient, and I agree that this disclosure statement has been verbally explained to me. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises.”

Client Name(s) Printed

Client Signature(s)

DATE: _____

DATE: _____

If client is under 18 years old, Parent(s) or Legal Guardian(s) Name(s) Printed

DATE: _____

DATE: _____