Seeds of Hope Counseling, LLC
Jacey Wall, P-LPC, NCC
8484 MS Hwy 15, Ackerman, MS 39735
jacey.l.wall@gmail.com | 662.905.1862

Confidentiality and Disclosure – Adult

Please print neatly. You will see certain questions repeated several times in this paperwork; this is for legal and insurance purposes. Please complete every item on every page. Thank you.

Appointment Date: ______________________ Client's DOB: ______________________ Age: _____
Client's Name: ____
Client's Address: ____
City, State, Zip Code: ____

Occasionally, it will be necessary for me to contact you. I will always be discreet in any message or correspondence, but I cannot guarantee confidentiality once a message, email, or mail is sent. Please mark yes if you give consent for me to contact you or leave you a message via the following methods. If you DO NOT give consent, please draw a line through the method. Thank you.

Client's Phone Cell #: ____________________________ May we leave a message? ( ) Yes ( ) No
Client's Home #: ________________________________ May we leave a message? ( ) Yes ( ) No
Client's Work #: ________________________________ May we leave a message? ( ) Yes ( ) No
Client's Email Address: ____
May we leave a message via email? *NOTE: Emails may not be confidential* ( ) Yes ( ) No

In case of an emergency, who do you give permission for us to contact?
Name: ______________________________________ Relationship: ___________________________
Phone Cell: ______________________ Home: _____________________ Work: _____________________
Does this person know that they are documented as your emergency contact? ( ) Yes ( ) No

Referral Source – How did you learn of our services? Name: _____________________________________
Please check which apply: ( ) Physician ( ) Friend ( ) Pastor ( ) Google ( ) Phonebook ( ) Newspaper
( ) Radio ( ) Other: ____

Office Policies and Agreements

Please read and review the following information. Your signature indicates your understanding, acknowledgement, and agreement to these policies. Please feel free for assistance should you have any questions while completing paperwork.

Notice of Information Practices

NOTICE: As your counseling provider, we keep a dated record of the services we provide to you. You may ask to see and review your record at any time; however, a schedule appointment must be made to review the records in the presence of the Therapist. You may also ask for clarification about the record or to correct the record. WE WILL NOT disclose your records or acknowledge your client status to others UNLESS you direct us to do so or UNLESS the law authorizes or compels us to do so. Applicable fees and past due balances must be paid in advance before your record will be reviewed with you, released to you, or copied for legal disclosure. **Policy requires written request and notice at least 15 business days before records may be released under any circumstance.**

Financial Policy

Thank you for choosing Jacey Wall, P-LPC, NCC as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill as a responsible financial practice is considered part of your treatment. The following is a statement of my Financial Policy which is required for you to read and sign prior to any treatment. **Please ask any questions you may have before signing the agreement.**

Full payment (or a pre-determined co-payments) is expected at the time of service. We accept cash, check, or payment through PayPal. All returned checks are subject to a fee of $50.00.

Regarding Insurance:

I am able to provide you with a receipt appropriate for submission to your insurance carrier for each visit/service. The balance is your responsibility whether your insurance company pays or not. You may also be responsible for a filing fee for any third-party billing. For clients seeing a Licensed Professional Counselor or even a Preferred Provider, please be aware that some, and perhaps all of the services provided may be non-covered services or may not be considered to be reasonable and/or necessary under your medical insurance program. It is your responsibility to contact your insurance carrier to determine whether your policy covers our services and what fees are allowed for reimbursement. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do not guarantee payment from your insurance company.

Regarding Court Proceedings:

I understand that my counselor will not willingly testify in any court proceeding as this role, more often than not, nay jeopardize the therapeutic relationship. However, if required by law to appear and/or testify. I understand that I will charged **$200.00 per hour** for time spent in activities preparing for a courtroom appearance, including travel time. I also understand that I will be charged **$200.00 per hour** regardless of the

time spent in the courtroom and regardless of whether my counselor is able to testify that day or not. Payment for courtroom appearance will be required prior to my counselor's appearance in court.

*****Fee Agreement*****

I agree that I am responsible for payment to Jacey Wall, P-LPC, NCC for each counseling/service session. I agree that invoices for rendered services may be mailed to my address listed on the intake sheet. If I do not agree to such mailings, I must notify this office in writing of how to inform me of any balance due. I also agree to the fee schedule for all rendered services, whether reimbursed by my insurance carrier or not, as acknowledged by my signature below and as signed and indicated in the Financial Agreement. I HAVE READ AND UNDERSTAND THESE OFFICE AND FINACIAL POLICIES, AND AGREE TO SAID TERMS.

Client Signature: ____ Date: _______________

Spouse/Parent/Guardian Signature: ____ Date: ________________

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication information if necessary.

Please Initial One Below:

_____ I agree to release any applicable mental health/substance abuse information to/from my PCP.
My Primary Care Physician is: ____
Address: ____
Telephone Number: ____

_____ I agree to release only medication information to/from my PCP.

_____ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to notify him or her.

_____ I do not have a PCP and do not wish to see or confer with one. I therefor WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

I, the undersigned, understand that I may revoke or change this consent at any time. I have read the information and give my authorization as initialed above:

Client Signature: ____ Date: _______________

Patient Rights

You can end this authorization (permission to use or disclose information) any time by informing your counselor and signing below.

Patient Signature to end Authorization: _________________________________ Date: _______________

If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits. You have the right to a copy of this signed authorization. Please keep a copy for your records. You do not have to agree to this request to use or disclose information.

Information to be completed by Behavioral Health Provider
(A copy of the PCP Disclosure may be sent to the PCP, the original will be kept in the client's file.)

I saw ________________________________ on ___________________ for ______________________.
(Client Name) (Date) (Diagnosis)

Revised 10/17/2023

Seeds of Hope Counseling, LLC
Jacey Wall, P-LPC, NCC
8484 MS Hwy 15, Ackerman, MS 39735
jacey.l.wall@gmail.com | 662.905.1862

Qualifications:

I, Jacey Wall P-LPC, NCC, am a Provisional Licensed Professional Counselor (P-LPC) and Nationally Certified Counselor (NCC) and have completed the required internship supervision hours as directed by Liberty University and the State of Mississippi's Rules and Regulations. I hold a Bachelor of Science in Psychology from Mississippi College and have earned a Master of Arts in Clinical Mental Health Counseling from the School of Behavioral Sciences at Liberty University. I am a member of the American Counseling Association, and am currently practicing as a therapist at Seeds of Hope Counseling, LLC in Ackerman, MS.

As a P-LPC, I am required by the State of Mississippi's Rules and Regulations, as well as the Mississippi State Board of Examiners for Licensed Professional Counselors to obtain supervision. My current supervisor is Rachel Allen, LPC-S who can be contacted by phone number at (662) 562-3318 or at her current work address 4975 Hwy 51N, Senatobia, MS, 38668. Seeds of Hope Counseling, LLC is a private practice setting owned by Connie Holland, LPC, NCC, who will remain on-site while I provide counseling services as required by the State of Mississippi. Connie Holland, LPC, NCC, BC-TMH can be reached by email at connie.b.holland@gmail.com or by phone at (662) 489-1918.

Counseling Relationship:

Counseling is an avenue for developing skills and a deeper understanding of oneself through a collaborative relationship between client and counselor. The purpose of counseling is to provide clinical mental health care to individuals to aid in meeting personalized goals. These goals may include processing experiences and emotions, learning how to identify emotions, changing and reframing maladaptive thought processes, and learning healthy coping mechanisms for life stressors. The ultimate goal, however, is for the client to no longer need additional help and support as they learn how to utilize skills developed throughout counseling in various aspects of their life when needed.

The relationship between the counselor and client is a unique and intimate yet professional relationship. It consists of professional boundaries while also maintaining room to discuss the client's intimate life details and struggles. This relationship is also collaborative in which the counselor is the teacher and provides guidance and psychoeducation, and the client is the student learning how to apply this guidance and psychoeducation into their own lives. Counselor and client work hand in hand to create goals, adapt goals as necessary, and work together to meet the goals. This requires that the client take an active role in the process, both in session and outside of the office. A counselor can provide effective tools, but a client must be willing to challenge themselves (or step out of their comfort zone and) and put these tools into practice outside of the counseling environment. However, a counselor will continuously come alongside the client offering empathy and compassion as the client shares these intimate life details and struggles, and ultimately achieves their counseling goals.

In practice, I focus on person-centered therapy and cognitive-behavioral therapy (CBT). I believe that compassion and empathy are vital components on the road to effective change and that many clients are in need of a nonjudgmental environment to share their concerns. This may include identifying, naming, and processing

emotions as an essential step in the healing process before CBT can be fully introduced into the client's treatment plan and sessions. I believe that clients often face a core maladaptive belief which can negatively impact various areas of their lives. By utilizing cognitive-behavioral therapy, the counselor and client work together to identify, challenge, and change this core maladaptive belief. To achieve this goal, I utilize various techniques such as thought logs and journaling to identify the client's thought patterns as well as cognitive restructuring/reframing to change maladaptive thoughts and patterns. I also utilize relaxation and stress reduction techniques to encourage grounding and relaxation throughout the counseling process.

Areas of Focus/Services Offered/Clients Served:

I gained experience in addictions counseling while working at The Oxford Treatment Center during my Practicum and Internship, utilizing brief solution-focused therapy as well as motivational interviewing to elicit change in patients. I also have experience with the college-aged population, gained while working at Northwest Mississippi Community College during my Internship where I utilized cognitive-behavioral therapy to work with clients to identify, challenge, and change maladaptive thoughts. I now work with various ages beginning at age 18 at Seeds of Hope Counseling, LLC to provide person-centered therapy and cognitive-behavioral therapy to identify, set, and meet clinical goals.

Office Procedures/Clinician Assessibility:

Appointments are made by contacting Seeds of Hope Counseling, LLC through the official website, email, or phone. *Clients may contact Connie Holland, LPC, NCC, BC-TMH (662.489.1918) or **me (662.905.1862 / jacey.l.wall@gmail.com)** directly to request a session. I am currently only accepting appointments on Tuesdays. Appointments are available on Tuesdays from 9:00am until 5:30pm, and the office closes at 6:30pm.* Clients are encouraged to contact the counseling office 24 hours in advance if they need to cancel their session or if they will be over 15 minutes late to their scheduled session. Clients who do not cancel sessions within 24 hours of their scheduled appointment as well as clients who are over 15 minutes late to their scheduled appointment without notice will be charged a $25 fee which must be paid before the next counseling session. If the client is over 15 minutes late, the Therapist may request for the client's session to be rescheduled. I accept self-pay clients and do not accept insurance, but this is subject to change in the future. If your account with me is unpaid and you have not arranged an approved payment plan, I can use legal means to receive payment. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

Termination of Services:

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the therapy is not being effectively used. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified professionals. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance or communicated to your therapist, I must consider the therapeutic relationship discontinued.

Code of Conduct:

As a P-LPC, as well as a member of the American Counseling Association, I am required by law to adhere to the Code of Conduct and Ethical Practices that has been adopted by the licensing boards and the guidelines established by the above organizations. A copy of these materials is available to you upon request. Complaints may be filed at lpc.ms.gov by locating the "File A Complaint" tab at the bottom of the website.

Confidentiality:

I will treat what you tell me with great care. My professional ethics and the laws prevent me from telling anyone else what you may tell me unless you give me written permission. These laws and ethical guidelines require that the content of your sessions remain confidential and that information will not be released to anyone outside of Seeds of Hope Counseling, LLC, without your written permission. However, I cannot promise that everything you tell me will never be revealed to someone else. There are times when the law requires me to tell things to others and there are also other limits to confidentiality. Because I want you to understand clearly what I can and cannot keep confidential, your review of these limits is very important. Additionally, as a P-LPC, I am required by Mississippi State laws to attend weekly supervision meetings in which I may consult with my supervisor (Rachel Allen, LPC-S) or other clinical professionals in order to provide you with the best possible treatment. Please read these pages carefully and sign below acknowledging your understanding of the limits of confidentiality. At our next meeting, or at any time, we may discuss any questions that you might have.

Additionally, there are some exceptions to confidentiality. I am legally required to disclose information in the following situations:

1. If you report that you are suicidal or homicidal or have intentions to cause bodily harm to another person.
2. If you report knowledge of suspected abuse or neglect of children, elderly, or a disabled person.
3. If I am subpoenaed to testify in a court of law.

In any of these situations, I would reveal only the information needed to resolve the immediate crisis or risk of danger. If I believe you are in danger of hurting yourself or others, I may contact people in a position to prevent this danger/harm. This includes but is not limited to the person listed as your emergency contact, family members, friends, and appropriate medical and legal authorities.

Confidentiality for marriage and/or family counseling:

1. When I treat children under the age of 18, most details of the things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told, especially if these others' actions put them or others in any danger. "When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors may protect the confidentiality of information received – in any medium – in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards" (ACA 2014 Code of Ethics, B.5.a. Responsibility to Clients).
2. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.

3. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep that information confidential. I will work with you to decide on the best way to handle situations like this. *See Couple Therapy Policy: Limited Secrets Policy. A copy of this policy will be provided, and a signed copy will be kept within the client records.
4. If you and your spouse have a custody dispute, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
5. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
6. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record.

If you become involved in a court case or proceeding, you may prevent me from testifying in court about what you have told me. This is called "privileged communication" and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations in which a judge or court may require me to testify:

1. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
2. In cases where your emotional or mental condition is important information for a court's decision.
3. During a malpractice case or an investigation of me or another therapist by a professional group.
4. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
5. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you do not have to tell me what you do not want the court to find out through my report.
6. If you were sent to counseling with me for an evaluation by worker's compensation or Social Security disability, I will be sending my report to a representative of that agency, and it may contain anything/everything that you tell me.
7. In a court proceeding or deposition when a subpoena or court order has been issued.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

Emergency Situations:

If an emergency should arise, you should seek help through local hospital emergency room facilities or by calling 911. For crisis situations that may arise but DO NOT warrant medical assistance, you may attempt to contact us by calling (662) 489-1918 or (601) 543-9702 and *leaving a confidential message.* We will respond to your call as soon as possible. Please understand that we may be with another client or out of the service area when you call. Understand that you may be responsible FOR ANY FEES ASSOCIATED WITH FREQUENT OR EXCESSIVE EMERGENCY CONTACTS WHETHER BY PHONE OR IN PERSON. Again, we will return your call as soon as we are possibly able; should your situation worsen before we speak, please seek help by calling 911, going to the ER, or contact your emergency contact person. **Additional numbers for after-hours assistance include the national talk-line at 1-800-273-TALK, the Suicide and Crisis Lifeline at 988, or the local CONTACT HELPLINE at 1-800-377-1643, there are not charges for these calls.**

Client Responsibilities:

You, as a client, are a partner in counseling. Your honesty, openness, and effort are essential to the success of the counseling process and to the positive outcome of the goals you set. As we work together, should you have any questions, suggestions, or concerns about your counseling, I expect that you share these with me so that we can make any necessary adjustments. If you choose or we determine that your counseling needs would be better served by another professional, I will help you with the referral process and any transitions that are made. If you are currently receiving services from another mental health professional, individual, or group (psychiatrist, psychologist, medical doctor, support group, pastor, etc.), we expect you to inform of us this. If deemed necessary, a written release of information may be requested to grant us permission to obtain and release information with this professional so that we may coordinate services for you.

Potential Counseling Risks:

You, as the client, should be aware that counseling may pose potential risks. In the course of working together, additional problems or issues may surface of which you or we were not initially aware. If this occurs, you are encouraged to immediately share these new concerns with your therapist.

Audio/Video Recording:

I will not record our therapy sessions on audiotape or videotape without your written permission. I may ask for a recording of our therapy session for supervisory and educational purposes. You are not required to allow any of your therapy sessions to be recorded and have a right to decline if I ask for a session to be recorded. No consequences to you, your therapy sessions, or the therapeutic relationship will occur if you decline to record a session.

If sessions are recorded for supervision purposes, with your written consent, they will be recorded through Kaltura Capture, which is a HIPAA Compliant online resource. Rachel Allen, LPC-S, will have access to all recorded tapes. Recordings through Kaltura Capture will be shared with supervisors through a secured, HIPAA-compliant link and will be destroyed within an appropriate timeframe of 180 days, following client consent. Videos may be deleted sooner than the timeframe of 180 days upon the client’s request.

Please initial the statements and sign below acknowledging that you have read, understand and agree.

_____ Confidentiality – I agree to the limits of confidentiality and understand their meanings and ramifications.

_____ Disclosure Statement – I acknowledge and have been given the opportunity to read a statement containing the qualifications and experience of my therapist. A “Rights to Privacy” (HIPAA) statement is also available upon request.

Client Signature: ____ **Date:** _______________

Therapist Signature: ____ **Date:** _______________