Laila Alsaffar Daniel, MA, LCMHC, CCMHC, CADC, BC-TMH

Laila@RisingPhoenixPLLC.com

308 Hay Street, Suite G

Fayetteville, NC 28301

P: (910) 964-4673 F: (833) 964- 0863

**Office Policies & Agreement for Psychotherapy Services:**

I received a master’s degree in Counseling and Human Services in May 2004 from the University of Colorado in Colorado Springs. I was a High School Counselor for five years. Consecutively, I volunteered as a Readjustment Counseling Therapist at the Colorado Springs Vet Center for three years. I worked as an addictions counselor on Panzer-Kaserne military base in Stuttgart, Germany for a year. I’ve traveled around United States military posts as a Military Family Life Counselor (MFLC) since 2014 and work part-time in private practice. The majority of my experience has been counseling military families. I am familiar with the multiple aspects of life and relationships within this dynamic culture. I work with people and families who are struggling with depression, suicide intervention, anxiety, post-traumatic stress disorder, career-transition, adjustment disorders, infidelity, parenting, addiction and marriage counseling. I also work with people who are well adjusted and simply looking to achieve more happiness and success in life.

My relevant credentials are as follows:

North Carolina Licensed Clinical Mental Health Counselor #6823

North Carolina Licensed Clinical Mental Health Counselor Qualified Supervisor #QS124302

Texas Licensed Professional Counselor #71878

National Board Certified Counselor #89770

Certified Mental Health Counselor #89770

Certified Addictions and Dependency Counselor #205

Certified Laughter Yoga Leader

Board Certified Telemental Health #351

Completed Level 3- Practicum Training in Gottman Method Couples Therapy

Gottman Seven Principals Leader

Gottman Bringing Baby Home Program Educator

**Confidentiality:**

All information disclosed within sessions and the written records pertaining to therapy sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Exceptions to confidentiality include harm to self and/or others, indication of child or elder abuse, neglect or suspected neglect of children, and court orders to violate privilege by judges in child-custody, divorce or other cases.

**Therapy Process:**

Participating in therapy can create multiple benefits for you ranging from improving your self-esteem and interpersonal relationships to energy level as well as resolving the specific reasons you are seeking therapy. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings and behavior. I will periodically ask you to respond openly and ask for your feedback and views on your therapy and progress. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant feelings, events or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, fear, worry, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions in order to create different ways of looking at, thinking about and handling situations that cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issue that brought you to therapy in the first place such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Change will sometimes be easy and swift but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include reality, existential, person-centered and cognitive-behavioral orientation of therapies. The style of therapy used will be determined by your commitment of time to therapy and research-based recommendations according to your symptoms of diagnosis.

**Treatment Plan:**

Within a reasonable period of time after the initiation of treatment, I will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, y expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

**Termination:**

As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy I assess I am not effective in helping you reach your therapeutic goals I am obliged to give you referrals that may be of help to you. If at any time you want another professional’s opinion or wish to consult with another therapist, I will assist you in finding someone qualified. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

**Emergencies:**

Rising Phoenix Counseling Services, PLLCmay be reached after business hours at the number provided below if you are unable to obtain emergency services through your assigned emergency procedures noted in specific treatment plan. If there is an emergency, please contact 911; go to the nearest emergency room; or contact your local Management Entity (LME) or mental health emergency contact number.

Your signature on this form indicates that you have received this information and are aware of this protocol.

 Laila Alsaffar Daniel, MA, LCMHC, CCMHC, CADC, BC-TMH

Cell Phone (910) 964-4673

**Consultation:**

I consult regularly with other professionals regarding my clients; however, the client’s name or other identifying information is never mentioned. The client’s identity remains completely anonymous, and confidentiality is fully maintained.

**Financial Responsibility Form Explanation of Services/Fees:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rising Phoenix Counseling Services, PLLC charges clients for services that are not covered by their insurance provider. Rising Phoenix Counseling Services, PLLC requires payment in full at the time services (or before next scheduled appointment) unless alternative arrangements are agreed to in advance, in writing, or the client is a member of an HMO, PPO, or other managed care organization. If you are a member of such an organization, you may be responsible for obtaining an authorized number prior to receiving services. **If proper initial authorization is not obtained, you will be responsible for the full cost of the services rendered.** We must ensure that payments are collected to ensure that we are able to provide services and continue to operate our business. In addition, we have a legal and contractual obligation with insurance carriers to collect your co-payment at the time we render professional services. *True emergencies are an exception and you are aware of what a true emergency is, but can contact the office if there are questions.*

**Fees that are billed to clients/responsible party that are not covered by insurance companies include the following:**

-Co-payments for services -Missed appointments or No Shows – $100.

-Appointments cancelled with less than 24hrs notice that are not emergencies- $100.

-Returned check fee-$50. (Checks only accepted if PayPal billing is refused by client.)

-If physical presence is required in court, a fee of $250 (per client) per hour with a 4 hour minimum is charged and payable prior to the court date (unless discussed by client and therapist have agreed upon another agreement). These charges are non-refundable unless I am notified within 3 business days prior to the appearance that physical presence will not be required in court. However, IF preparation of and for court has already been conducted you will be billed for this requested time.

**Co-payments are due via PayPal by scheduled session or within 24-hours of receiving an invoice after completed session. Invoices will be sent out automatically for recurrent appointments and individually as needed.** If you would like to pay via PayPal please email Laila@RisingPhoenixPLLC.com from your PayPal e-address and/or write here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. **PayPal provides receipt of payment so retain for your records.** *FYI:* Laila@RisingPhoenixPLLC.com is *HIPPA compliant; however, email is only used for business purposes. Please do not send personal or therapeutic information via email unless your email is encrypted AES-256 or RSA-2048, or it is not secure.*

If financial obligations are not met, client account information may be turned over to a collection agency. The information provided will include client’s name, address, telephone number, and amount due. **You are responsible for informing us of any other health insurance you may possess in addition to your primary carrier and any policy changes that may affect your mental behavior health benefit. Failure to do so may result in your being liable for payment of services rendered if your insurance company fails to pay.**

Initial noting reading and understanding of Financial Responsibility Form Explanation of Services/Fees: My signature on this page means that I have read and have agreed with the information presented above, and that I have the legal right to make such agreements. I am agreeing to the mental health assessment and to have all mental health treatment reviewed and discussed with me by my therapist. I also state that I have read and understand the Notice of Privacy Practices which is available in the agency and on the agency website.

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Signature of Client/Responsible Party Printed Name Relationship to Client Date

**Notice of Privacy Practices**

**Receipt and Acknowledgment of Notice Patient/Client**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Rising Phoenix Counseling Services, PLLC’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Laila Alsaffar Daniel, LCMHC, Privacy Officer at 308-G Hay St., Fayetteville, NC 28301 or contact by telephone at 910-964-4673.

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

Signature of Patient Date

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

Signature or Parent, Guardian or Personal Representative Date

 \* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_ Patient/Client Refuses to Acknowledge Receipt:

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

 Signature of Staff Member Date

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**Contact by Telephone/Verbally in Event of Breach of Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client Name), authorize Rising Phoenix Counseling Services, PLLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Rising Phoenix Counseling Services, PLLC. Such conversation shall be documented by Rising Phoenix Counseling Services PLLC. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Rising Phoenix Counseling Services, PLLC.

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

Client Name Client Signature Date

**Distance Counseling Agreement**:

* I understand that I will be engaging in online distance counseling (telemental health services).
* My counselor has explained how the video conferencing technology will be used and I understand that I will not be in the same room as my counselor during sessions.
* I understand there are potential risks to this technology, including interruptions, vulnerability to unauthorized access, and technical difficulties. I understand that my counselor or I can discontinue the distance counseling session if it is felt that the videoconferencing connections are not adequate for the situation.
* I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The aforementioned people operate under a business associate agreement and will all maintain confidentiality of any information obtained.
* In an emergent situation, I understand that the responsibility of the distance counselor is to refer me to supports and emergency resources in my local area.
* I have had the alternatives to distance counseling explained to me and I had the opportunity to ask questions in regard to this method of counseling. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

 Initial Here: \_\_\_\_\_\_\_\_

**Social Media:**

In accordance with ethical guidelines and recommendations, counselors do not

accept friend or linkage requests from current or former clients on social networking sites. These

sites can compromise your confidentiality and privacy. For the same reason, counselors request

that clients do not communicate or attempt to reach out via any interactive or social networking

websites.

Initial Here: \_\_\_\_\_\_\_\_

**Permission to Seek Emergency Medical Care:**

I give permission for my counselor to coordinate emergency medical care as needed. I understand

the counselor will try to reach the legal guardian and/or individuals listed as an Emergency Contact

as quickly as possible in an emergency. I agree to hold my counselor harmless from any liability

that results from the provision of emergency medical coordination. At least one Emergency Contact

person is required for every client and is to be provided at time of client registration.

Initial Here: \_\_\_\_\_\_\_\_

**Complaints:**

The North Carolina Board of Licensed Clinical Mental Health Counselors has the general responsibility of regulating Licensed Clinical Mental Health Counselors and processing formal complaints, according to Chapter 53 section .0404. Please report unethical behavior along with your signature, address and telephone number, date and location of the alleged violation(s), a detailed description of the incident(s), and a required signed release to:

NCLCMHCB
P.O. Box 77819
Greensboro, NC 27417

1-844-622-3572

**I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Laila Alsaffar Daniel MA, LCMHC, CCMHC, CADC, BC-TMH Date**