



CONSENT FOR TREATMENT AND PROFESSIONAL DISCLOSURE STATEMENT

E. Reeves Howard, MA, LPC, LPCS

Contact Information:

Dogwood Counseling, LLC
5107 N Rhett Ave, Suite 400
N. Charleston, SC 29405

Phone: 843-327-8083
FAX: 843-353-2591
E-mail address:
ReevesHowardLPC@gmail.com

The most reliable and confidential form of communication is telephone. If you choose to use texting or email, please understand that these are not encrypted and confidentiality cannot be guaranteed, although efforts are made to do so, for example password protection. Please also understand that when the counselor is unavailable, this will be noted in voicemail, not text or email. If you do not receive a response to a text message or email, you must follow up with a phone call. These forms of communication are best used for logistical matters, such as scheduling and appointment details. Please do not include your identifying information in text messages. Sending photos, videos, or voice recordings is not permitted. Text messages and emails are never appropriate for emergencies.

Professional information about Reeves Howard

Licensure:

Licensed Professional Counselor (SC): #5023
Licensed Professional Counselor Supervisor (SC): #6050
The South Carolina Board of Examiners for Counselors
PO Box 11329
Columbia, SC 29211-1329
803-896-4652



Education:

Bachelor of Arts in German, University of Georgia

Master of Arts in Psychology, Clinical Counseling, The Citadel

Reeves Howard receives ongoing supervision with peers and participates in continuing education.

Areas of interest and expertise:

Adults: Anxiety disorders, adult and childhood trauma, depression, assertiveness skills training, family systems issues, individuation, clarification, parent education, premarital counseling, and prenatal counseling.

Children/Adolescents (4years and older): Anxiety disorders, depression, parent-child/adolescent conflict, risky behavior, trauma, family transitions, and sexual behavior problems.

If you have any questions about my training, experience, or approach to counseling, please ask during your sessions.

Ethics:

I follow the following ethical codes:

1. The South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-Education Specialists.
2. The American Counseling Association



These ethical codes include direction for therapists' professional behavior. One example of ethical behavior expected of all therapists and counselors is around sexual conduct:

“ ...sexual intimacy between a practitioner and client is never acceptable.”

Confidentiality:

The information you share in counseling is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations.

Your therapy file can be subpoenaed in South Carolina through a court order (only if signed by a *judge*). Therapists are mandated by state and federal regulations to breach confidentiality when:

a client is threatening suicide or self-harm;

a client is threatening homicide or harm to another person;

there is suspicion of child abuse or neglect;

there is suspicion of elder abuse or neglect;

a client requests that his or her health information be released to someone (by signing a release of information form);

a parent requests information about his/her child's treatment.

I may need to consult with other professionals on your case for supervision purposes. I will keep your identity in the strictest confidence in this process.

All records are kept under lock and key. I am not able to identify our clients without their authorization.

Please note, in the event that I have an emergency and am unable to notify my clients personally, a representative will contact you who has access to your name and phone number only.



Fees and credit card policies:

Counseling session 50-60 min: \$125

Crisis telephone call: \$25 per 10 min

Court attendance (whether required to testify or not): \$125 per hour out of the office including travel

Copies of file: \$0.25 per page

-I accept cash, credit/debit cards, and checks. It is customary to pay the fee at the end of each session.

-When a child is the client, the parent who brings the child is responsible for payment regardless of custody arrangements. Please arrange in advance to pay at the time of service.

-I do not file insurance claims, However, I am happy to provide the information you request so that you are able to request reimbursement for the services.

-There is a \$35 fee for returned checks and insufficient funds on credit card charges.

-If you cannot afford these fees, please request a financial assistance application. You will need to provide information about your gross income and the income of other household members. You will also be asked for supporting documents (tax statements and/or paycheck stubs). Assistance is based on financial need.

Cancellations:

In order to maintain a timely schedule, there is a policy regarding missed appointments. Please give as much notice as possible when canceling or rescheduling. Counseling sessions may be changed or cancelled 24 hours in advance (one full day) without penalty. If you do not give 24-hours notice, you will be charged a session fee. This 24 hours refers to business days.

Emergencies:

If you anticipate that emergencies may arise, we need to discuss that as soon as possible and develop a plan. I am not available on call 24 hours a day. If there is a life



threatening emergency, call 911, your primary care physician, or go to the nearest hospital emergency room. Please leave me a voicemail and I will get back to as soon as I can.

Informed Consent:

Therapy can be a challenging process and may not be the only solution to the concerns that you want addressed. There are alternatives and other professionals able to assist you.

Therapy sometimes makes behaviors and emotions more intense before they get better.

Therapy is not always successful and may open unexpected emotionally sensitive areas.

Your signature verifies that you have been given this Consent for Treatment and Professional Disclosure Statement, and a document outlining HIPPA regulations. Signing indicates that you have read and understand this information and give your consent to counseling. Please be sure to ask questions if there is any content that you do not fully understand.

Printed Name

DOB

Signature

Date