Professional Disclosure Statement

Breanna Herock
Head and Heart Therapy
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Philosophy and Approach:

I believe in approaching therapy from a holistic perspective, taking into account biological, psychological, social, cultural and spiritual components of each individual. I utilize an eclectic approach with a strong reliance on cognitive behavioral and dialectical behavioral aspects in session.

Formal Education and Training:

I hold a master's degree in clinical mental health counseling from Youngstown State University. Major coursework included professional orientation and ethics, human growth and development, social and cultural diversity, helping relationships(e.g. counseling theory, counseling methods), career development, group work, assessment and diagnosis, clinical consultation and supervision, and research and program evaluation.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

Fees:

Fees may vary based on the client's insurance. Out of pocket fees are $185 for an initial appointment and $155 for a 53-minute appointment. For those who can't afford the out-of-pocket rates, an income-based sliding scale fee schedule is available upon request.

As a client of an Oregon licensee, you have the following rights:

• To expect that a licensee has met the qualifications of training and experience required by state law;

• To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;

• To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);

• To report complaints to the Board;

• To be informed of the cost of professional services before receiving the services;

• To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions:

1) Reporting suspected child abuse;

2) Reporting imminent danger to you or others;

3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies;

4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me;

• To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

You may contact the Board of Licensed Professional Counselors and Therapists at:
3218 Pringle Rd SE, #120, Salem, OR 97302-6312 Telephone: (503) 378-5499
Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT
For additional information about this counselor or therapist, consult the Board's website

Informed Consent to Treatment

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by giving your signature at the end of this document.

The Therapeutic Process

You have taken a courageous and positive step by beginning therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, be uncomfortable. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. Please know that my role is to support you and help you in your change process, reflecting what you want out of life. However I cannot promise that your behavior or circumstance will change, as it is your life to live.

Confidentiality

The session content and all relevant materials to your treatment will be held confidential unless the you request in writing to have all or portions of content released to a specifically named person/persons. Limitations of client held privilege of confidentiality exist and are listed below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Please know that if we see each other accidentally outside of the therapy office, I will not acknowledge you first in order to protect your right to privacy and confidentiality. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Client Name _____

Client Signature _____

Date _____