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## Professional Disclosure Statement

### Therapy with families, individuals and children

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. Please read this form carefully and sign in the appropriate places. You will receive a copy of the signed form for your own records. Feel free to ask questions or discuss this information with me at any time.

#### Philosophy and Approach to Therapy:

My philosophy of therapy is holistic, meaning that I believe that people are made up of many parts — body, soul (mind, emotions, will) and spirit. I believe that God created all these parts for wholeness, which comes from a relationship of love with God, others and oneself. Brokenness can occur if any of these relationships are out of balance, causing pain, which signals the need for help, forgiveness and healing.

My approach to therapy is from a systematic perspective. I believe that people work in relationship systems and each person in the relationship is important to the balance of the whole. When relationships become out of balance, it is a result of many different factors and patterns which can be examined in the therapy sessions. I place a strong emphasis on healthy communication and problem solving. In my work, I counsel families, couples, individuals and children.

#### Code of Ethics & Supervision:

As a marriage and family therapist, I am bound to the American Association for Marriage and Family Therapy Code of Ethics and the laws of the state of Michigan. I have completed my Master's Degree in Marriage and Family Therapy.

#### Formal Education and Training:

Master's Degree in Marriage and Family Therapy  
Licensed Marriage and Family Therapist  
Certified Advanced Addictions Counselor  
Clinical Member of American Association of Marriage and Family Therapy

#### Professional Boundaries:

I will not acknowledge the existence of the relationship outside of the therapy session unless initiated by the client. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at any time. Such a relationship, in my view, would be detrimental to our purposes of therapy.

**Your rights as a client:**

1. You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy. If you desire, I will explain my usual approach as well as qualifications.
2. You have the right to decide not to receive therapeutic assistance from me or to seek a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. In a professional relationship, such as ours, sexual intimacy between therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the American Association of Marriage and Family Therapy.
5. You have the right to expect confidentiality within the limits described under #7 below.
6. If you request in writing, any records can be released to any person or agency you designate (note that consent from all clients in the treatment unit is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.
7. There are certain situations in which I am required by law to reveal information obtained during therapy without your permission. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if a court of law issues a legitimate court order (signed by a judge); (c) if you reveal information relative to physical abuse, sexual abuse, or neglect of a child (in the past as well as the present); (d) if you are in therapy by order of a court of law; or, (e) if you are involved in a criminal or delinquency proceeding.

**Consent to Treatment:**

**I affirm that prior to becoming a client of John A. Becker, he gave me sufficient information to understand the nature of therapy, including the possible risks and benefits of therapy, and the nature of confidentiality. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. My signature below affirms my informed and voluntary consent to receive therapy. With the understanding of the above information and conditions, I agree to participate in therapy.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Therapist's Signature \_\_\_\_\_

Date \_\_\_\_\_

### Appointment Issues:

In order to serve you in the best way possible and meet your needs for therapy services, the following is my policy on missed and canceled appointments.

1. I expect 24-hour notice from you if you need to change your appointment time for anything other than an emergency. If I am not given this notice, I will expect payment for that hour of time at our agreed upon rate. If an emergency occurs, **please call** and you will not be charged for the appointment.
2. If you are late for a session, the time of your session may be shortened, but you will be required to pay for a full session.
3. For individuals who haven't called and are late to an appointment, I will wait for up to 15 minutes, then assume you are not coming. The regular fee will still be expected for the time I reserved for you. If an emergency occurs that causes this, we can discuss the exception.

### Financial Considerations:

1. My standard fee for therapy is **\$165 per 50-minute session**. If we agree to longer or shorter sessions, you will be charged accordingly. Payment in full is expected at the end of each session.
2. There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances (in the case of children's cases only), phone calls lasting over 10 minutes, and missed appointments.
3. For those who are unable to pay my standard fee, I have a sliding fee scale. You may request information about this if you think you may qualify.
4. Therapists have the right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.
5. When diagnostic testing is appropriate and recommended, the costs for testing are in addition to the usual therapy fee. The cost for testing varies depending on the test. Some psychological assessment needs may be referred to another mental health professional who will determine his or her own fee.

### Health Insurance Claims:

You are responsible for your bill and for recovering the insurance reimbursement. I am happy to supply you with a receipt for each visit for proof of payment.

**I have read the above and both understand the financial considerations and agree to the appointment policy. The agreed upon fee for a standard therapy session is \$165.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Therapist's Signature \_\_\_\_\_

Date \_\_\_\_\_