JACKELINE N. VÁZQUEZ

LPCA PROFESSIONAL DISCLOSURE STATEMENT & INFORMED CONSENT

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My Qualifications

I earned a Master's degree in Professional counseling on May 12th, 2017 from Liberty University in Lynchburg, VA. Prior to this I earned an undergraduate degree in psychology from Winston Salem State University. I have counseled as a lay counselor for more than ten years at Iglesia Nueva Vida in Winston Salem, NC and headed their lay counseling department. During that time we trained under American Association of Christian Counselors. I am currently a member of that association.

Restricted Licensure

Currently I am pursuing licensure as a Professional Counselor Associate (License No. A13609) with the North Carolina Board of Licensed Professional Counselors. Upon approval by the board I will operate under the supervision of Jennifer Locklear, LPCS, to acquire 3000 hours that are required for unrestricted licensure in the State of North Carolina. My supervisor can be reached at (336) 945-0137. Her address is 6614 Shallowford Road, Suite 250 Lewisville, NC 27023 and her email address is jennifer@lewisvillefamilycounseling.com.

Counseling Background

During my time as a counseling intern I have counseled children ages 9 and older, teens, adults and couples. My theoretical orientation is mainly cognitive behavioral. Cognitive Behavioral Therapy (CBT) makes a distinction between thoughts, emotions and behaviors. CBT allows you to see that you can have control over your thoughts and actions when trying to cope and it offers power by establishing stability. CBT explores how irrational thoughts can lead to troublesome feelings and behaviors.

I have the most experience working with couples, and individuals who are suffering through anxiety, depression and panic symptoms. I also have experience working with survivors of sexual assault. I have worked extensively with Hispanic clients concerning acculturation, multi-generational and cultural adaptation issues.

Session Fees and Length of Service

The designated fee for my services is $60.00 per 55 minute session. Because I do not accept payment from insurance companies, I offer a sliding scale based on annual income. The sliding scale is attached to this form. As proof of income please bring your previous year taxes and the most recent pay stub from everyone in the household.

After discussing the sliding scale with my counselor, my fee for one counseling session will be: $ ______.

Methods of payment accepted are cash, check, and credit card. I do not accept insurance at this time, however if you would like to attempt to submit paperwork on your own to your insurance company to be reimbursed, I will gladly sign and include your diagnosis if one applies. I can provide you with a superbill to submit to your insurance company for possible out-of-network reimbursement. If you need to cancel or reschedule your appointment please contact my office at (336) 661-8142 or email me at jackie@thecounselingcenter.ws at least 24 hours prior so you will not be charged the full session fee.

Use of Diagnosis

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Complaints

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone: 844-622-3572 or 336-217-6007
Fax: 336-217-9450
E-mail: Complaints@ncblpc.org

Acceptance of Terms

By signing this form you are indicating that you have read the Professional Disclosure Statement as well as agree with the office's terms & guidelines.

______________________________ ______________________________ _____/_____/________

Client/Guardian Signature *Counselor Signature* *Date*

This sliding scale fee schedule is for total household income.
Select the session fee amount that is paired with your annual household income.

Select	Annual Income	Session Fee
☐	Below $20,000	$30.00
☐	$20,000 - $30,000	$40.00
☐	$30,000 - $40,000	$50.00
☐	$40,000 +	$60.00

CLIENT REGISTRATION

3153 REYNOLDA RD. WINSTON-SALEM, NC 27106

Today's Date: _____/_____/________

Client Information

First Name: ______________________ Last Name: ______________________

Address: ____

City: ______________________ State: _______ Zip: __________

Home Phone: (   ) ______ - ________ Cell Phone: (   ) ______ - ________ Sex: ☐ M ☐ F

*Email: ____

Age: ________ Date of Birth: _____/_____/________ Ethnicity: ______________________

Military background? ☐ Yes ☐ No (If yes when ______________________)

Marital Status: ☐ Married (How long? __________) ☐ Divorced (How long? __________)

☐ Separated (How long? __________) ☐ Widowed (How long? __________)

☐ Single

** Please note: Email correspondence is not considered to be a confidential medium of communication so the use is limited to appointments and general information or questions.*

Family Status

Spouse/Partner: ______________________ Parent/Guardian Name(s): ______________________

Place of Work/School: ______________________ Who is coming for counseling? ______________________

Previous counseling? ☐ Yes ☐ No (*If yes, why* ______________________)

Are you or another family member currently seeing a psychiatrist or another counselor? ☐ Yes ☐ No

If so, what family member? ______________________ *If Yes, why?* ______________________

List name, birth date or age, sex, relationship of all children, and whether they live at home with you.

Name	Age	Sex	Relationship (Step, Foster, Yours, Adopted)	At Home?
		M F		Yes No
		M F		Yes No
		M F		Yes No

Emergency Contact Name: ______________________ Relationship: ______________________

Daytime Phone: (   ) ______ - ________ Evening Phone: (   ) ______ - ________

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family Member(s)
Alcohol/Substance Abuse	Yes No	______________
Anxiety	Yes No	______________
Depression	Yes No	______________
Domestic Violence	Yes No	______________
Eating Disorders	Yes No	______________
Gambling/Pornography/Sex addiction	Yes No	______________
Obesity	Yes No	______________
Obsessive Compulsive Behavior	Yes No	______________
Schizophrenia	Yes No	______________
Suicide Attempts	Yes No	______________
Was Abused/Neglected (physical, sexual, emotional)	Yes No	______________

General Health & Mental Health

Have you ever had any thoughts or feelings of harming yourself? ☐ Yes ☐ No
If yes, when & explain why ______________________________

Have you ever had thoughts or feelings of harming someone else? ☐ Yes ☐ No
If yes, when & explain why ______________________________

Do you have any present and/or past problems with: ☐ Pornography ☐ Sexual Addiction
☐ Gambling ☐ Spending ☐ None (*If so, when* ______________________________)

Have you had any significant life stressors or losses in the last year? (*Death of a loved one, job, home, etc.*) ______________________________

Primary Care Physician: ____________________ Last exam: ____________
Are you currently taking any prescribed medication? ☐ Yes ☐ No
Please list: ______________________________

Have you received any type of mental health services in the past (*counseling, psychiatric, hospitalization*)? ______________________________

Any past surgeries or medical hospitalizations? *Why & when* ______________________________

Any problems with: ☐ Eating ☐ Sleeping ☐ Weight changes
☐ Headaches ☐ Chronic pain ☐ Loss of consciousness
(*Describe any answers checked above* ______________________________)

Have you ever been sexually, physically, emotionally or mentally abused? ☐ Yes ☐ No
If yes, by who? ______________________________

Have you ever experienced an abortion (pregnancy termination)? ☐ Yes ☐ No
If yes, when? ____________ Other medical problems: ____________

Other Information

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

Any specific denomination? ____________________ What values are important to you? _______________

____

What has brought you to counseling now? ____

____

What would you like to see change in your life? ____

____

What do you consider to be some of your strengths? ____

____

What do you consider to be some of your weaknesses? ____

____

How did you hear about us? ____

Consent for Treatment

I hereby give my consent to my counselor to provide an evaluation and treatment that we may mutually determine to be appropriate. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. I understand I will likely gain the most benefit from counseling if I am committed to the process and attend regularly. I understand that no promises have been made to me as to the results of therapy provided by this professional. If at any time during treatment I cannot wait for a return call from my counselor, I agree to contact my psychiatrist, family physician, call Forsyth Medical Center Crisis Response Team @ 1-800-718-3550 or 911.

______________________________	______________________________	_____/_____/________
Print Name	*Client/Guardian Signature*	*Date*