Positive Reframe
Debra Wallace MS, Licensed Marriage & Family Therapist

Disclosure Statement

Welcome! I am pleased you chose my services. As a consumer of therapy, it is essential that I provide a statement of my qualifications, therapeutic philosophy and your rights as a client.

Qualifications:

- Licensed Marriage and Family Therapist #846, Colorado (2008) and #166.000901, Illinois (2012)
- Master of Science in Human Development and Family Studies Colorado State University (2003)
- Bachelor of Arts in Psychology, minor in Elementary Education, Summa Cum Laude, Clemson University (2000)
- Since 2003, been providing individual, child, couple, and family therapy in accordance to high ethical and professional standards with the American Association of Marriage and Family Therapy (AAMFT) and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I am passionate about the neurophysiological impact of stress and trauma on human development as well as promoting self-regulation, resiliency and healthy relationships. I have innovatively synthesized evidence-based practices into experiential interventions to maximize human potential and heal transgenerational trauma. My career has provided extensive experiences working with children and families in clinical, educational, and recreational settings. I have contributed my expertise to many different settings and formats such as books, websites, hospitals, schools, conferences, legal hearings, committees, agencies, and local media.

Therapeutic Philosophy:

I view therapy as a challenging yet self-loving process where individuals, couples, and family members can safely explore their thoughts, emotions and behaviours regarding sensitive issues. Negativity often arises from unprocessed stress and unmet needs. Engaging in therapy can draw out negative patterns or events in one's life which initially may feel uncomfortable. There are various approaches to therapy and improving wellbeing. The length of therapy typically depends on 1) the number of goals the client(s) have; 2) the amount of unprocessed stress or unmet needs; and 3) how much authentic effort the client(s) put forth in and outside of therapy sessions. Therapy is most effective when the client(s) and I have an honest and respectful relationship. To optimize effectiveness, I typically recommend other supportive resources as well as collaboration with other health or systemic providers with which client(s) may be involved. If this is an option the client(s) would like to explore, I would need a signed Release of Information from the client(s).

Client Rights:

- To know the degrees, credentials, and licenses I have;
- To receive information about the methods and techniques of therapy used, the duration of therapy (if known) and the fee structure;
- To seek a second opinion from another therapist;
- To terminate therapy at any time, although for closure purposes, I would appreciate the opportunity to discuss your decision;
- To have access to your records;
- To file a complaint. For example, sexual intimacy is never appropriate and should be reported to: Department of Financial and Professional Regulation Division of Professional Regulation, Complaint Intake Unit, 100 West Randolph Street, Suite 9-300, Chicago, Illinois 60601, (312) 814-6910

Confidentiality:

All information shared in therapy sessions is legally confidential. Information can only be shared with other persons or agencies with your written permission. However, there are certain situations where I am legally and ethically mandated to break confidentiality without your permission, such as follows:

- If I believe you are in imminent danger to yourself.
- If you threaten grave bodily harm or death to another person, or directly endanger the life of another;
- If I believe you are a threat to national security;
- If I suspect any past or current abuse or neglect of any child(ren);
- If I am ordered to release information by a judge in a court of law, including any legal or ethical actions initiated by client.

To provide you with the best service, I consult with a peer supervision team. Your name or any identifying information will not be shared to maintain confidentiality.

With couples and family therapy, I meet with partners and family members for individual sessions and have a "No Secrets" policy. Thus, what is said in those individual sessions will be considered part of the couples/family therapy and will likely be discussed in joint sessions. I use clinical judgment when revealing information and safety for all members is paramount. I will not release records to any outside party unless authorized to do so, in writing, by every member of the couple/family in treatment able to execute a waiver.

Sessions and Fees:

A session is 45-60 minutes in length. The full rate fee ranges from 120-180 per session depending on length and type of session (i.e. initial assessment or individual, couple or family), contracted rate and benefits with insurance company or Employee Assistance Program (EAP). I require payment at the end of each session via online portal with Officite. Other arrangements may be made on request. You are responsible to update insurance and payment details as well as pay balances contracted with insurance or if coverage lapses.

Cancellation Policy:

I require 24-hour notice when canceling an appointment. If you are late or do not show up, I will wait 10 minutes past appointment time and contact you. You will be charged for a $60 fee if 24-hour notice is not given (exceptions may be made for emergencies).

Availability:

As a private practitioner, it is not my intent to handle crisis situations or be available 24 hours a day. If you need to talk to someone immediately, call 911, your local police or go to your nearest hospital emergency room. Call 1-800-273-8255 https://suicidepreventionlifeline.org/ or Text 741741 from anywhere in the USA to text with a trained Crisis Counselor https://www.crisistextline.org/

Informed Consent

Client ID: _____ **Client Name:** _____

Telemental Health and Electronic Transmission of Information:

- I the undersigned, a citizen of IL, USA, my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with Debra Wallace MS LMFT (IL), a behavioral health care practitioner ("practitioner").
- This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

- It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").
- I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

- I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

- I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Telebehavioral Health Process:

- My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Electronic Presence:

- In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my practitioner.

Limitations:

- Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

- I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

- In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Release of Information:

- I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

- I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.
- I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.
- I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.
- Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

- I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

- The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation effectiveness.

Records:

- I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.
- I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.
- I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Contact Information:

- I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (see header on page) Address: 39469 N Shore Dr. Spring Grove, Il., 60081
- I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

- I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead,
- I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.
- These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

Name	Telephone Number
Name	Telephone Number
Name	Telephone Number

Final Agreement:

- I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.
- With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein from Debra Wallace MS LMFT.

X	X
Client Signature & Date	Client Signature & Date

X 

Debra Wallace MS LMFT's Signature