

Professional Disclosure Statement and Informed Consent

Tracey Galgoci Counseling, PLLC
Tracey Galgoci, MA, LPC, NCC
License # 6401008530
215 W. Broadway St., Mt. Pleasant, MI 48858
(989) 630-4335

Counseling Practice: Welcome! I have had the pleasure of practicing in the Central Michigan area since 2003. I have a M.A. in Professional Counseling from CMU and a B.S. in Health Fitness, also from CMU. I am also a Nationally Certified Counselor (NCC). My goal is to provide professional, quality counseling services to my clients. I provide therapy to individuals, children, couples, and families for a variety of issues. I specialize in anxiety disorders, ADHD, grief and loss, and life adjustment issues. Therapy sessions will generally last 55 minutes and require your active participation.

Fees: I am paneled with several insurance companies and will do my best to bill your insurance for the contracted rate when possible. If you do not have insurance, my fee is \$100/individual session. **Session fees and co-pays are due at the end of every session.** I accept cash, check, credit, debit and HSA cards. Deductible amounts will be billed to you and payment should be made within 30 days.

Court Appearances: The only time I will agree to court appearance is when subpoenaed by the court and then the following applies: reports and court appearances require professional time for which I charge a rate of \$175 per hour, payable in advance in the form of a retainer fee, to account for time spent preparing for the court appearance, time spent in court, and time spent commuting to and from the courthouse.

Philosophy and Approach: I adhere to a client-centered approach to counseling, but I am also strongly influenced by cognitive-behavioral therapy, systems theory, and a variety of other approaches as they are appropriate to use with my clients. I strive to create a comfortable, therapeutic environment where a safe, collaborative relationship between client and counselor can be established. The partnership between counselor and client facilitates the ability to examine issues, set goals, and work together to achieve those goals. I believe positive change or outcomes are possible and that you possess untapped, inner resources to help you directly deal with your concerns and problems. Counselors do not have the ability to fix your problems; that power belongs to you. For counseling to be effective, you must make a commitment of time and energy and be an active participant in the process. Your involvement both during and between sessions will be required. Homework may involve reading, writing exercises, or practicing new behaviors. It is important you realize there are risks involved with any type of counseling. You may feel worse before you feel better. You may experience uncomfortable emotions such as anger, frustration, or fear. It is also not possible to make any guarantees about counseling outcomes.

Professional Roles/Boundaries: I have many different roles in the local community, including, but not limited to, the following: workshop presenter, mediator, business owner, church member, club/organization member, and parent. You may, therefore, encounter me outside the counseling setting. When this happens, I will protect your confidentiality by not acknowledging our counseling relationship unless initiated by you or, for professional reasons, warranted by me. For that same reason, I will not be able to "friend" or "follow" you on social media.

Client Rights: You have the right to refuse any suggestion(s) I may give you during your counseling sessions. You have the right not to talk about something if you don't want to. You also have the right, at any time or for any reason, to decide you do not want to continue counseling. In that case, I request that you inform me of your decision and schedule a final session to bring closure to our work together.

Missed or Cancelled Appointments: I would appreciate a phone call whenever you need to cancel an appointment. Missing a scheduled appointment without notification greatly inconveniences other clients who are waiting to get in for an appointment. I reserve the right to charge you up to \$25 for appointments that are not canceled 24 hours in advance.

Confidentiality: Your therapy sessions are strictly confidential except under certain circumstances when I am required by law to report information you have shared. These exceptions to confidentiality include:

- Report of child or elder abuse or neglect
- The intent to harm yourself or someone else
- Court-ordered subpoenas
- Report of your intent to commit a felony

I may also consult with other professionals about your circumstances and how I might proceed in order to help you, but I will do so without using your name or any other identifying information. You have the right to ask me not to consult with anyone.

Please be informed that your health insurance company requires that I provide them with information pertaining to your counseling sessions. I must give a clinical diagnosis. Sometimes I have to provide additional information such as treatment plans or summaries. I will make every effort to release only information that is necessary. By signing this agreement, you agree that I can provide requested information to your insurance carrier.

Consent for Email and/or Text Message Communication: Email and text messaging allows me to exchange information efficiently for the benefit of clients. However, email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you agree to have email and/or text messages sent to you that contain your health information (such as corresponding about scheduling, providing invoices and receipts for services), please sign the Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your services with me in any way.

Signature

Coordination of Care: To provide you with the best care possible, it is sometimes necessary to release information to your physician when medication management is part of the treatment plan. By signing below, you give me permission to coordinate care with your physician when necessary.

Signature

Professional Affiliations: American Counseling Association, Michigan Counseling Association, Association for Creativity in Counseling, Michigan Mental Health Counselors Association.

Questions or Concerns: If you have any concerns about this disclosure statement or the counseling provided by this agency, please feel free to discuss them with your me. You may also direct your concerns to: Michigan Department of Community Health, Health Regulatory Division, P.O. Box 30670, Lansing, MI 48909. Phone: 517-373-9196.

Consent to Treatment and Bill Insurance: I understand the above issues and agree to receive counseling services from Tracey Galgoci Counseling, PLLC. By signing below, I acknowledge a copy of the Privacy Practices has been made available for me to review. By signing below, I give Tracey Galgoci Counseling, PLLC, permission to bill my insurance.

Client Signature

Date