George Brenner, M.S
Licensed Marriage & Family Therapist
Licensed Clinical Addictions Counselor
Licensed Clinical Social Worker

7526 E 82nd St., Suite 150 • Indianapolis, IN 46256 • 317-585-1060 • http://www.fcahelp.com

DISCLOSURE STATEMENT

I. EDUCATION & TRAINING

George Brenner, LCSW, LMFT, LCAC has a Master Degree in Psychology from the University of Evansville. George is a Licensed Clinical Social Worker, Marriage and Family Therapist, and Clinical Addictions Counselor in the State of Indiana. George has clinical, supervisory and administrative experience since 1973 in the areas of problem gambling, substance use disorders, mental health, and integrated care for Co-Occurring Disorders. He is a trainer and consultant in these areas as well as Motivational Interviewing. George was the clinical supervisor and administrator for Addictions Services from 1990-2011 for Community Health Network: Behavioral Health Services, and since 2009 addictions specialist on the Psychiatric Consultation and Liaison Team for Community Health Network, and a partner in Continuing The Care: A Recovery Monitoring Program. George was trained in Motivational Interviewing by William Miller, PhD, Theresa Moyers, PhD and additional staff of the University of New Mexico. George serves on the Boards of Mental Health America in Indiana and Indiana Council on Problem Gambling. George is the current Chair on the Behavioral Health and Human Services Licensing Board of the Indiana Professional Licensing Agency as a representative of the Addictions Counselors section.

II. THEORETICAL & TREATMENT MODEL

III. SCHEDULING SESSIONS

An initial session can be scheduled by calling the Family Counseling Associates Main Office at (317) 585-1060 or Toll Free (888) 701-1060. Additional sessions are generally scheduled on a regular, weekly basis and are not limited to any particular number of sessions or course of time. However, it is your responsibility to confirm and/or reschedule your next session.

IV. BILLING AND INSURANCE INFORMATION

The fee for counseling will be $150 for the Initial Evaluation Session and $120 per 50 minute follow-up treatment sessions and payments are to be made at each session via Cash, Personal Check, or with Authorized Major Credit Card. Our office is pleased to check into your Insurance Carrier for possible Healthcare Benefits, but it is your responsibility to assist, as needed, in the process and ultimately, Insurance is a contract between you and your Insurance Carrier. Sessions cancelled within less than 24 hours will also be charged a $50 cancellation fee (Illnesses and Emergencies are exceptions). Fees may increase periodically and any change in fees will be communicated with two weeks prior notification.

V. VOLUNTARY

It is your right to select a counselor or therapist of your choice and you may terminate counseling with me at any time. I recommend one final session upon termination to reflect on our experience together and address any future concerns.

VI. CONFIDENTIALITY

Not only is confidentiality with a Licensed Mental Health Provider guaranteed to you under Indiana State Law, I believe the confidentiality of our work together to be of the utmost importance in creating a safe place for you to explore issues of your concern. Therefore, I strive to uphold the strictest standards of confidentiality in my practice. You should be informed of the *legal exceptions to confidentiality* in the following circumstances when information you share with me could be shared with others without your permission:

1) The Uniform Health Care Information Act may allow for disclosure of information to another health care provider who is serving you.
2) You may give written permission to release confidential information. If you wish to disclose to a third party, you must sign a Consent To Release Information form.
3) If you reveal that you are contemplating, planning, or have acted out a crime, I may be required to report this to the appropriate authorities.
4) If you are a minor, I may discuss with your parents or guardians some of the information from our counseling. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
5) If you reveal that a child or adult has suffered abuse or neglect, I have an obligation to report this information to the appropriate authorities.
6) If information you have revealed to me is subpoenaed, disclosure may be required by law.

If possible, I will attempt to discuss any required breaches of confidentiality with you prior to doing so.

Additionally, I adhere to the standards set forth in Family Counseling Associates' *Notice of Privacy Practices* (see ACKNOWLEDGEMENT OF PRIVACY PRACTICES).

VII. SUPERVISION AND CONSULTATION

As a Licensed Provider (LMFT), I provide my services without the necessity of Clinical Supervision, however, on occasion I may find it helpful in the service of my clients to consult with other Professionals in the field. This is customary in our work and enhances the potential to offer the highest level of care for your needs. In the event that it should be deemed necessary to consult with your Physician or a Psychiatrist regarding your case, I will request a written Release of Information from you for doing so.

VIII. STATE REGULATIONS FOR PROFESSIONAL CONDUCT.

The State of Indiana Department of Health as well as the Indiana Professional Licensing Agency oversees and regulates the practice of mental health counselors in order to ensure the health and safety of the public. If you believe that I have acted unethically or unprofessionally in my work with you, I ask that you address the issue directly with me. Additionally, you may direct a complaint to the authorities of the state:

Office of the Attorney General
Consumer Complaint Division
402 West Washington Street, 5th floor
Indianapolis, IN 46204
(317) 232-6330/1-800-382-5516
http://www.indianaconsumer.com/filecomplaint.asp

IX. ADDITIONAL COMMUNICATION

If you need to communicate with me outside of your scheduled session time, you can call (317) 585-1060 and press "0" for the Receptionist. The office staff of Family Counseling Associates will be available to take your call. I will generally limit phone communication to session scheduling and emergencies, and reserve the right to charge a fee for the phone call proportionate to the regular session fee. I will limit communication via email for the purpose of transmitting electronic documents/information (i.e. intake form, inventories online, etc.)

X. EMERGENCIES

If you are experiencing an Emergency call our Main Line (317) 585-1060 and press "1" to reach the Therapist On-Call. The Therapist will return your call within minutes and offer recommendations, however, in the event of a life-threatening Emergency, please call one of the following numbers:

- General Emergencies: 911
- Mental Health Association of Greater Indianapolis 24-hr Hotline: (317) 251-7575

SIGNATURE of RECEIPT AND ACKNOWLEDGEMENT

I have read and understand all of the information presented above in this form, and I have received my personal copy of this document.

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand this information to be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain third party payment for my mental health care services.
- Conduct normal mental health care operations such as quality assessment and improvement activities.

I have been informed of Family Counseling Associate's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected mental health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my mental health provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or mental health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Printed Name: _____

Signature: _____ Date: _____

Signature of Parent/Guardian (If Applicable): _____ Date: _____

Family members also covered by this acknowledgement:

_____

_____

_____

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Christ centered professional counseling

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