PROFESSIONAL DISCLOSURE

CONTACT INFORMATION

Jeremy Michael George, M.A., LPCA

Life Care Counseling and Coaching
1601 Jones Franklin Road
Raleigh, NC 27606
(919) 851-1527

QUALIFICATIONS

Jeremy M. George received a Master of the Arts in Clinical Mental Health from Wake Forest University in August of 2017.

COUNSELING BACKGROUND

A great strength is that i have 18 years of professional ministry experience working with adolescents and families. I have logged over 800 hours of clinical experience with a broad spectrum of clientele during practicum, and three consecutive clinical mental health internships. I have enjoyed working with adult men and women, adolescents and families. I have seen clients from all walks of life, and from a wide variety of cultures and ethnicities. I have amassed a great deal of experience with assessment, case conceptualization, treatment planning, collaboration toward goal setting, and positive treatment outcomes. I have been privileged to contribute to the effective treatment of many clients with complex cases. My primary modalities are Cognitive Behavioral Therapy and Time Limited Dynamic Psychotherapy. I am also competent in the provision of Rational-Emotive Behavioral Therapy (REBT), Motivational Interviewing, Solution Focused Therapy, Narrative Therapy, Grief/Loss Therapy and Family Systems Therapy.

SESSION LENGTH & FEES

A typical session lasts 50 minutes. The standard fee for one session of counseling is $120.00. Payment is due when services are received. Cash, personal checks and credit cards (Mastercard or Visa) are acceptable forms of payment. Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most companies require that a diagnosis must be rendered if the client is going to be reimbursed. Some conditions for which people seek counseling do not qualify for diagnosis. 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.

Fee Schedule

No Show	$120.00
Late Cancellation	$60.00
Telephone Consultation	Based on Time Required
Reports and Letters	Based on Time Required
Photocopying	Based on Time Required

Court Preparation / Appearance ……. $200.00

CONFIDENTIALITY

The confidentiality of your personal, private health information are very important to us. We may disclose your personal information for the following purposes: (1) Abuse, (2) Neglect, (3) Domestic violence or (4) a Court Order.

As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence or court order. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

PROBLEM RESOLUTION

If you are dissatisfied with any aspect of the services provided by me, please inform me and attempt to resolve any concerns directly. If we cannot resolve your concerns adequately you may speak further with my supervisor, Jerry Lankford or the office manager.

If your concerns are not yet resolved directly, you may submit a written complaint to the North Carolina Board of Licensed Professional Counselors. Procedures for submitting a complaint may be found at the following website address:

http://www.ncblpc.org/Enforcement

You must submit your complaint in writing, citing any ACA Codes you feel have been broken on the complaint form provided you by the NCBLPC.

ACCEPTANCE OF TERMS AND FINANCIAL RESPONSIBILITY

If the terms outlined above are agreeable, please indicate your receipt of notices and request for services below.

_____ I have read the professional disclosure statement for Jeremy M. George.

_____ I acknowledge receipt of the Notice of Privacy Practices.

_____ I hereby unconditionally guarantee payment to Jeremy M. George for all costs, charges and expenses incurred by said client at this office unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of $40.00 for any checks that are returned paid. I understand if the client balance for services provided is not paid within 30 days of billing, the amount due will be deemed delinquent.

_____ I hereby request professional services from this professional. I agree to these terms and will abide by it's guidelines.

_____	_____
Signature of Client	Date
_____	_____
Legally Responsible Person	Date
_____	_____
Provider / Counselor	Date