



INTEGRATED WELLNESS AND STRATEGIES, PLLC

Amber W. Pearson, MA, LCMHC, EMDR-CT

Your path to healing and transformational growth...

2509A Lewisville Clemmons Rd

#1033

Clemmons, NC 27012

P: 720-644-6378, F: 720-446-3520

strategiesintegrated.com

LCMHC PROFESSIONAL DISCLOSURE STATEMENT

THERAPIST INFORMATION

Name: Amber W. Pearson

NC Business Mailing Address: 2509 Lewisville Clemmons Rd., #1033; Clemmons, NC 27012-8712

Business Phone: 720-644-6378

Business Fax: 720-446-3520

Office Hours: 7am to 8pm EST Tuesday-Friday, 7am to 12pm Monday & Saturday

Education: Master of Arts (MA) in Clinical Psychology from the University of Denver in 2008

Credentials, Certifications & Registrations:

- I received my License in Clinical Mental Health Counseling (LCMHC) # 17608 in the state of North Carolina on May 25, 2022. This license is current, active and in good standing.
- I received my License in Professional Counseling (LPC) # 6479 in the state of Colorado as of April 23, 2012. This license is current, active and in good standing.
- I received my License in Mental Health Counseling (LMHC) in the state of Washington # LH-61289048 on July 18, 2022. This license is current, active and in good standing.
- I am an EMDR Certified Therapist in accordance to the EMDR International Association as of February 17, 2022. This certification is current, active and in good standing.

Years of Clinical Counseling Experience: 14

Counseling Background: My therapeutic experience includes working individually and in groups with adolescents, adults and families in the following settings: home-based, outpatient, and inpatient. I have extended experience working with traumatized populations of various socio-economic, cultural, religious and ethnic backgrounds; as well as those who have grief and loss, issues with chronic illness, depression, anxiety, and psychosis.

Current Services Offered: Currently my practice focuses on working with adults who are struggling with previous trauma, chronic illnesses, bereavement, anxiety, depression and/or psychosis. I conduct individual psychotherapy sessions that are typically 60 minutes in length, depending on what the client needs.

Approach to Therapy: I utilize the following approaches and styles with all of my clients:

- Integrative: Combining many therapeutic modalities.
- Strategic: Creating strategies with you so that you can be fully engaged and aware.
- Wellness-Based: Helping you become your best self physically, mentally, emotionally and spiritually.
- Holistic: Respecting the view that individuals are an interconnection of mind, body, energy, and spirit.
- Person-centered: Empowering and motivating you to fulfill your own goals of growth and transformation.

Therapeutic Modalities & Areas of Competence: I am competent in the following therapies and modalities, and use them in accordance with client need and treatment plan:

- Trauma-focused Therapy: Recognizing how trauma affects the brain and body and how its effects can be healed.
- Dialectic Behavioral Therapy (DBT): Applying tools related to mindfulness and cognition.
- Cognitive Behavioral Therapy (CBT): Applying tools related to cognition and behavior.
- Eye Movement Desensitization and Reprocessing (EMDR): Alleviating distress and reprocessing related to disturbing and/or traumatic memories.
- Internal Family Systems (IFS) Therapy: Limited training with Rachel Walker specific to how to understand and work with internal parts.
- Motivational Interviewing: Helping you find motivation when you feel ambivalent.
- Multi-cultural Therapy: Utilizing your own culture, beliefs, family systems, personal history, and beliefs.
- Transpersonal Therapy: Integrating clients' spiritual, religious, and philosophical belief systems.

CLIENT RIGHTS AND CONFIDENTIALITY

All of our communication becomes part of the clinical record, which is accessible to you upon request. Your rights as a client, include:

- **Boundaries:** In a professional relationship (such as ours), boundaries are important. Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the North Carolina Board of Licensed Clinical Mental Health Counselors
- **Treatment Direction and Concerns:** You have a right to voice any concerns you may have about the direction of therapy and treatment. If at any point you are uncomfortable in any way about therapy or therapeutic style I encourage you to voice these concerns to me directly. I will be happy to shift my therapeutic direction or modality when able, and refer you to another therapist if that is what is needed.
- **Second Opinions:** You may seek a second opinion from another therapist at any time.
- **Confidentiality:** The information you tell me during therapy sessions is generally considered confidential. Confidentiality means that I am responsible to keep private all information relating to a client, unless the client gives me permission to or under extreme exceptions.
- **Exceptions of Confidentiality:** I will keep confidential anything you say as part of our counseling relationship, with the following exceptions:
 - You direct me in writing to disclose information to someone else. I have a Release of Information form you will need to complete in this instance.
 - I am ordered by a court to disclose information.

I am required to break confidentiality with or without your approval in the following circumstances:

- Any cases of possible abuse or neglect of a child 18 years and under.
- If you are determined to be a danger to yourself.
- If you are determined to be a danger to others.

In these particular situations, I may be required to take protective actions which may include notifying the potential victim, contacting the police, and/or calling child abuse or elder abuse hotlines. If a legal exception to confidentiality arises during therapy, you will be informed accordingly when possible.

Initials _____

REGULATORY REQUIREMENTS AND INFORMATION

I abide by the ACA Code of Ethics (<http://www.counseling.org/Resources/aca-code-of-ethics.pdf>). If you are every unhappy with what is happening in therapy, I encourage you to speak with me about it directly so that I may respond to your concerns. I take criticism seriously, with care and respect.

However, if you believe I have been unwilling to listen or respond or that I have behaved unethically, 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. The practice of Licensed Clinical Mental Health Counselors (LCMHC) in North Carolina is regulated by the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC).

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

PSYCHOTHERAPY SERVICES

The following information outlines what you can expect with the psychotherapy services I provide:

- **Free Consult:** For those who are interested, other than EAP clients who are assigned to me, I offer a free 30 minute face-to-face consult. During this consult I will give you more information about myself, answer any

questions you have, and ask some questions about what you are interested in getting out of therapy. If you would like to pursue therapy with me following this consult, we will set a session date and discuss fees.

- **Initial Session:** During your first session, I will assess and evaluate your needs and take a detailed history in what is called a “Psychosocial Assessment.” At the end of this assessment, I will be able to offer you some first impressions of what I believe our work could include. After this we will work together to create a treatment plan.
- **Continued Sessions:** I provide non-emergency psychotherapeutic services by scheduled appointment only. I prefer to provide clients with a specific weekly or bi-weekly time-slot. Psychotherapy has both benefits and emotional risks. When certain feelings, thoughts, or events are approached it will likely be emotionally painful. Learning to tolerate painful emotions is part of the therapeutic process. In addition, any type of changes in beliefs or behaviors can generate fears and potentially disrupt relationships in your life. Please consider carefully whether you are willing to face these risks. The majority of people who take these risks find therapy to be helpful in the long-run. However, there is no guarantee on how you will be affected by therapy.
- **Ending Session:** Your participation in psychotherapy is voluntary and you have the right to refuse or withdraw from treatment at any time. However, I ask that when you are thinking about ending therapy you discuss this with me so that we can create a termination plan together. Typically, therapy is ended in mutual agreement between therapist and client, and occurs when it is evident that the client no longer needs services. In this instance an ending session is provided to review goals met, and lessons learned.

CONTACT OUTSIDE OF SESSIONS

Below is information about contact that may occur outside of session:

- **How to Contact Me Outside Sessions:** If you need to reschedule an appointment you may do so via phone call, text, or email. I only provide non-emergency psychotherapeutic services by scheduled appointment and am not available 24 hrs per day 7 days per week. I can be contacted via phone 7am to 8pm EST Tuesday-Friday, and 7am to 12pm Monday and Saturday. I check my phone regularly during these hours. If you have an urgent need and I do not answer my phone, please notify me by voicemail. I will check my voicemail at least every 5 hours within office hours, and will return your call as soon as possible. If you have an urgent need and cannot wait for my call please look at the subsequent sections “Mental Health Crisis” and “Mental Health Emergency.”
- **Unplanned Contact:** If we come into contact outside the office or a scheduled session I may nod or smile at you, but will not speak to you unless you speak to me first.

MENTAL HEALTH CRISIS

A mental health crisis is defined as a non-life threatening situation in which you are having extreme emotional disturbance or behavioral distress, considering harming yourself or others, disoriented or out of touch with reality, have a compromised ability to function, or are extremely agitated and unable to be calmed. If you are in a mental health crisis and/or need immediate support outside my office hours or when I am on vacation - or cannot wait during office hours - you agree to call or text one of the below support lines, which are staffed 24/7/365 with certified mental health professionals:

- National Suicide Prevention Lifeline – Call: 800-273-TALK (8255)
- National Crisis Text Line: Text “HOME” or “CONNECT” to 741-741

Initials_____

MENTAL HEALTH EMERGENCY

A mental health emergency as a life-threatening situation in which you are having serious thoughts, desires, and intention to harm to yourself or others, severely disorientated or out of touch with reality, a severe inability to function, or feelings being out of control due to extreme distress. If you are having an emergency, you agree to call 911 or check yourself into the nearest hospital emergency room.

Initials_____

FEE STRUCTURE, BILLING, PAYMENTS AND LENGTH OF SERVICE

SELF-PAY CLIENTS NOT UTILIZING INSURANCE

The Full Service Rate at IWS, PLLC for Individual Therapy sessions is \$130 for 50 minutes, \$140 for 60 minutes, and \$170 for 90 minutes of Individual Therapy. The Full Service Fee for Intake Sessions is \$150. Please note that these fees are based only on service type. Below is the Sliding Scale Rates chart for 60 minute sessions for whom these fees are not financially viable:

Total Household Income Range	Number per Household					
	1	2	3	4	5	6 +
\$0 to \$40,000	\$100	\$100	\$100	\$100	\$100	\$100
\$40,000 to \$45,000	\$105	\$100	\$100	\$100	\$100	\$100
\$45,000 to \$50,000	\$105	\$105	\$100	\$100	\$100	\$100
\$50,000 to \$55,000	\$110	\$105	\$105	\$100	\$100	\$100
\$55,000 to \$60,000	\$110	\$110	\$105	\$105	\$100	\$100
\$60,000 to \$65,000	\$115	\$110	\$110	\$105	\$105	\$100
\$65,000 to \$70,000	\$120	\$115	\$110	\$110	\$105	\$105
\$70,000 to \$75,000	\$125	\$120	\$115	\$110	\$110	\$105
\$75,000 to \$80,000	\$125	\$125	\$120	\$115	\$110	\$110
\$80,000 to \$85,000	\$130	\$125	\$125	\$120	\$115	\$110
\$85,000 to \$100,000	\$135	\$130	\$125	\$125	\$120	\$115

By checking the following two boxes and initialing below you agree to *either* pay the Full Service Rate *or* your Base Sliding Rates:

- ☐ Agree to pay the Full Service Rates as follows (if the Sliding Scale Rates do not apply):

- o \$140 for 60 minutes of Individual Therapy
- o \$150 for Intake
- o \$130 for 50 minutes of Individual Therapy
- o \$110 for 30 minutes of Individual Therapy
- o \$170 for Intake

Initials_____

- ☐ Agree to pay the following for Individual Therapy sessions:

- o _____per 60 minutes of Individual Therapy – which is your Base Sliding Scale Rate.
- o _____per Intake (*Add \$10 to the Base Sliding Scale Rate*).
- o _____per 50 minutes of Individual Therapy (*Subtract \$10 from the Base Sliding Scale Rate*).
- o _____per 30 minutes of Individual Therapy (*Subtract \$30 from the Base Sliding Scale Rate*).
- o _____per 90 minutes of Individual Therapy (*Add \$30 to the Base Sliding Scale Rate*).

Initials_____

By initialing below you:

- Recognize that these service fees are subject to change due to cost of living increases. If these fees are going to change, Integrated Wellness and Strategies, PLLC will inform you at least a month prior.

Initials_____

- Understand that we will review your financial circumstances at the beginning of each year to determine whether your fee per session needs to be readjusted. Unless this occurs, these fees will remain the same.

Initials_____

- Understand that if you become insured and/or your financial circumstances change, you will notify me within one month so that we may either begin billing your insurance company or readjust your fee per session. Unless this occurs your fees remain the same.

Initials_____

CLIENTS UTILIZING INSURANCE OUT OF NETWORK

For clients who have insurance that is Out of Network for this provider, the following information outlines my fee structure, billing, and payment expectations:

- Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that 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.
- When a third party such as an insurance company is paying for part of your bill, I will be required to provide them with a diagnosis of your mental-health condition so that I can be paid or before they will agree to reimburse you. Diagnoses are technical terms that describe the nature of your problems and will come from the DSM-V and ICD-10. 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 submitting the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Initials_____

- Agree to pay the Full Service Rates as follows (if the Sliding Scale Rates do not apply):
 - \$140 for 60 minutes of Individual Therapy
 - \$150 for Intake
 - \$130 for 50 minutes of Individual Therapy
 - \$110 for 30 minutes of Individual Therapy
 - \$170 for Intake

Initials_____

- You will be provided a Superbill Receipt to submit to your Insurance Company if you wish to attempt Out of Network reimbursement and/or wish have your payments go towards your deductible.

Initials_____

ALL CLIENTS

In addition to the above, by initialing below you understand:

- It is a standard for Integrated Wellness and Strategies, PLLC to meet with clients for 60 minute Individual Therapy sessions either weekly or every other week. The frequency of sessions, length of sessions, and length of treatment depends on a variety of factors (ex: presenting concerns, diagnoses, desired frequency of sessions, type of treatment being sought (short-term versus long-term), etc. Depending on the amount of progress we are able to make together, I typically meet with clients who are seeking short-term therapy for 3-6 months, and those seeking longer-term treatment, for 1-4 years (or longer depending on their needs). This will be subject to change depending on your needs.

Initials_____

- Payment will be due at the time of each session. I accept all major credit cards, checks, and cash for payment. I do not accept the following forms payment: direct transfers between banks, PayPal, or bartering.

Initials_____

- If you write a check and it bounces, you will be charged a \$30 fee in addition to the original amount. I will make every attempt to work with you to figure out an affordable payment plan, if necessary. However, if you refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency as a last resort.

Initials_____

- Completion of paperwork for third parties such as workplace and/or apartment complexes is charged separately from insurance. This includes but not limited to short-term work disability, long-term work disability, reasonable accommodation, emotional support animals, etc. These fees are not covered by insurance. Should you be in need of these services, fees and options will be discussed directly with you.

Initials_____

- Court testimony on my/our behalf is charged at a higher rate - including but not limited to verbal testimony, subpoenaed testimony, and related matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. These fees are not covered by insurance. Should you be in need of these services, fees and options will be discussed directly with you.

Initials_____

Please know that I am very willing to work with you if you are having financial difficulties, but communication is key. I am open to changing your fee as your life circumstances change. However, it is your responsibility to inform me of any household income changes, insurance, and/or credit card changes.

MISCELLANEOUS BUSINESS INFORMATION

Ethically, there are certain ethical and business practices Amber W. Pearson and Integrated Wellness and Strategies, PLLC have in place. These practices are listed below:

- **Vacations and Holidays:** I will take periodic vacation and holiday breaks away from the office. I will provide you with dates when I will be out of the office in advance whenever possible.
- **Outside Consultation:** There may be times when I need to consult with a colleague or another professional, like an attorney, about issues raised by you in therapy. Your confidentiality will still be protected in every way possible during consultation and professional consults. Signing this disclosure statement gives my psychotherapist permission to consult as needed to provide professional services to you as a client.
- **Therapist Incapacitation or Death:** In the event of my death, incapacitation, or grave disability, selected colleagues have agreed to be my primary and secondary professional executors. Specifically, Maggie Young, LCSW is my primary - and Susan Weinstein, LCSW is my secondary. My primary executor would have the capacity to review limited confidential information I have collected about you in for the purpose of contacting and advising you of options for continuity of treatment.

PROFESSIONAL RECORDS

The ethical and legal requirements of my profession require me to keep records of your treatment with me. I will take notes in each therapy session. These notes will specify what time we met, interventions that occurred in the session, and topics we discussed. I maintain your records in a secure location that cannot be accessed by anyone other than me, in accordance to HIPAA standards. You have the right to:

- Request your records at any time. *Note: If you do want copies of your records I will need a written request that includes a time-frame of when you will need the records by.*
- Request that I correct any errors in your file. *Note: Any error correction requests must be in writing as well.*
- Request that I make a copy of your file available to any other health care provider. *Note: I will not release any of your records until after you have completed a Release of Information form.*

Due to the nature and terminology necessary to professional mental health records, it is possible that information in these records may be upsetting to untrained readers. So, if you wish to see your records, I recommend that you review them in my presence so we can discuss them together. You will be charged an appropriate fee for copies made and any professional time spent in responding to information requests.

In addition, records for adults 18 years of age or older shall be retained for a period of 7 years, commencing on either the termination of professional counseling services or the last date of contact with the client, whichever is later. Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client 18 years of age or older, must file a complaint or other notice with the licensing board within 7 years commencing on

the date of termination of services or on the date of last contact with the client, whichever is later. In no event shall records be kept for more than 12 years.

THERAPIST BOUNDARIES

Please keep in mind that I, as your therapist, do reserve the right to terminate therapy possibly without mutual consent. These circumstances are as follows:

- If I believe your psychotherapeutic needs are outside my scope of competence, that my methods and expectations are not a good fit for you, or that you are not benefiting from my services I will be obligated legally to refer you to another practitioner, terminate, and/or get outside consultation.
- If payment is not consistent or timely. In this instance I will work with you directly to try to come to a resolution prior to termination.
- If you miss 3 consecutive sessions via late cancellation and/or no show and I am unable to contact you. In this instance, a letter will be sent to you explaining that your services with me have terminated along with a closing bill for any unpaid balance. You will still be financially responsible for fees related to missed sessions, per the CANCELLATION & NO SHOW POLICY.
- If you are violent, harassing, or threatening towards me, my staff, anyone at my office, or my family members verbally or physically - I reserve the right to terminate you unilaterally and immediately from treatment.

When you are ending therapy with me in the above circumstances, I will make every attempt to refer you to a professional who could better fit your needs when this applies. However, I cannot guarantee that this person will accept you for therapy. If you have any questions or would like additional information, please feel free to ask me anytime during the psychotherapy process.

ACCEPTANCE OF TERMS

We agree to these terms and will abide by these guidelines.

Client Name (printed)	Client Signature	Date
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Therapist Name (printed)	Therapist Signature	Date
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