Jamie Ross, MS, LCPC
60 South State Rte. 157, Suite C3
Edwardsville, IL 62025
(360) 305-6790

DISCLOSURE STATEMENT

I earned a Bachelor of Arts degree in Psychology from Western Washington University in 2002 and a Masters of Science degree in Marriage and Family Therapy with an emphasis on children and adolescents from California Lutheran University (CLU) in 2005. While earning my masters degree, I worked at the CLU Community Counseling Center with children, adolescents, families and couples of all ages. After moving back to Washington, I began working at a community mental health center as a Child and Family Therapist. After obtaining my Washington State License in Mental Health Counseling, I started a private practice in 2009. My family then moved to Edwardsville at the end of 2015 and I am now a Licensed Clinical Professional Counselor in Illinois.

My commitment is to improve the lives of children and families in the community by delivering effective mental health services. I am a Child Mental Health Specialist and focus my practice on children, adolescents and families. I employ varied counseling techniques to individualize treatment to each client. I work hard to support parents and caregivers with communication and effective parenting skills. I work with adults individually and specialize in mood disorders during pregnancy and the postpartum period.

I am pleased that you have selected me as your mental health counselor. This document is designed to ensure that you understand our professional relationship.

FEE AGREEMENT AND CONSENT FOR TREATMENT

Fees and Payments: My current out of pocket rate for individual and family consultation services is $90 per 50 minute session. Intake sessions, couples, groups, external consultation, training services, and court attendance may be billed at different rates and in accordance with our contracts. Payments should be made at the **time of the appointment**, unless we have specifically agreed on another method of payment. I reserve the right to charge for telephone calls in excess of ten minutes, meetings that I am requested to attend on you or your child's behalf, clinical reports, and to charge interest for late payments.

If you wish to pursue insurance coverage for counseling services, I will provide you with a receipt of payment that you can provide to your insurance company for reimbursement.

Appointments: I have assigned time in my schedule for your appointment, which begins at the scheduled time, **not** when you arrive. If you must cancel an appointment, please do so at least **24 hours** prior to your scheduled time or you **will be charged the session fee**. Emergent situations can be discussed and adjusted.

Telephone communication and emergencies: You are free to leave a confidential message on my voicemail and I will return your call as soon as I am able. I do not use email or social media to communicate with clients, and only use text communication for appointment scheduling purposes. In the event that I am out of town or unreachable via telephone I will assign another mental health therapist to cover important calls. In the event of a life-threatening emergency, call 911 or proceed to a hospital emergency room.

Confidentiality: As your mental health counselor, I will keep confidential anything you say to me, with a few exceptions as required by law. Illinois State Law insures the confidentiality of your treatment relationship unless there is suspected child abuse, suicidal behavior, or potential harm to client or others involved in the case. In certain situations the court does have the right to subpoena treatment records. In the event of a potential subpoena, this process would be discussed with you.

Concerns or Complaints: If at anytime, for any reason, you are dissatisfied with my services, please let me know. It is always appropriate for you to raise concerns you have about your treatment. You have a right to request a change of treatment, a referral to another therapist, or the discontinuation of services.

Authorization for a Minor: I hereby authorize Jamie Ross, MS, to provide mental health counseling services to _____. This authorization is an informed consent without exception.

Agreement of Client: I have read the above information and have received a copy of it. I agree to the terms of services outlined above without exception. I understand my responsibility as well as the responsibility of the consultant in the rendering of mental health counseling services.

_____ _____
Signature of client or parent/guardian Date

_____ _____
Jamie Ross, MS Date
IL License No. 180.010953