John Penn Turner, M.S., LPC, LSATP, NCC

Professional Disclosure Statement

INTRODUCTION TO COUNSELING SERVICES:

This introductory material (as well as the client agreement form which is enclosed) serves to clarify policies and reduce potential confusion so that your counseling process can be more effective in assisting you with changes you want in your life.

ABOUT JOHN PENN TURNER, LPC/LSATP

DEGREE:

December 1994 MS in Rehabilitation Counseling ***Specialization in Addiction Services*** Medical College of Virginia – Richmond, Virginia.

LICENSES:

Virginia-	Licensed Professional Counselor	LPC	*0701002755 Expires 6/30/23*
New Mexico	Licensed Professional Clinical Counselor	LPCC	*0169391 Expires 9/30/22*
New Mexico	Licensed Alcohol & Drug Abuse Counselor	LADAC	*0169401 Expires 9/30/22*
North Carolina-	National Clinical Counselor	NCC	*312596 Expires 6/30/23*

EXPERIENCE:

From 1994 to 2003, I worked for a variety of agencies/organizations (**INPATIENT** *HOSPITAL-BASED*, **OUTPATIENT** *PUBLIC MENTAL-HEALTH* & **PRIVATE PRACTICE**), and from 2003 to the present I have been with Albemarle Counseling Associates, PLLC.

DESCRIPTION OF COUNSELING SERVICES:

Counseling resources are available by appointment only and include individual, couple and group counseling. I do not offer testing, medication or hospitalization services. When these services are needed, however, I will coordinate the appropriate referral.

Counseling services are designed to help individuals gain insight into personal issues, concerns and problems resulting from being in a complex and sometimes difficult world. The focus of my work is on developing skills necessary to deal effectively with life's issues and personal transitions. It is my responsibility to listen, to understand and be helpful. A helping professional cannot solve a client's problems. Instead, the counselor assists with learning coping skills and increasing one's potential as a fully functioning, continually developing and always unique person.

The client's responsibility is to help the counselor understand the client's life situation, thoughts and feelings and to be honest in the therapy relationship. The client needs also to challenge herself or himself to try new methods to manage problem areas. A commitment to practicing the skills learned in the therapy session between sessions is highly encouraged.

The relationship between counselor and client is confidential and protected by the ethical code of the counseling profession except where limited by law (see the client agreement form for clarification).

LOCATION AND CONTACT INFORMATION:

My office is located at 106 Caty Lane, Charlottesville, Virginia, 22901. Our office is located in the new Belvedere Neighborhood across from CATEC off of East Rio Road between Dunlora and Covenant Church. From East Rio turn NORTH onto Belvedere Boulevard. Drive approximately ¾ of a mile to the traffic circle. Go ¾ of the way around the circle and turn RIGHT onto West Farrow Road. Take the 2nd LEFT onto Tyree Lane. Stay on Tyree around the block. When you get to CATY LANE, which is the alley, park on the street. You will then walk down CATY LANE to 106. This is the Yellow Stucco Carriage House. Walk through the gate, which is open when I am there, and go through the door to your RIGHT. We are on the second floor.

My office number is 434.978.3900. I will not 'friend' you on ANY social media. I will not TEXT with you.

Service	Length of Service in MINUTES	BILLABLE or NOT for Insurance/EAP	Fee

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CLINICAL SERVICES			
Initial Evaluation	50-75	YES	$150.00
Couples	50	NO	$150.00
Individual	45/60	YES	$150.00
Court Appearance *For any reason related to your treatment.* *(Per Hour/ Minimum of 4 hrs.)* ***Due in advance***		NO	$350./ hr
PHONE CONSULTATION			
Less than 15 Minutes	<15	NO	$0.00
15-30 Minutes	15-30	NO	$65.00
30-50 minutes	30-50	NO	$150.00
No Show or Late Cancellation ***(Late is considered less than 24 hrs prior to session)***			
Couples	50	NO	$150.00
Individual	45/60/90 A R T	NO	$130/$150
MISC items			
Returned Check Fee			$50.00

We do not offer a sliding scale.

We will bill your insurance company and you will be charged only for your co-pay / co-insurance which is due at the time of service.

NOTE: It is your responsibility to know your co-pay amount. ***Be aware*** that your co-pay amount may change depending on your specific policy and benefit plan.

All bills are considered the responsibility of the patient or guardian, and payments are due the day of services unless other arrangements have been made. If you have insurance, your co-payment is due the day of service. Fees not covered by insurance are due 30 days after insurance settlement with the primary carrier. If insurance does not render final payment within 60 days, the entire balance becomes due. Filing with your secondary insurance is your responsibility. Special arrangements may be made with the receptionist for extensive or unusual treatments. Accounts beyond 90 days will be charged interest at the rate of 1 1/2% per month 18% per annum. Accounts delinquent will be sent to collections and any collection costs or attorneys fees incurred will be charged to the patient.
By signing this form you acknowledge that your therapist has permission to share any and all necessary information that is required in order to bill and collect fees for services to the appropriate billing agency including but not limited to your insurance company, 3rd party billing agency, collections agency, etc. Your signature on this form serves as your proxy on the HCFA 1500, or other billing form for any 3rd party payor, as appropriate, including but not limited to blocks 12 and 13 on the HCFA 1500 billing form.

We accept- *Cash, Check & Credit Cards.* ***Payment is due at the time of service.***

CONFIDENTIALITY:

For the purposes of billing your insurance company and documentation of services and treatment planning I will be making a diagnosis as indicated by your needs/issues. Your personal health information is protected by HIPPA and (Federal Regulation 42 CFR). Your personal information will not be shared with anyone else unless you direct me to do so with a **SIGNED** ***RELEASE OF INFORMATION*** indicating the information that you want share and with whom you want the information shared.

There are some exceptions:

If you share intent ***to harm yourself or some other person*** or ***if there is an indication of child or elder abuse***, I will release the information that is necessary to protect you/others. ***If there is a court order,*** I will provide the information that they request to the appropriate authorities or agency.

PROCEDURE FOR REGISTERING A COMPLAINT

VIRGINIA: Virginia Residents treated in VA
Virginia Board of Counseling
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond VA 23233-1463
Voice 804.662.1717
Online: www.dhp.state.va.us

NEW MEXICO: New Mexico Counseling and Therapy Practice Board
PO Box 25101
Santa Fe, NM 87504
Voice (505)-476-4622
Fax: (505) 476-4645 or by
Email: counseling.board@state.nm.us

Online: www.ncblpc.org

Client Signature: ________________________ Date: _______
Printed Name ________________________

Witness Signature: ___________________ Date: ________