

DISCLOSURE STATEMENT

Daniel L Richards Ph.D. LCPC, NCC
Licensed Clinical Professional Counselor
1321 Washington Av
Suite102
Portland Me 04103
207-712-0497

Licensure and Certification

State License: Licensed Clinical Professional Counselor
Issued in Maine, May 6, 1992 CC 86
Expiration date: May 31, 2020
National Board for Certified Counselors
Issued: January 29, 1983 #2200
Expiration date: January 31, 2024

Education

State University of New York at Buffalo 1978 Ph.D. in Counseling

Professional Affiliations

Member of the American Counseling Association
National Board for Certified Counselors
Member Emeritus of Maine Clinical Counselors Association
Member Emeritus of Maine Counselors Association

Areas of Competence

My areas of competency include, but are not limited too, working with both men and women in individual counseling. My areas of specialty include: codependency, men's issues, substance abuse issues, issues surrounding loss and grief of family members, pre-marital issues, divorce, remarriage and step-families, couple communication issues, assertiveness training, building self esteem, reducing shame and anger, midlife issues, employment issues, depression, anxiety disorders, Post-traumatic stress disorders, and obsessive compulsive disorders. See web site for future information, www.drdranrichards.com

Course of Treatment

At the first meeting I explain my personal view of doing therapy and answer any questions you might have. I then take a history of what brought you to therapy. When that is concluded I work with you to develop the best approach to helping you understand, confront, and change those obstacles to your health and enjoyment that brought you to therapy. I view therapy as an active process that needs to go on outside of the hour that we will meet. Consequently I may recommend books, specific tasks and other homework activities that will enhance the effectiveness of your treatment with me. Where many problems have a chemical base to them I may ask you to consult with your family doctor to evaluate whether medication would be helpful. Therapy is often an evolving process so at various times we may reassess our goals and use different approaches than we began with.

Confidentiality

Confidentiality, while an essential aspect of the counseling process and the client-counselor relationship, has its limitations. Confidentiality will be maintained in accordance with the standards of the American Counseling Association and the National Board for Certified Counselors. Exceptions to confidentiality include: (1) cases involving the client's intention to do serious harm to themselves or others, (2) cases in which clients request their records to be released to themselves or a third party, (3) cases in which a court orders a counselor to make records available, (4) cases where there is reasonable suspicion of child abuse or abuse of an elder or other incapacitated

person, (5) cases in defense against a legal action or formal complaint, which the client makes before a court or regulatory board, (6) as part of my professional development or in consultation with my supervisor. During such discussions a client's case may be discussed but confidentiality of the identity of the client will be maintained.

Record Keeping

All records that are developed as part of your sessions with me, such as but not limited to; forms, requests, reports, and any other materials will be destroyed 2 years after your last session with me. The only record that will be retained is the listing of dates of services and amount paid, as required by law.

Supervision

To best serve my clients, I will at various times choose to consult with other professionals about my treatment and approach to a particular situation. During those times I will not be using the name of my clients only the treatment or approach issues.

Fees and Appointments

Counseling sessions are scheduled by appointment only. The fee for first session is \$175.00. The fee for a fifty-(50) minute counseling session is \$175.00. **Your fee may be different depending on whether you are using insurance coverage.** If you are using managed care insurance and they will not authorize further sessions you will be responsible for the full fee unless other arrangements are made. Evening appointments are not available. Payment is made by check or cash and is expected at the time of the appointment. **A 24-hour notice of cancellation** is required or you will be responsible for the **full fee** for the individual missed. I personally schedule my own appointments and will make every attempt to return your calls on the same day they are received. **My telephone number is (207) 712-0497.**

Insurance

Some insurance companies will reimburse you for professional counseling. It is your responsibility to contact your insurance company and find out about the criteria for reimbursement. It is also your responsibility to file for such reimbursement unless I have a specific contract with your insurance company or health maintenance organization. If you do use your insurance, you understand that a diagnosis will be requested me. This diagnosis will becomes part of the insurance company records and also become part of your personal medical record. If you are going to use a health maintenance organization you understand that they will request updated reports on your progress in therapy and will use these reports to continue or deny coverage. If your insurance company denies any further coverage you will be responsible for the full fee unless some other arrangement is made. I highly recommend that you discuss insurance issues with me and are clear about the effects on your privacy before treatment begins.

Dissatisfaction/Complaints

Please feel free to discuss your problems and concerns with me directly. Any dissatisfaction should initially be directed to my attention. Should we be unable to resolve your concerns, then you have the option to contact: Board of Counseling Professionals Licensure, 35 State House Station, Augusta ME., 04333 (207) 624-8626
Your signature indicates that you have read this statement and understand its contents.
Thank you.

| | | | |
|-------------------------|------|----------------------------|------|
| Signature of the Client | Date | Signature of the Therapist | Date |
|-------------------------|------|----------------------------|------|