PROFESSIONAL DISCLOSURE STATEMENT
STATE OF NORTH CAROLINA

Jeff S. Shaeffer, LPCA, MA, MDiv

The following disclosure statement will provide you with some basic information regarding my history of expertise and procedures. Hopefully many of your concerns will be addressed in the information that will follow. You may also contact me directly to clarify or address any issues that you do not understand or may be unsure about.

My Experience and Education

I am a North Carolina Licensed Professional Counselor Associate (#**A12759**). In 2014 I received a Master's in Biblical Counseling from Southeastern Baptist Theological Seminary. In 1997 I received a Masters of Divinity from Gordon-Conwell Theological Seminary. I have completed training in Sexual Identity Therapy (SIT) from Dr. Mark Yarhouse, a leading researcher in the field of LGBT studies. I have completed Level I training in the Gottman Method Couples Therapy.

I am in the process of certification from the Sexual Wholeness Institute in Atlanta, Georgia to become a certified sex therapist. Additionally, I am working towards my certification for treating sexual addiction (CSAT) through IITAP, an organization founded by Dr. Patrick Carnes, a pioneer in the field of sexual addiction.

During my tenure as a pastor, I provided counseling to individuals, couples and families on a regular basis. As part of my Master's degree in counseling, as of 2009 I began seeing clients through a Southeastern Baptist Theological Seminary program at Summit Church. This experience included up to three treatment sessions per week with clients, as well as weekly debriefing and supervision on my cases.

I have experience counseling adults with a variety of concerns, including depression, anxiety, personality disorders, marital issues, anger, divorce, attention deficit hyperactivity disorder (ADHD), same sex attraction (SSA) and addictions.

Therapeutic Orientation

Therapeutic orientations most often utilized in counseling include cognitive behavioral, solution focused, and a variety of other techniques including, but not limited to Gestalt, group therapy, and role playing. The individual needs of the client combined with the

treatment goals established often determines the orientation(s) that will be most effective. It is also important for the client to feel as though the therapeutic orientation is a good match for his/her personality and needs.

Fees and Length of Service:

Sessions usually run for 50 minutes but can be scheduled for longer as needed. My hourly rate is $150 for a 50 minute session for a single client and $200 for a couple. Payment is required on the date of service in the form of cash, check or credit cards. At this time no insurance is accepted, but receipts are provided which can be submitted to insurers.

I understand that urgent situations arise. However, if an appointment is missed or not cancelled within 24 hours of the scheduled session, a $50 fee will be charged. If I am required to testify or appear in court on your behalf, there will be a fee of $300 per hour for my services.

Confidentiality

Confidentiality is very important to the therapeutic relationship and all possible measures will be utilized to maintain privacy within the extent of the law. As a Licensed Professional Counselor Associate (LPCA), I may feel the need to share information deemed important with my supervisor or other professional colleagues to get a better clarification with regard to certain issues. This is for the betterment and health of the client.

The following are exceptions to the right of confidentiality:

- If I suspect that a child or adult is being abused
- If I believe you may harm yourself, or may harm another individual
- If a court requires me to testify or share client information

If you decide to file a claim with your insurance company, they may inquire about treatment progress and treatment goals. A diagnosis will need to be provided to them and will become part of your permanent medical record.

With children and adolescents, confidentiality can become more of a challenging issue. The age of the child or adolescent and issues discussed will have a direct impact on the level of confidentiality that is permitted. These limits will be discussed at the initial intake session and a separate disclosure will need to be signed.

Availability

I am typically in the office Monday through Friday between 10:00 a.m. and 6:00 p.m. I can be reached by email or telephone during these times, unless I am in a session with another client. If I am unavailable and there is an immediate emergency, please call 911 or contact Holly Hill Hospital at 919-250-7000. Holly Hill is located at 3019 Falstaff Rd, Raleigh, NC 27610. You may also go to your nearest emergency room. **If I am on vacation or unable to provide counseling services for any reason, please call my supervisor, Sophia Caudle.**

Termination of Counseling Services

If you miss a scheduled appointment and do not call and reschedule within 14 days, I will assume that you wish to terminate counseling services. A note will be placed in your file noting that counseling services have been terminated. If it has been 30 days since your last appointment, and you have not rescheduled, I will send a follow up letter to you to determine if you wish to continue counseling services. It is important that you respond to this letter and notify me of your wishes.

Your Rights as a Counselee

As a counselee you have the right to discuss possible outcome and challenges regarding counseling and receive an estimate of the predicted length, goals, and outcomes, as well as alternative options. You have the right to ask about and/or refuse any techniques used. You should report to any impropriety you felt occurred to your counselor's supervisor:

If you have not received the satisfaction you desired you then have the option to contact the North Carolina Board:

North Carolina Board for License Professional Counselors
P.O. Box 77819
Greensboro, NC 27417
884.622.3572
http://www.nclpc.org

Acceptance of Disclosure Statement

By signing below, I agree that I have read and been given a copy of the Professional Disclosure Statement for Shaeffer Counseling Services. I agree to its terms and conditions and understand that I may withdraw from therapy at any time.

____ __________________
Signature of Client Date

____
Printed Name

____ __________________
Signature of Client Date

____
Printed Name

____ __________________
Signature of Therapist Date

Credit Card ______________________________ Expires ___/___ Code ______