Disclosure Statement
Sarah Maurer, LMFT, PLLC
Maine License# MF 4643
New Hampshire License # 182
27 Gorham Rd, Suite 226 Scarborough ME, 04074
Tel: 207-730-0557
Office Hours: By Appointment Only

The following disclosure statement is provided to give you information regarding my training and credentials, the therapeutic process, your rights as a client, and information concerning office policies.

License and Credentials
I am fully licensed as a marriage and family therapist (LMFT) in the State of Maine. I am additionally licensed as a marriage and family therapist (LMFT) in the state of New Hampshire. I hold a Master of Science Degree in Marriage and Family Therapy obtained from the University of New Hampshire, awarded on August 18, 2012.

Training and Professional Experience
My training and professional experience includes therapeutic work with individual adults, children, and adolescents, as well as couples, families, therapeutic groups, and larger systems. I have therapeutic experience in working with clients experiencing relationship difficulties, symptoms of depression, anxiety, post-trauma, severe and persistent mental illness, addictive behaviors, and adjustments to major life changes.

Confidentiality
Confidentiality is a central aspect of my role as a therapist. All information, including treatment plans, progress notes, assessments, and verbal communication regarding our time together will remain confidential except under the following circumstances: for treatment, payment, and health care operations; if there is a threat of serious harm to self or others; if there is reasonable suspicion of abuse, neglect, or exploitation of a child, elder, incapacitated or dependent person; by voluntary release signed by the client or guardian; during supervisory consultations; or if court ordered to produce such information.

We live in a small community, and as such we may find ourselves running into one another outside of treatment. In an effort to uphold your confidentiality, should we encounter each other outside of treatment, my policy is to only acknowledge you if you should choose to acknowledge me. Please let me know if you have any thoughts or concerns about this, and we can discuss it further.

Therapeutic Process
At first interview, we will begin the intake process and gather necessary information for an initial assessment. This will include any reasons you have decided to seek treatment, and symptoms that are being experienced. At the completion of the assessment period I will be able to provide a diagnosis, offer impressions of what work will include, and will be able to coordinate a treatment plan if you choose to continue.

I view therapy as a collaborative process between the therapist and client. You have a specific knowledge of your life experience, and I have knowledge of working with families, couples, and individuals in relational or individual dilemmas. The therapeutic process is one of ongoing exploration, uncovering, and recognizing of aspects of life experience and self-discovery. I will act as a guide through this process, in an effort to assist you in creating change that is right for you.

It is important to make you aware that there are potential risks and benefits to entering therapeutic treatment. Potential benefits include a significant reduction in feelings of distress, enriched relationships, and resolution of specific problems. The risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy may also involve considering unpleasant aspects of your personal and family history. It is important to also understand that no promises or guarantees can be made with regard to the results of therapeutic treatment.

Treatment Planning

As described above, a treatment plan will be created if you decide to continue with therapy. A treatment plan is a document that identifies your goals for therapy, as well as the process for which those goals will be achieved. Treatment goals are reviewed regularly, and clients are expected to participate actively in the treatment plan process.

Paperwork Fees

Your records are kept, securely by me, in accordance with state rules and regulations. In the event you should require a copy of your records, the fee for my services to collect, copy and print your records will be $100, plus 25 cents per page.

Communication

I do not consider e-mail or text messages to be confidential forms of communication, therefore I request that all confidential communication be primarily phone contact or through my SimplePractice client portal, which is HIPPA compliant and secure. I do allow my clients to text or email regarding appointment cancellations and changes, but insist no confidential information is shared.

I do my best to get back to you within 48 business hours.

Emergency Coverage

If you have an emergency during normal business hours you may attempt to reach me by phone. After normal business hours or if you cannot reach me, you can access crisis services in your community by going to the nearest emergency room, calling the statewide crisis number **1-800-639-6095**, or by calling **911**.

Cancelations and No Shows

It is the responsibility of the client to give notification of cancellation at least 24 hours in advance. **No showing an appointment or Failure to give cancelation notice 24 hours in advance will result in a $50.00 fee for the missed appointment.**

Payment Policies

The standard length of a session is 50 minutes, with intake appointments lasting longer to complete initial paperwork. Clients are expected to make payment at the start of each session. Currently, cash or check is accepted for services. The cost of the initial diagnostic assessment is $150.00. The usual customary fee for subsequent appointments is $100 per session (individuals) or $125 (couples and families), and when approved, third party payments must be arranged prior to the start of treatment.

For insurances that are not accepted, I am able to offer a receipt for services which client's may be able to take to their insurance company for possible reimbursement for services. It is the responsibility of the client to contact their insurance company prior to the start of treatment to verify their insurance coverage policies. Any uncovered fees will be the responsibility of the client to pay. Fee modifications may be discussed upon request and on an individual basis.

If payment is not made for services already received, the therapist may choose to stop treatment.

Agreed Fee Amount per Session _____ Initials _____

A $10.00 fee will be applied for any checks returned to cover bank fees charged to the therapist for a bounced check.

Termination

Clients have the right to discontinue therapy services at any time. In some cases, the therapist may choose to refer client to alternative care if they become aware that services needed are beyond their scope of practice, or the needs of the client exceed their ability to provide adequate care. Clients will still be responsible for paying in full for the services already received.

Grievance Procedures

I encourage you to ask questions, express concerns, or address dissatisfaction regarding treatment at any time. Although it is hoped that any concerns may be satisfied directly, the practice of counseling is regulated by the Office of Professional and Occupational Regulation. The board is authorized by law to discipline counselors who violate the board's law or rules. To learn about the complaint process, or to file a complaint against a counselor please contact:

Department of Professional & Financial Regulation
Office of Professional and Occupational Regulation
35 State House Station
Augusta, Maine 04333

Telephone: 207-624-8603
https://www.maine.gov/pfr/professionallicensing/contact_us.html

I have read the Disclosure Statement and have had the opportunity to ask questions and have them answered fully. My signature below indicates that I agree to the terms and conditions listed above and give my consent to treatment with Sarah Maurer, LMFT, PLLC.

Client Signature_____ Date_____

Client Signature_____ Date_____

Witness_____ Date_____