



**Curtis Trent, MA, LMHC**  
Licensed Mental Health Counselor  
License # 39002142A

7526 E 82<sup>nd</sup> St., Suite 150 • Indianapolis, IN 46256 • 317-585-1060 • <http://www.fcahelp.com>  
North Office: 17777 Little Chicago Rd., Noblesville, IN 46060

## **DISCLOSURE STATEMENT & INFORMED CONSENT**

### **I. Education, Training, Experience**

I received a Bachelor's of Arts in Psychology in 2003 from Anderson University (Anderson, IN). For the following two years, I worked with the Center for Mental Health (Anderson, IN) as a case manager in Community Support Services. I primarily served persons with chronic and persistent mental illnesses and obtained certification as a Qualified Mental Health Professional (QMHP). I then completed a Masters of Arts in Counseling Psychology from Mars Hill Graduate School (Seattle, WA) in 2007 where my professional training was paired with a supervised internship at Northwest University's (Kirkland, WA) student counseling center. Upon completing my graduate training, I returned to central Indiana where I first worked as a therapist in an intensive treatment center for adolescents with substance abuse problems and their families. I joined Family Counseling Associates in August of 2008 and I offer counseling services to individuals, couples, and families for a variety of needs and problems. I am a licensed mental health counselor (LMHC) in the state of Indiana.

### **II. Counseling Orientation**

My conceptual approach to counseling involves various influences including object-relations theory, attachment theory, dynamic psychology, and systems theory, all integrated within a Christian worldview. My style of counseling is equally integrative, including elements of interpersonal, narrative, experiential, and cognitive-behavioral therapy, and I will always seek the best match between counseling style and your counseling needs. Most importantly, I will seek to create an opportunity for you to safely explore whatever is of concern to you in an open and authentic way. My goals for counseling with all persons is a strengthened sense of self, more enriched relationships, and a courage to embrace the freedom life offers. Essential to the accomplishment of these goals will be our *collaboration* throughout the course of counseling together.

Family Counseling Associates is a Christ-centered professional counseling group. As a counselor, I seek to meet you just where you are in your own spiritual journey and will allow you to determine how your own faith and spirituality is integrated into the counseling practice.

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**III. Scheduling Sessions**

An initial session can be scheduled by calling the Family Counseling Associates main office at 317-585-1060. Additional sessions are generally scheduled on a regular, weekly basis and are not limited to any particular number of sessions or course of time. However, it is your responsibility to confirm and/or reschedule your next session.

**IV. Fees and Insurance Information**

The fee for counseling will be \$110 per 50 minute session and payments are to be made at each session via cash, personal check, or with authorized credit card. Additionally, a sliding fee scale is available for persons who are unable to afford the full fee; The sliding scale factors include annual income and # persons dependent on that income. Fees may increase periodically and any change in fees will be communicated with two weeks prior notification.

Please note: Sessions cancelled within less than 24 hours will also be charged a \$45 cancellation fee (illnesses and emergencies are exceptions).

If you choose to use your health insurance coverage to help cover my services, please know that it is a contract between you and the insurance company. As a service to you, our office will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of those payments. In some cases insurance companies may consider certain services as not reasonable or necessary, or may determine that services are not covered. In such cases the client, responsible party and/or insurance policy holder is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The client, responsible party, and/or insurance policy holder is responsible for paying funds not paid by the insurance company or third-party payers after 60 days. Payments not received after 90 days are subject to collection. A 1½% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. All insurance benefits will be assigned to this clinic unless the account balance is paid in its entirety each session. Clients are responsible for payments at the time of service. The adult accompanying a minor is responsible for payment for the child at the time of service. Reimbursements to client will be made only after all outstanding debt for the client and all family members is paid.

**V. Choice of Provider**

It is your right to select a counselor or therapist of your choice and you may terminate counseling with me at any time. I recommend one final session upon termination to reflect on our experience together and address any future concerns.

**VI. Confidentiality & Acknowledgment of Privacy Practices**

Not only is confidentiality guaranteed to you under Indiana State Law, I believe the confidentiality of our work together to be of the utmost importance in creating a safe place for you to explore issues of your concern. Therefore, I strive to uphold the strictest standards of confidentiality in my practice. You should be informed of the *legal exceptions to confidentiality* in the following circumstances when information you share with me could be shared with others without your permission:

(Cont.)

- 1) The Uniform Health Care Information Act may allow for disclosure of information to another health care provider who is serving you.
- 2) You may give written permission to release confidential information. If you wish to disclose to a third party, you must sign a Consent To Release Information form.
- 3) If you reveal that you are contemplating, planning, or have acted out a crime, I may be required to report this to the appropriate authorities.
- 4) If you are a minor, I may discuss with your parents or guardians some of the information from our counseling. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
- 5) If you reveal that a child or adult has suffered abuse or neglect, I have an obligation to report this information to the appropriate authorities.
- 6) If information you have revealed to me is subpoenaed, disclosure may be required by law.

If possible, I will attempt to discuss any required breaches of confidentiality with you prior to doing so.

### ACKNOWLEDGEMENT OF PRIVACY PRACTICES

You have been informed of your rights to privacy regarding your protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). This information is used to:

- Provide and coordinate your treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain third party payment for your mental health care services.
- Conduct normal mental health care operations such as quality assessment and improvement activities.

You have been informed of Family Counseling Associate's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of your protected mental health information. You have been given the right to review and receive a copy of such *Notice of Privacy Practices*. You understand that your mental health provider has the right to change the *Notice of Privacy Practices* and that you may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment or mental health care operations and that we are not required to agree to your requested restrictions, but if we do agree then we are bound to abide by such restrictions.

### **VII. Supervision and Consultations**

I sometimes seek supervision and consultation with other professional therapists and counselors about the clients to whom I am providing counseling services. Doing so enhances the services I can offer to you as a counselor. Supervision and consultations always maintain your confidentiality. Supervision and consultations for the possibility of referrals to other healthcare providers are particularly important if I feel that I can not provide you with adequate care (i.e. referrals for medical concerns, additional areas of specialty, etc.).

### **VIII. State Regulations for Professional Conduct**

The State of Indiana Department of Health as well as the Indiana Professional Licensing Agency oversees and regulates the practice of mental health counselors in order to ensure the health and safety of the public. If you believe that I have acted unethically or unprofessionally in my (cont.)

work with you, I ask that you address the issue directly with me. Additionally, you may direct a complaint to the authorities of the state:

Office of the Attorney General  
Consumer Complaint Division  
402 West Washington Street, 5<sup>th</sup> floor  
Indianapolis, IN 46204  
(317) 232-6330/1-800-382-5516  
<http://www.indianaconsumer.com/filecomplaint.asp>

**IX. Additional Communication**

If you need to communicate with me outside of your scheduled session time, you can call 317-585-1060. The office staff of Family Counseling Associates will be available to take your call, or you can leave a message for me on the confidential voicemail (x45) and I will attempt to return your call with 24 hours. I will generally limit phone communication to session scheduling and emergencies, and reserve the right to charge a fee for the phone call proportionate to the regular session fee. I will generally limit communication via email for the purpose of transmitting electronic documents/information (i.e. intake form, inventories online, etc.)

**X. Emergencies**

If you are experiencing an emergency and cannot reach me via the number listed above, please call one of the following numbers:

- General Emergencies: 911
- Mental Health Association of Greater Indianapolis 24-hr Hotline: 317-251-7575
- Family Counseling Associates, Inc. On-Call Therapist: 317-585-1060, press 1.

*I have read and understand all of the information presented above in this form, and I have received my personal copy of this document.*

\_\_\_\_\_  
Client's Name (Printed)

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Name (Printed)

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent/Guardian (If Applicable)

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Family members also covered by this acknowledgement:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**INTAKE FORM**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Alternative Phone:** \_\_\_\_\_ (work, mobile)  
Can I leave a voice message for you?  home  work  mobile

**Email address:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Sex:** M / F **Date of Birth:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Relational Status** (circle one): Single Married Separated Divorced Living w/Partner Widowed

**Spouse/Partner's Name** (If Applicable): \_\_\_\_\_

**Children's Names & Ages** (If Applicable): \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Reason for seeking counseling at this time:**

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**Please circle any of the following that apply to you:**

- |                 |                   |                         |                   |
|-----------------|-------------------|-------------------------|-------------------|
| Anxiety         | Depression        | Fears/Phobias           | Eating Disorders  |
| Sexual Problems | Suicidal Thoughts | Separation/Divorce      | Relationships     |
| Finances        | Drugs/Alcohol Use | Career Choices          | Anger             |
| Self-Control    | Unhappiness       | Insomnia                | Spiritual Matters |
| Work/Stress     | Health Problems   | Cutting/Self-Mutilation | Thought Patterns  |
| Other: _____    |                   |                         |                   |

**Primary physician's name, address, and phone number:**

\_\_\_\_\_

**List any surgeries, accidents, or serious illnesses and their respective dates:**

\_\_\_\_\_

**Have you ever participated other psychological/psychiatric care, including alcohol/drug treatment before? Y / N** If yes, please list with whom, when, the purpose of the care, and the results:

\_\_\_\_\_

\_\_\_\_\_

**Have you ever been prescribed medication for a psychiatric or emotional reason? Y / N**  
If yes, please list the medication, who prescribed the medication, when, and the results:

\_\_\_\_\_

**Please list all medications you are currently prescribed:**

Medication _____	Dosage _____	Frequency _____	Prescribed by _____
Medication _____	Dosage _____	Frequency _____	Prescribed by _____
Medication _____	Dosage _____	Frequency _____	Prescribed by _____

**Overall Physical Condition:** Good Average Poor **Recent Weight Loss/Gain:** \_\_\_\_\_

**Is there anything else you think I should know prior to our first appointment?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Legal Guardian (If applicable)

\_\_\_\_\_  
Date