

**Sterlingworth Neurofeedback & Counseling, LLC**  
 Mary Blair Dellinger, LPC, BCN, QEEG-DL  
 Licensed Professional Counselor (#7808) in South Carolina, Board Certified in Neurofeedback  
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## **Professional Disclosure Statement and Consent for Treatment**

*Welcome to Sterlingworth Center! As a client, our foremost priority is offering you the help you need to achieve your personal goals. We are collaborative and proactive with our clients, and once we determine what your symptoms are, we then develop tools to help you handle those situations.*

### **Professional Disclosure**

Therapy sessions consist of integrating neurofeedback and mental health counseling depending on the individual client's needs. Services include personalized treatment for children, adolescents, and adults who suffer from a wide range of challenges including: Neurodevelopmental Disorders, Anxiety Disorders, OCD, Mood Disorders, and Neurocognitive Disorders (Traumatic Brain Injury/Concussions)

#### **Qualifications:**

- South Carolina Licensed Professional Counselor -License Number 7808
- Board Certified in Neurofeedback by the Biofeedback Certification International Alliance (BCIA)
- Board Certified at the Diplomate level with licensure by the International QEEG Certification Board (IQCB)
- Specialized training in use of advanced neuroimaging procedures such as Low Resolution Electromagnetic Tomography Analysis (LORETA) and Quantitative EEG (QEEG)
- Master's Degree in Professional Counseling from Liberty University in Lynchburg, VA
- Bachelor's Degree in Psychology from University of South Carolina in Columbia, SC

### **Confidentiality:**

Our counseling, coaching, psychological and consulting services are confidential. Our team of mental health professionals hold our services in the highest of confidence. Even if, by chance, you should encounter your therapist in the community, we leave it up to you to decide if you want to acknowledge knowing us. Again, this is to assure your confidentiality. Some limits do exist regarding confidentiality. I am mandated by standards - through Duties to Warn - to break confidentiality if I discover:

1. a client threatening self-harm or suicide
2. a client threatening to harm another or homicide
3. a child has been or is being abused or neglected
4. a vulnerable adult has been or is being abused or neglected

### **Physical Contact:**

During the course of neurofeedback sessions physical touching and positioning of your body may be necessary to place an electrode cap, assess your muscular and bodily reactions to specific changes, as well as to ensure that you are in a proper posture and body alignment. Occasionally, I will be gently placing my hands on the client's body (over the clothes) or around the face in order to assess and help decrease muscle tension. This may include light physical touch on the forehead, jaw line, neck, shoulders, and/or abdomen. If you have reservations about being touched (or about your child being touched) in the manner described above please let me know now. Neurofeedback training is a process of providing information to the client about brainwave and/or other physiological activity. Sensors are attached the forehead, the earlobes and the scalp to gather information. The sensors simply measure activity in the systems monitored. There is the remote possibility that some individuals may develop skin irritation from the sensor paste or cleaning materials; however, these universally accepted techniques have been used for many years with no significant deleterious side effects reported. The feedback information is seen on a computer screen and/or heard through speakers or earphones.

The client is able to see and/or hear indications of change in physiological activity. By practicing self-regulation techniques, the client can learn to correct dysregulation in the system(s) being monitored.

### **Termination of Therapeutic Services:**

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Therapist may determine to terminate treatment if client defaults on payment and/or if it becomes evident that treatment is not being effectively used after appropriate discussion about the decision with the client. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

### **Ethics:**

I follow the Code of Ethics of the American Counseling Association and the South Carolina Board of Examiners for Licensed Professional Counselors. Any type of sexual behavior between therapist and clients is unethical. It is never appropriate and will not be condoned.

### **Legal Proceedings:**

**I do not testify in court cases or give depositions.** If you are working with an attorney at any time, please make sure your attorney is aware of my limitations in legal proceedings.

### **Scheduling Appointments:**

Appointments can be scheduled, canceled, or rescheduled using the online scheduler at: <https://mary-dellinger-schedule.as.me/>

Appointment types include: (1) Initial Qeeg Intake (Neurofeedback clients only); (2) Neurofeedback Session; (3) Counseling Session; and (4) Virtual Counseling (Teletherapy). Please select the appropriate appointment type based on what you have discussed with the therapist.

Regular sessions are important to facilitating your progress and creating change. We ask you to commit to the therapy sessions and to **notify us at least 24 hours in advance** should you be unable to attend your scheduled session. **A minimum of 2 sessions a week is required for the first month when beginning Neurofeedback treatment.** It is strongly recommended that the client not go more than 5 days between sessions during the first month of neurotherapy. This is to help ensure that you receive the most effective treatment for training your brain toward enhanced stability and improved functioning. Counseling appointments are scheduled either weekly or biweekly, depending on the individual client's needs and therapist's availability. Requests to change the length of an appointment need to be discussed in advance with the therapist in order for time to be scheduled.

### **Missed Appointments:**

If a client cannot make his or her appointment and does not contact me **24 hours in advance to cancel the session, then the client will be held responsible for the full cost of the missed appointment** unless otherwise specified. If you are late for a session, you may lose some of that session time.

### **Billing and Payments:**

The fee for an initial QEEG appointment is \$500, this includes the EEG data acquisition, analysis, and summary of the findings. The fee for an approximately 90 minute Neurofeedback session is \$175. The fee for an approximately 90 minute counseling and virtual counseling session is \$150. The fee for an approximately 60 minute counseling and virtual counseling session is \$120. I accept **payment via venmo, zelle, cash or check.** **Payment with a card (including HSA & FSA) through Square is also acceptable. I use the Headway platform for all insurance payments and billing.** For clients using insurance to pay for sessions, the Headway team will reach out with an email to help you set up your account and add your insurance and payment details. You'll see your cost per session ahead of time and can check your benefits through the client

portal. Clients using insurance to pay for sessions are required to pay any remaining balance not covered by insurance.

Payment in full is expected at the time of each appointment unless alternative payment arrangements are agreed upon prior to beginning treatment. I am an out of network provider and therefore am unable to take payment directly from any insurance. I will provide clients with a superbill with information they may need to submit a claim with their insurance company for reimbursement purposes. I will also provide clients with a list of questions that they can ask their insurance company about reimbursement options. Please note that should fees increase, Mary Blair Dellinger will give clients a minimum of 30 days notice before price increase goes into effect.

#### **Use of Diagnosis:**

Some health insurance companies will reimburse clients for counseling and or neurofeedback services and some will not. In addition, most will require that a diagnosis of a mental-health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

#### **Disclaimer:**

In all cases, it is the responsibility of each client, or his/her parent or legal guardian, to seek appropriate professional treatment for any symptoms of disease and/or debilitating mental disorder that they may be experiencing prior to or during Neurofeedback therapy. In no case during treatment, shall Sterlingworth Center or Mary Blair Dellinger be held liable for lack of change in or intensification of symptoms which might occur during the course of Neurofeedback treatment or thereafter. Mary Blair Dellinger is not able to guarantee that a personal problems or symptoms (either expressed or implied) presented by a client or by a client's parent will be resolved by Neurofeedback treatment.

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If I have any questions regarding this consent form or about the services offered at Sterlingworth Center, I may discuss them with Mary Blair Dellinger. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me at Sterlingworth Center. I understand that I may stop treatment at any time.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

**Print Name**

**Client/Parent/Guardian (circle one):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_