



**Renew Your Life Counseling, L.L.C.**  
**Declaration of Practices and Procedures**

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Counseling can be conducted in varying ways, depending on the counselor. As my client, you have the right to know my qualifications, methods, and mutual expectations of our professional relationship, as detailed in the following document, in order for you to decide if my services are suitable for your needs. While we will discuss this document together, feel free to address with me any questions or concerns that may arise about anything in this document at any time after our discussion.

**Qualifications:** I hold a Masters of Science Degree in Clinical Mental Health Counseling Degree from Loyola University. I am also a National Certified Counselor (NCC) with the NBCC and my Certification # is 319952. My License number in the State of Connecticut is 2706, in the State of Hawaii is 394, in the State of Illinois is 178.011508, in the state of Louisiana is 7025, in the State of Missouri is 2017009374, in New Mexico is CTB-2023-0885, in Puerto Rico is 4353, in South Dakota is 20951, and in Texas is 88647.

**Counseling Relationship:** I see counseling as a process in which you, the client, and I, the Counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life, and work in a systematic fashion toward realizing those goals.

Although counseling is highly personal in nature, it is essential to remember that our relationship is a professional rather than a personal one. I believe that you will benefit the most if our relationship remains focused on your concerns.

The length of counseling varies due to individual circumstances and situations. As long as you are benefiting from counseling, I recommend that you continue attending sessions. However, I will let you know when it is my professional opinion that you no longer need counseling. Counseling is completely voluntary, and you may terminate counseling at any time.

**Areas of Expertise:** I focus on clients with relationship, marriage, and family issues and sex therapy, as well as client issues relating to anxiety, depression, grief/loss, and emotional, career, and life difficulties. I work with adolescents, adults, and couples in a variety of settings, such as individual therapy, family/couples therapy, and group therapy.

**Fee Scales/Rescheduling:** The fees for counseling are generally \$100 per hour for most types of counseling. Other sessions/services may vary in price, and other discounts may apply. Several different insurance plans are accepted as well. If you are using insurance, you will be responsible for any applicable co-pays/co-insurance charges/deductible charges. Sessions are 60 minutes in length, and I require that you contact me by phone or email (email preferred) no less than 24 hours before a scheduled appointment to cancel or reschedule. If you fail to cancel or schedule at least 2 hours prior to your scheduled appointment, you will be billed in full for the missed session. Should an extenuating circumstance arise, I ask that you contact me by phone or email as soon as possible. **As the client, you are expected to, and have the responsibility of, attending scheduled counseling sessions consistently every week. If you are not able to attend, you have a duty to be prompt in canceling or rescheduling sessions as soon as possible. A lack of attendance will have a significant effect on your progress in the counseling process, and may impede your ability to reach the stated therapy goals.**

**Services Offered and Clients Served:** The theoretical approaches and counseling strategies I operate from in session are dependent upon the specific characteristics of each client and the types of issues presented by the client. In the course of establishing a good, safe, and trusting counseling relationship and alliance, I may implement interventions using a variety of theoretical approaches that may include, but are not limited to, strategic and solution focused therapy, structural and family systems therapy, and cognitive-behavioral therapy. I see clients of all ages and backgrounds, with the exception that I do not work individually with children under seven years of age.

**Code of Conduct:** As a Clinician, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available to you upon request.

**Privileged Communication:** Material revealed in counseling will remain strictly confidential except for material shared in consultation/supervision and under the following circumstances in accordance with state law:

- 1) The client signs a written release of information indicating informed consent of such release,
- 2) The client expresses intent to harm him/herself or someone else,
- 3) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult,
- 4) A court order is received directing the disclosure of information.
- 5) As a Counselor, I participate in Supervision and Consultation in which material from our sessions will be shared and discussed. My colleagues in supervision/consultation are bound by the same rules and regulations with respect to maintaining the confidentiality of all material shared from our sessions.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family members only with the client's written permission. Any and all material obtained from a minor client may be shared with the client's parent or guardian.

**Emergency Situations:** If an emergency situation should arise, you may seek help through your nearest hospital emergency room facilities or by calling 911. For international clients, you may seek help by calling your local emergency services number and through your nearest hospital emergency room facilities.

**Client Responsibilities:** You, the client, are a full partner in counseling. Your honesty, effort, and transparency are essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me promptly so that we can make the necessary adjustments. You, as the client, are responsible for making all final decisions regarding your treatment. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

**Physical Health:** Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so and to list any medications that you are now taking. In many cases, mental health difficulties/symptoms may be linked to a physical health issue/illness and physical health examinations/consultations can assist in the success of your overall treatment.

**Potential Counseling Risk:** The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, you should feel free to share these new concerns with me.

**I have read, understand, and agree with the above information, and I understand that my digital signature constitutes a legal signature confirming that I agree with the above information.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Minor Clients:**

I, \_\_\_\_\_, give permission for Basem Darwish, M.Sc., LMHC, LPC, NCC to conduct counseling with my (relationship): \_\_\_\_\_

Name of Minor: \_\_\_\_\_

Signature of Minor: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Counselor: \_\_\_\_\_ Date: \_\_\_\_\_