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Informed Consent for Counseling Services: Treatment, Disclosures, Payment Information, & Privacy Rights

THERAPIST CREDENTIALS: I am a master's level Licensed Mental Health Counselor (LMHC), Licensed in the State of Washington, LH60210343. I have completed a CACREP accredited Master's degree program, and a one year approved clinical internship; I have also completed post- graduate: 3000 hours of supervision by a licensed clinician, and have passed the National Board of Certified Counselors examination. I am a Mental Health Professional (MHP), and I am intensively trained in Dialectical Behavioral Therapy.

RISKS OF THERAPY: There are few known risks associated with Counseling. However, some people report a heightened emotional awareness which can bring on stronger emotions. In some cases, people feel more depressed and have thoughts of suicide. Also, as you grow and learn things about yourself, your relationships with others may change.

CLIENT RIGHTS: Clients have the right to: 1) be treated with respect and dignity in the therapeutic environment; 2) confidentiality and privacy; 3) refuse or terminate counseling at any time; 4) not be discriminated against; 5) obtain a copy of client records or request to amend a record; 6) to file a formal complaint against the therapist. If the client desires to terminate the counseling contract, it is helpful when this is discussed in advance, so that proper closure, including referrals, when appropriate, can be provided.

TREATMENT: I typically see clients once a week unless sessions are arranged otherwise. Clients may schedule appointments as needed according to their therapeutic goals. Treatment may last anywhere from short term (10-12 sessions) to long term (up to several years), depending on client symptom relief and perceived change. Counseling is a process of change and will not happen overnight. A client may choose to continue maintenance counseling as desired, unless it is determined that sessions are no longer helpful or otherwise unnecessary. I help clients develop a treatment plan to track their progress in life domains and create goals that are meaningful and measurable. Exceptions made at discretion of therapist.

CONFIDENTIALITY: I maintain the confidentiality guidelines of the Washington Administrative Code (WAC), the Health Insurance Portability and Accountability Act (HIPAA) and the American Counseling Association (ACA). I will not disclose any personal or identifying information to anyone outside the therapist-client relationship without a client's written authorization. Specific to child therapy, I will not testify in court in regards to my therapy with your child, unless mandated by the court. Exceptions to confidentiality include: 1) evidence suggests physical, sexual or emotional abuse and neglect of a child, a disabled individual, or the elderly, 2) the client presents with suicidal ideation and refused to comply with safety commitments, 3) the client reports a plan to harm a specific-named individual, 4) where permitted by or required by law (i.e., insurance agreement, legal subpoena), 5) consultations with my DBT consult group. These conversations with my consultants will take place in an area and in a manner in which they will protect your privacy. My duty to provide confidentiality will survive the death of a client unless otherwise authorized by the client prior to death.

RECORD KEEPING POLICIES: I will maintain documentation of all consents, authorizations, notices of privacy practices, Office Policies and Procedures, trainings, and patient requests for records or amendments to records. I will document complaints received and their disposition. Client records will be kept locked in my office or in a locked file cabinet offsite. I will keep client records for seven years from the date of the last treatment session. With respect to the records of a minor, I will keep those records for at least seven years or until the patient is twenty- one years old, whichever is longer. Thereafter, I may destroy client records. When records are destroyed they will be done so in a manner that protects client privacy and confidentiality.

COVERAGE IN MY ABSENCE OR DEATH: There may be times when I take vacation. If you feel you would like to meet with another clinician in my absence, I will talk to you about having access to one of my colleagues in the office. In the case of my death, the custodian of your records is a designated colleague in my office. Exceptions made at discretion of therapist.

CRISIS CONTACT INFORMATION: If a client is in crisis and unable to reach me, please call the 24 hour Crisis Clinic Line toll free 1-866-427-4747 or TDD Line access 206-461-3219. If you have life threatening emergency, call 911 immediately or go to the nearest hospital emergency room. I will designate an on-call therapist for coverage in the case of my own personal emergencies or vacation. Please be aware, my email address is not a crisis resource, is not checked regularly, and is only to be used for scheduling or cancellations.

FEES AND BILLING PRACTICES: My fee for a 75 minute intake assessment is $225. For a 50 minute session is $150. Fees are to be paid at the beginning of the session unless discussed otherwise. I accept cash, check, or credit cards. I take exact change only, as I do not keep a cash box or safe on the office premises for change. If a client is unable to pay the service fee, I have the right to terminate therapy and refer the client to a low cost counseling center. There is a $25 fee for any returned checks. I am open to phone calls between sessions and phone calls that last more than 15 minutes will be charged at my hourly rate. Work such as writing assessments or letters on your behalf or talking to other care providers will be charged at my hourly rate. It is my policy not to become involved in clients' legal matters (e.g. divorce, custody, immigration, etc.) If subpoenaed to testify in court regarding you and your psychological work with me, my base fee would be $375/hour and additional fees may apply. Exceptions made at discretion of therapist.

CANCELLATION POLICY: I have a 24 hour cancellation policy. If you are sick or otherwise unable to make it to the scheduled appointment, you must contact me at least 24 hours before the appointment. Failure to do so will result in being charged the full session rate. This fee will be due at the beginning of the next session. Exceptions made at discretion of therapist.

CORRESPONDENCE: If a client chooses to contact me via cellular phone, text message, email, or fax, she/he understands complete client privacy and confidentiality will be at risk due to intercepted calls, technological hackers, or accidentally dialed fax numbers. Clients are responsible for advising me if there is not a safe phone number or address to be contacted, otherwise, I have the right to attempt contacting clients according to the information provided by the client on the registration form.

ACCOUNTABILITY: It is my philosophy that counseling and consultation is a joint effort. Your active participation is a key factor for successful outcome. We will jointly create a plan for treatment based on your needs and goals. At times, individuals will experience the services offered to result in emotional discomfort, changes in relationships, and temporary worsening of symptoms. These difficulties typically subside as our work together progresses. However, it is important that you share this information during sessions. Please feel invited to bring up any needs, requests, concerns, or questions at any time. Remember, you always have the right to request changes in, or to refuse, treatment at any time. Termination of Counseling Services is assumed after 4 consecutive missed sessions, and at that time, your file will be closed.

CLIENT AGREEMENT

By signing this form below, I acknowledge I have read and understand the above therapist disclosure, consent to receive counseling services, client responsibilities and treatment contract. I have received copies of the HIPAA privacy practice guidelines. I agree to abide by the above client responsibilities and to actively participate in the counseling environment. I understand that if I withhold important critical information from my therapist, I will be interfering with my own counseling progress and I will potentially jeopardize the therapeutic process. I understand my rights as a client. I have been given the opportunity to ask questions. I understand this is a legal document and contract. I have been given a copy of this contract.

Client name ____________ Client signature ____________ Date

Client name ____________ Client signature ____________ Date

Client name ____________ Client signature ____________ Date

Client name ____________ Client signature ____________ Date

Therapist name ____________ Therapist signature ____________ Date

Treatment of a child under the age of 13: Parent/legal guardian name, Signature, & Date