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Disclosure Statement and Agreement for Services

My Background:

In 2013, I graduated with a Masters of Arts degree in Clinical Counseling from the University of Northern Colorado. I started my experience in counseling with an internship at RSA, Inc., an agency providing sex offense specific treatment with individual and group therapy. In 2014, I worked at Sound Mental Health for two years providing therapy and case management for individual adults and groups. I prefer an eclectic style of therapy to best meet the needs of each client which include Client-centered, Motivational Interviewing, Narrative, Solution-focused, Mindfulness, Internal Family Systems and Cognitive Behavioral Therapy models.

Confidentiality and Privacy:

I will keep confidential anything you say to me, as well as the fact that you are my client, with a few exceptions by law. See the Ethics and Professional Standards section of this document to review these exceptions.

Be aware communication by email and voicemail is not confidential. I generally limit communication with email and voicemail to scheduling needs. If you prefer a HIPAA compliant and confidential means for scheduling, I encourage you to use the Simple Practice Secure Messaging through your Simple Practice Client Portal.

Please note writing an online review of my services, whether positive or negative, will violate your confidentiality and privacy. I strongly discourage using this method to provide feedback due to the permanent violation of your privacy and confidentiality as a client. I follow the ethical standards provided by the American Counseling Association. If you are needing to report a violation of these ethical standards please follow the procedure listed in the Ethics and Professional Standards below.

Our Relationship:

I believe in counseling as a collaborative process between the client(s) and therapist. I greatly value your input regarding what you feel is helping or not helping in your therapy. I also welcome any questions you may have during our work together. Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the paid sessions you have with me, and that we do not have a social, romantic, or sexual relationship with each other.

Fees and Payment:

When paying as a private pay client, the agreed upon session fee of $150.00 will be billed for a 50 minute session. This fee is payable in cash or check at the beginning of each session or using a credit card through Stripe on your Simple Practice account. Your credit card will be automatically charged at the end of day when scheduled.

I accept Kaiser Permanente, First Choice and Premera insurance as an "In Network Provider". For all other insurance networks, I can provide a monthly statement for you to submit to your insurance provider for "Out of Network" benefits. Insurance sessions are billed at a contracted rate determined by your insurance company. Feel free to ask me any questions regarding what to expect from insurance coverage payments and billing, and I will give as accurate information as possible. In order to thoroughly understand your mental health benefit coverage, please call your insurance provider prior to our first meeting to be informed of your yearly deductible and your copay or coinsurance. It is your responsibility to learn about your particular insurance plan. The number for your insurance company should be listed on your insurance card.

If you request my witness in court my rate is $225.00.

Under Washington State Law, you are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement.

Appointments and Cancellations:

Please understand text messaging or email are not considered private and confidential. Confidential communication is available to you through your Simple Practice Client Portal.

You may choose to schedule appointments by Simple Practice Secure Messaging, email, phone or texting. If you need to cancel an appointment, please notify me at least 48 hours in advance. If you do not show for an appointment you will be charged a **"No Show Fee"** of $150.00. If you call and cancel with less than 48 hours notice, you will be charged a **"Late Cancelation Fee"** of $150.00. If you are on a sliding fee rate less than $150.00 a **"No Show Fee"** or **"Late Cancelation Fee"** will be charged at your agreed upon sliding fee rate.

Mental health treatment requires regular meetings, therefore we will no longer be working together with a lapse in meeting for longer than 30 days.

Use of Telehealth for Therapy:

I use Telehealth for conducting therapy when in person therapy is not an option due to my extenuating circumstances. The use of Telehealth for your therapy treatment will be decided on with consideration to what is clinically appropriate to maintain progress in treatment in addition to accommodating unavoidable circumstances causing disruption to the initiation of or continuity of therapy. I do not use Telehealth therapy as a primary way of delivering therapy. If Telehealth is your preferred way of receiving therapy for convenience or long term accessibility needs, then we may consider a referral to a Telehealth Therapist.

Any changes in therapy location from in person to Telehealth must be proposed and agreed upon at least 48 hours prior to the scheduled session time. If changes to the therapy location need to be made from in person to Telehealth within the 48 hour window prior to your session time, then this will be considered a **"Late Cancelation"** with the **"Late Cancelation Fee"** of $150.00. This policy is here to encourage intentional use of Telehealth as a tool for delivering therapy when needed and to avoid this being used only for convenience.

When attending a Telehealth session you must be in a private space with sufficient connection to WI-FI. The privacy of your space is imperative for the effectiveness of therapy. If you are not able to have privacy from others for your Telehealth session, then the session must be canceled and the **"Late Cancelation Fee"** will apply.

Emergencies:

If you need to contact me between sessions, call me at 206.659.9210. If a phone contact of more than 10 minutes is necessary, a fee will be charged at my usual hourly rate. If in crisis, **please call the 24-hour Care Crisis Line at 206.461.3222**. In the case of life threatening emergencies please call **911** or visit your local **emergency room**.

Ethics and Professional Standards:

I honor all regulations in the Counselor Credentialing Act (18.19 RCW). The purpose of the law is:

(A) To provide protection for public health and safety

(B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. You have the right to choose counselors who best serve your needs and purposes.

As a psychotherapy client you have privileged communications under state law. With the exceptions of situations listed below, you have the right to have information shared in therapy sessions to be held in the strictest confidentiality, including the fact that you are seeing me for psychotherapy. The privilege is yours, not mine, and cannot be waived without your written consent. I will always act to maximize your privacy even when you waive your confidentiality.

The following are exceptions to your right to confidentiality:

1) If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.

2) If I believe that you may be physically or sexually abusing or neglecting either a minor child or a vulnerable adult, or if you report information to me about the possible abuse of a minor child (under 18 years of age) nor vulnerable adult (one who is dependent upon another adult for physical and/or emotional caretaking, unable to do so for themselves), I am required by law to report this to either Child Protective Services or Adult Protective Services, state agencies.

3) If you submit claims to your insurance company, they will likely require some information regarding your treatment with me. You have the right to know the diagnosis that I may use in communication with them or their related third-party payer. All diagnoses I use are found in

the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), Fifth Edition. A copy of this book is available in my library and you are free to read it.

4) The court may require such information and at that point we would discuss together how to proceed.

For specific details about exceptions, please refer to the Counseling or Hypnotherapy Clients brochure provided to you. Should disclosure of confidential information be necessary, I will work with you as respectfully and directly as possible.

If you have any concerns about your experience, please discuss it with me. If you feel I have been unethical or unprofessional, you can contact the Washington State Department of Health, Health Professions Quality Assurance Division, PO Box 47869, Olympia, WA 98504-7869. You may also call (360) 236-4902 Mondays through Fridays 8AM to 5PM.

State of Washington Disclosures:

The State of Washington requires that I provide you with the following information.

You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Therapist who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of public health and safety. Credentialing of an individual with the Department of Health does not include recognition of any practice standards, nor necessarily imply the effectiveness of treatment.

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

_____	_____
Client's Signature	Therapist's Signature
_____	_____
Printed Name	Date
_____	
Date	