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COUNSELING DISCLOSURE STATEMENT AND INFORMED CONSENT

Washington State law requires that therapists provide clients with written information about their education, qualifications, treatment philosophies, and service policies. It is your right and responsibility to choose the provider and treatment modality that best suits your needs and objectives and also your right to refuse treatment at any time. Please read the following information carefully and ask me any questions that you may have prior to signing this form. The course of treatment will be determined by your self-identified goals and needs.

My Approach to Counseling

I believe counseling is a collaborative work between the counselor and the client. While my expertise is human behavior I believe clients are experts on their lives and I see my role as helping people navigate their own lives better. The course of treatment will vary with each client's unique needs and goals and we will typically begin with defining what it is you want to work on. I believe that most of our problems and pain are experienced in relationships so examining past and present relationship dynamics will typically be a part of our work. I use a combination of psychodynamic theories with strengths based and cognitive behavioral interventions to help clients develop awareness and practical ways to deal with different issues. I'm a spiritually inclined person and am willing to help clients engage their own spiritual beliefs in therapy but this is absolutely at the discretion of the client as my goal is always to work within your values and belief system. I will always honor the client's right to refuse treatment if they do not feel I am well suited to serve them and would do my best to refer them to a more suitable therapist.

My Education

I hold a Bachelor's degree in Psychology from Texas A&M University and a Master of Arts in Counseling from Western Seminary. As an LMHCA I'm currently under the supervision of Doug Chapman LMHC, Washington License Number LH00006800. I regularly consult with Doug to ensure my clients are receiving the best care possible. With that being said I make a concerted effort to protect client's identity when consulting with my supervisor and He is required by ethical standards to honor client confidentiality.

Client Rights and Confidentiality

You have the right to ask questions about your treatment at any time and to receive respectful treatment. You have the right to refuse treatment or end therapy at any time. Your treatment is confidential and protected under HIPAA guidelines. I will not release information about you without your expressed written permission with exception to certain instances which I am required to breach confidentiality. These exceptions include the following: a legal subpoena, a suspected instance of abuse of a child or vulnerable adult, an instance where I believe a client to be in immediate danger to him or herself or

others, in the case of a complaint brought against me by a client, and for the purpose of consultation with my supervisor, Doug Chapman, Washington LMHC License no. LH00006800. Additionally if insurance is being utilized, insurance companies may request information about your treatment.

Payment and Fees
Payment must be made at the time of session by check or cash and sessions can be paid for in advance, with the payment to be refunded if clients cease therapy. Clients are expected to pay their full fee if they cancel or reschedule a session less than 24 hours before the scheduled time or do not appear for a scheduled session. Additionally clients are responsible for a prorated hourly fee charged for any phone calls made by the counselor at your request; prorated hourly fees are assessed at 7-minute increments. My standard rate is $90 for individual sessions and $110 for couples' sessions. I do see a limited number of clients at a reduced rate if cost presents a hindrance to counseling.

Potential Risks and Benefits of Counseling:
Like any healthcare service, there are potential risks and benefits to engaging in counseling. The following highlights some common risks and benefits associated with counseling however this list is not intended to be a comprehensive list and clients engaging in counseling services may have experiences that differ from the below information. During counseling you may experience:

Potential Risks:
- Uncomfortable feelings of sadness, guilt, anxiety, anger, or frustration
- Counseling may bring up painful memories
- You may not experience progress or growth or it may take some time
- In the beginning some behaviors and feelings may be exacerbated
- Others in your life may not support your decision to seek counseling or support the changes you implement in your life due to counseling.
- If you apply for a job that requires a security clearance, an in-depth background check may be conducted and your mental health treatment history may be cited as grounds for denying you employment or advancement

Potential Benefits:
- Improved relationships
- Improved communication skills
- Improved ability to cope with unwanted emotions
- More developed sense of self-awareness
- Improved internal regulation skills
- Healthier lifestyle and habits
- Increase in experience of emotions such as joy, calm, and freedom

Washington State Department of Health/Complaints
If at any point in time you wish to file a complaint you may do so by contacting the Washington Department of Health at:

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Email: HSQAComplaintIntake@doh.wa.gov
Phone: 360-236-4700

I, _____, have read and understand this statement and have discussed any questions I had regarding the information presented. My Signature indicates that I am comfortable with the terms and conditions of therapy as outlined and with signature, receipt of this form was witnessed and a copy was offered to me.

Client Signature _____ Date _____

Client Signature _____ Date _____

Counselor Signature_____ Date _____.

I,_____, acknowledge that I have been provided with a copy of the Notices of Privacy Practices and have been given an opportunity to ask questions in regards to this information.

Client Signature _____ Date _____

Client Signature _____ Date _____

Counselor Signature_____ Date _____.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to

make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many

conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of

information here. If no laws with greater limits apply to your entity, no information needs to be added.

- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

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COUNSELING INTAKE FORM

Please fill out the information below to the best of your knowledge. This will give me some context for the issues you're coming in to talk bout and will help me know how we can best work together. If there is anything you are uncomfortable writing but would like to discuss in person please note that on the form.

Today's Date _____ **Your Name** _____

Date of Birth _____ **Phone Number** _____

Physical Address _____

Email Address _____

Marital Status _____ **Number of Children and Ages** _____

Emergency Contact/Phone _____

Current Work or School _____

Briefly describe why you're coming to counseling _____

_____

_____

Have you ever been to counseling before? Please describe your experience and the reasons for going (please include any previous diagnosis) _____

_____

_____

Current Medications _____

_____

Please mark next to any of the following that are presently concerns for you or have been in the past

___Poor Sleep Habits
___Poor Eating habits/Weight gain or loss
___Unhealthy/Strained Relationships
___Marriage Difficulties
___Divorce/Separation
___Medical Issues
___Substance use (alcohol, drugs, tobacco)
___Impulsive, Compulsive or Addictive Behaviors
___Excessive Sexual Activity (intercourse, pornography, masturbation)
___Problems with Sexual Intercourse
___Sexual/Gender Identity Issues
___Past Abuse (physical, emotional, sexual)
___Traumatic Experience
___Grief/Loss
___Legal Issues (please note below if you were court ordered to attend counseling)
___Other (Please explain below)

Please explain more in depth the issues you marked as concerns.

_____

_____

_____

_____

_____

_____

Have you ever had any thoughts or harming or killing yourself: YES or NO

If Yes please describe when, how often, if you have ever attempted, and the nature of the thoughts or attempt

_____

_____

What do you hope to get out of counseling? _____

_____

_____