**Informed Consent & Profession Practice Disclosure for Psychotherapy**

**Tess Flaherty Counseling, PLLC**

**Tess Flaherty, LMHCA**

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| You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully.This document is to provide you, the client, with information regarding your counselor’s qualifications, methods, and mutual expectations of the professional relationship. The information provided is to help you decide if my services are suitable for your needs at this time. The following statement is required by law: “Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of such treatment.” (WAC 246-810-031) **I. Therapist Disclosure to ClientCredentials:** I am a Licensed Mental Health Counselor Associate in the State of Washington MC61086582. **Education, Training, and Experience:** I received my Bachelor of Arts Degree in Psychology from Central Washington University, and my Master of Education degree in Mental Health Counseling from Northwest University. I have worked in a residential treatment setting for adolescent eating disorders, and have also worked in outpatient settings assisting individuals with a variety of struggles. **Services Provided:** I provide counseling services to adolescents, adults, and families. My therapeutic approach pulls from a variety of counseling techniques that I use, based on the individual needs of the client. My goal is to provide you with counseling services that address your concerns in a respectful and supportive environment. The number of sessions will vary, depending on the type and severity of the problem, as well as your expressed needs and desires. Making changes to long term beliefs and behavioral patterns can take time. I will inform you of your options regarding counseling, and I will respect your needs and desires regarding frequency of sessions, and length of counseling services. **II. Working Relationship** **Confidentiality:** I am compliant with current Federal and State of Washington laws regarding your privacy of personal information. You have the right to be free from being the object of discrimination on the basis of race, religion, gender, or any other lawful category while receiving services. Everything you say during counseling will be kept confidential, including the fact that you are being seen as a client, with the exception of the following: 1. A release of information has been signed by you. 2. Washington State Law requires that others be informed if you threaten to harm yourself, or others. If that threat is perceived to be serious and towards another person, the local authorities and the person against whom the threat is made will be notified. (Duty to Warn.) Recent Washington State Law dictates a duty to warn, even if no specific victim is named. 3. In the event of a court order where I may be required to disclose information in the presence of a judge but will be reviewed with you beforehand. 4. In the event of a medical emergency, emergency personnel may be given necessary information.5. If you bring a complaint against me with the State of Washington Department of Health, information will be released. In order to provide the best possible treatment, I consult with other professionals regarding clients with whom I am working with. These consultations are conducted in such a way that confidentiality is maintained. *PARENTS/GUARDIANS & MINORS:* While privacy in therapy is crucial to successful progress, the involvement of parents/guardians can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents/guardians allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. It is also my policy to require that a parent/guardian be present with the child or adolescent under 18 years of age for the first four sessions so that I can make an accurate assessment about whether individual or family counseling is most indicated. All other communication will require the child’s agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See Adolescent Consent Form, to be signed by both adolescent and parent(s).] For child and adolescent clients, I will not tell your parent or guardian specific things you share with me in our private therapy sessions except for situations such as those mentioned above. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk- taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian. The following are some examples of when disclosing information to parents or guardians might be indicated: Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents/guardians, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. When working with child or adolescent clients individually, I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information. When working with child or adolescent clients individually, sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don’t have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm. Parent/Guardian: Check boxes and sign below indicating your agreement to respect your adolescent’s privacy: 🞎 I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. 🞎 Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent’s treatment. 🞎 I understand that per the Revised Code of Washington 71.34.530, any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen. I also understand that I have a right to participate in decisions about treatment options. 🞎 I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor. **Appointments:** Appointments will be scheduled either through email, phone, or at the end of our session. I ask that you notify me immediately with any emergencies or schedule conflicts that would require you to cancel, giving me a minimum of 24-hour notice. I will charge my full hourly fee for any missed appointments, since they will be considered a no show. I will charge a flat fee of $70.00 for same-day or late cancellations. Please be prepared to pay the appropriate fee from your last appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment. I do take into consideration emergencies that come up within the 24-hour window. It is the pattern of last-minute cancellations that I need to avoid, since it does not allow me to fill the time slot with someone else who needs to be seen. **Fee for Services:** My standard fee is $125.00 per 50-minute session. This is the same fee charged for any missed (“no show”) appointments. I have a strict 24-hour cancellation policy, and charge $70.00 for all same-day cancellation or late-cancelled appointments. Additional fees might include: preparation of requested documents, or copying and sending records. Please note that most documents I will decline to prepare since it is out of the scope of my expertise. I will discuss any fees with you at the time of a request. **Please inform me of any change in your financial situation that impacts your ability to pay for services.** **Payment for Services:** I accept cash, and debit/credit card payments. Payments are due directly to me at the time of service (at the end of each session). I will ask that your credit card information be put on file through a secured HIPPA compliant electronic health records system. If payments are not made in a timeframe we have agreed upon, then I may notify debt collectors. **Insurance:** I am an in-network provider for BCBS- BlueCross BlueShield, Lifewise, and Premera. For all other insurance providers, I am out of network and do not bill directly. I am happy to provide you a receipt that you can submit to your insurance company for reimbursement. You are responsible for securing accurate and up-to-date coverage information. Should insurance claims be denied for any reason other than my error, you are responsible for the remaining balance on your account. Additionally, insurance companies will only pay for services rendered; you will be responsible for the full fee for any missed appointments.  |
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**Record-keeping:** Your confidential information will be managed through an electronic patient health portal called Simple Practice. This includes your private health information, all client forms, financial and contact information, treatment goals, intake and session notes. Washington Department of Health requires me to document according to a medical model. My notes are summarized, and I make every effort not to document sessions verbatim. Washington State law requires the retention of records for seven years after last contact.

**Emergency, Urgent, or Other Contacts:** The best way to contact me is through email, because it is the most efficient way for me to address your needs. It is however not confidential, so please do not communicate emergency or crisis information. You may leave me a voice message at any time. I will make every effort to return your call within 24 hours. I do not provide on-call crisis or emergency services. If you have a physically or psychologically life-threatening emergency, please immediately call 911, and /or the King County Crisis Clinic at (206) 461-3222. The Crisis Clinic has 24-hour availability to offer crisis assistance, community resources, and emergency information.

**Therapy Relationship and Professional Boundaries:** It is my goal to create a safe, respectful, and supportive environment. The therapeutic relationship is the cornerstone of the healing process, and as such it is essential that I adhere to strong professional boundaries. Therefore, I will not have a relationship with you outside of our professional relationship, including social media. I cannot accept gifts from you, other than a card or note. If I were to see you out in public, I will not initiate contact in order to ensure confidentiality. If you choose to initiate a greeting, I am more than happy to reciprocate. I will only provide appropriate referrals to other health professions with your consent. Federal and State of Washington law upholds the confidentiality standards that during the course of therapy and after, our sessions are considered, “privileged”, and therefore neither your death or mine terminates your confidentiality rights.

**Therapeutic Work, Duration, and Termination:** You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person. If more than 60 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

**BY SIGNING AND INITIALING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Counselor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Confirmation of informed consent:***

\_\_\_\_\_\_ I have read the Disclosure Statement for Theresa “Tess” Flaherty and I understand it.

\_\_\_\_\_\_ I am clear that I can ask questions at any time and be provided further explanation pertaining to the Disclosure Statement.

\_\_\_\_\_\_ I give my consent for treatment as outlined in this Disclosure Statement.

\_\_\_\_\_\_ If requested, I have a copy of this Disclosure Statement with my signature.

\_\_\_\_\_\_ I understand and agree to abide by the 24-hour cancellation policy. I understand that if I do not give 24-hour notice, I will be billed $70.00 for the session I cancelled. I understand that I will be billed the full fee for any missed (“no show”) appointments.

\_\_\_\_\_\_ I understand that my therapeutic relationship with Tess Flaherty may be discontinued if the terms in this agreement are not fulfilled by either of us.