DISCLOSURE STATEMENT

NPI #: 1851780340 LMHC #: LH 61235396
Outside the Line Counseling & Art Therapy
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WAC246-809-710 requires the disclosure of the following information in written form by counselors to their clients.

Please take the time to carefully read this disclosure statement. As my client, you have the right to know my qualifications, methods, and mutual expectations of our professional relationship. The information presented here is provided to help you decide if my services are suitable for your needs. Please discuss any questions or concerns you may have either now or during the course of your treatment.

My qualification and license

I am a licensed independent Mental Health Counselor in Washington State (license number LH 61235396). I am also a registered art therapist provisional (Credential #: 21-460) with the Art Therapy Credentialing Board. I received my Master's Degree in Counseling with a specialty in Art Therapy from Antioch University, Seattle.

My professional background involves eleven years of working in community mental health with diverse populations ranging from adolescents, children, adults and geriatric psych clients, mostly in residential facilities and adult family homes where symptoms were severe. My experience as a mental health counselor equipped me to work with clients with a wide range of issues including anxiety, depression, conduct disorders, psychosis, dementia, eating disorders, trauma, mood, substance abuse, and obsessive compulsive. My specialties are focused in trauma, psychosis, mood, depression, anxiety, and personality disorders. I utilize Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT) and Art Therapy with a mindful and client focused approach.

The Therapeutic Process

I believe that therapy is a partnership. We as a team will begin to explore patterns and identify triggers that are the foundations of your distress and desire for treatment. It is my passion to develop a genuine relationship with my clients and hold space so we can safely have difficult conversations.

Past issues and memories can and very do often arise during therapeutic sessions. As a human being myself I am not "perfect". I may say or ask questions that can elicit a very strong emotional response. I encourage you to inform me when these do arise, so together we can examine the topic reaction closer. I will encourage you to get curious about your unique self, but at the same time to be gentle with yourself. There are few things that we can actually really control in life, but you can be gentle with yourself. Together we will walk the path to a better understanding of self and how to keep ourselves mentally prepared for the uncontrollable acts and individuals that we will encounter during our lifetime. My therapeutic modality is an integrated approach. I strongly resonate with the Sanctuary Model that stresses that everyone experiences loss and that by providing a safe and healing environment one can work through those difficult experiences. I rely heavily on DBT and some CBT, all at the same time encouraging mindfulness.
Therapy like surgery has its risks and rewards. During your course of therapy, you may experience changes in your symptoms and functioning in the different aspects of your life setting. Since we will be examining what can be distressing areas of your life, you may experience greater difficulty during our work together. I cannot promise nor guarantee the results of your therapeutic journey. Therapy traditionally produces benefits over a course of time. There will be times when painful issues of your past may be intensified. However, I am committed to the therapeutic relationship with my client. I will be there to provide the space for you to process these events and build upon your strengths. It is likely that you will see the benefits of the work you put in reflecting on improvements in the different aspects of your life.

I work with all my clients on a reoccurring, weekly basis. If you cancel several of your sessions, in which I will perceive as a barrier to the positive therapeutic process, I will ask that you be removed from your reoccurring appointment slot and be placed on my on call-list. The on-call list creates sessions based on cancellations. I will reach out to you by phone as those times available. If you do not show up to your appointment without notifying me, all your future appointments will be cancelled until I hear from you.

Client's Rights and Responsibilities
Clients have the right to choose a therapist who best suits their needs and purposes. You may ask questions about treatment at any time and may choose to terminate therapy at any time. Therapy may also be ended when I feel that your needs will be better met by another provider. In that case, I will try my best to make appropriate referrals. If you have any concerns or complains, you may contact Department of Health. Health Systems Quality Assurance Complaint Intake 360-236-4700 HSQA ComplaintIntake@doh.wa.gov P.O. Box 47857 Olympia, WA 98504-7857

Services
I offer therapy service for individuals and families. I see clients 11-75 years old. I do offer case management services, which include but not limited to providing paperwork for disability, unemployment, custody, adoption, foster care, car accidents and any type of legal issues. I do offer

therapy for individuals who are court mandated for treatment or seeking treatment in which disclosure of sessions will need to be provided to an outside entity.

Virtual Sessions

I _____ (patient's name) hereby consent to engage in Telehealth. I understand that "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using a system that is encrypted to the federal standard and HIPAA compatible. It is my responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the technology that you are interacting with. Additionally, I agree not to record any Telehealth sessions. During a Telehealth session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. I will ensure that I have a phone with me, and I have provided that phone number. I understand that all fees for Telehealth and non-Telehealth services are the same. I am financially responsible for all services rendered, late cancellations, and missed appointments.

Emergencies

As an independent, private practice clinician, I do not offer crisis coverage. If you are experiencing emergencies or a threat to yourself or others, please call 911 or go to the nearest hospital emergency room. You may call Crisis Clinic at 1-866-427-4747 (King County) or 1-800-584-3578 (Snohomish County) for urgent mental health crises.

Financial Responsibilities

Please confirm your insurance coverage and patient responsibility before your first appointment with me. Your co-pay or patient responsibility (deductible) determined by your insurer is due at visit before your session begins. My private pay rate is $135 per 55-minute in office session for individuals and $165 per 55-minute session in office session for family. In home session rates are $165 per 55 minute session and $185 per 55 minute family session (these prices include costs for travel expenses and time). Art therapy is included in all these fees should you choose to this additional intervention. Insurance carriers vary in coverage and copays. Please consult with your insurance provider for details in regards to cost breakdown and copay. If you are unable to pay the associated fees at the time of service for more than one visit, without developing a payment plan, your future appointments will be suspended until unpaid balances are resolved. Additional fees may apply to preparation of requested documents or copying and sending records. I will discuss any fees with you at the time of a request. Your appointment time is reserved specifically for you, and I will ask all my clients to respect this time. A minimum of 24 hours' notice is required to reschedule or cancel without a fee. A $110 fee is assessed for cancelations on a shorter notice than 24 hours' and no-shows, at my discretion. Insurance cannot be billed for missed sessions. Since this fee is assessed at my discretion, please direct all questions to me, not the administrative staff. I authorize my provider, Yvonne Marisa Doelling, MA, MHP, LMHC,

ATR-P, CDBT to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including; copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization and missed and late cancellation fees. If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature of Financially Responsible

Party:_____

Relationship to patient: _____

Date: _____

Confidentiality and Access to Records
All information disclosed within sessions is confidential. It will not be disclosed to anyone without your written permission. Disclosure will be required when a client is a danger to self or others. I keep brief notes of your sessions. You have the right to a copy of your medical records at any time. A response to your request in be made within 15 working days; this is in compliance with RCW 70.02.080.

My signature below is acknowledgement that I am the client or the person authorized to consent for mental health treatment for the client and consent to services provided by Yvonne Marisa Doelling, MA, MHP, LMHC, ATR-P and that I have read and understood the disclosure information and have received a copy of this disclosure form.

Responsible Party:

Print name: _____

Signing on behalf of:

_____

(if patient is unable to consent)

Relationship to patient:

_____

Client Name: _____

Client Signature: _____

Date : _____

Yvonne Marisa Doelling, MA, MHP, LMHC, ATR-P, CDBT

Date : _____