Informed Consent

Teresa Kincaid, MA LMFT LMHC

Counseling Relationship A counseling relationship needs to function under professional guidelines for it to provide maximum benefit. To avoid dual relationship issues, our contact will be limited to counseling sessions or other professional concerns such as scheduling and/or emergencies. If there is contact in another setting, I will protect your confidentiality by allowing you to initiate any interaction that occurs. Sessions are 50 minutes in length for individual and marriage counseling, unless otherwise agreed that they will last longer. The fee for services is $140 per hour for individual clients. Canceling sessions at least 24 hours in advance allows others to use the time vacated. Failure to do so, in other than emergency situations, may result in a 50% cancelation fee.

Effects of Counseling While benefits are expected from counseling, no specific outcomes are guaranteed. Part of the process is to establish goals and a plan for reaching them. Your time in counseling may lead to major changes in how you choose to view important issues in your life. The exact nature of these changes is not predictable and could affect significant relationships, your job, and your view of yourself. During the counseling process there may be periods of increased discomfort and strong feelings. The intent is to facilitate the best possible outcome based on your goals for counseling. Counseling techniques will be tailored to your presenting issue.

Client Rights The length of time in the counseling process varies from a few sessions to several years depending on the needs and goals of the client. You are in complete control of the decision and may terminate the counseling relationship at any time. However, I ask that you participate in a termination session when that decision is made. At any time, you may refuse or discuss modifications of any counseling techniques or suggestions. I am committed to providing my services in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, we can consult with another counselor, or I will help you locate another counselor to continue the counseling process. If you feel that any ethical violations have occurred, you may contact the Washington State Department of Health, Health Professions Quality Assurance Office at (360) 236-4700.

Confidentiality Communication in the counseling relationship is protected and confidential.

However, the following limitations to confidentiality do exist:

- I determine that you are at risk of harming yourself or someone else. This may include physical restraint from self-harm and requesting emergency assistance and transportation to a medical facility.
- You disclose abuse or neglect of a child, an elderly or disabled person.
- You disclose sexual contact with another mental health professional.
- I am ordered by a court or subpoena to disclose information or otherwise required by law to disclose information.
- You direct me to release your records. A release of Information form will be used for this purpose.
- Your insurance or third party payer requests information to authorize coverage of services. A copy of any written report will be made available to the client.

The client agrees to hold the counselor harmless for the disclosures and consequences of sharing of information with third party payers.
Children over the age of thirteen are considered legal adults when involved in mental health services. Therefore the same laws as adults govern confidentiality. Before the age of thirteen, communication of confidential information between counselor, client, and parents or legal guardians is at the discretion of the counselor.
In family counseling I will keep confidential, within the limits noted above, informations disclosed without your family member's knowledge. However, open communication among family members is encouraged and I reserve the right to terminate our counseling relationship if I judge the counseling process to non-therapeutic. I have a "no secrets policy" in couples counseling and ask that the partner share with me only that which can eventually be discussed together with the other partner.

Referrals There may be times that I refer you to other professionals to provide services that will enhance our work. If you and/or I believe that a referral to another counselor is needed, I will provide you with the names of other counselors who may assist you. You will be responsible for contacting and evaluating those counselors who may assist you. During you time in counseling, you will be expected to allow contact with other professionals such as physicians, counselors, and psychiatrists to maximize quality of care.

I am licensed in the state of Washington as a Mental Health Counselor (LMHC #60419565) and as a Marriage and Family Therapist (LMFT # 60419280). Consultation with my colleagues from Anchor Counseling Services, (Mark Young, Michele Holbrook, Kelly Tormey, Holly Cannard and Jeffrey Jarrett) may occur. No identifying information about you will be shared without your consent. If I am away from my office for any length of time, information will be provided and one of the above counselors will be available to you, should you require support.

Records All records become property of the office of Anchor Counseling and Teresa Kincaid LMFT, and LMHC. Only my official designee or I may disclose copies of written patient information or release client information over the phone. Adult client records are disposed of five years after the file is closed. Minor client records are disposed of seven years after the client's eighteenth birthday.

By your signature below, you are indicating that you have read and understand this Informed Consent, and that any questions you had were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client's Signature(s) Print Name(s)

_____Date_____ _____

_____Date_____ _____

_____Date_____ _____

Counselors Signature

_____ Date _____ Teresa J Kincaid MA LMFT LMHC