Jennifer E. Harris, LMFT
Licensed Marriage and Family Therapist
Washington State
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CLIENT-THERAPIST AGREEMENT

Client Rights and Responsibilities

You have the right to choose a therapist who best suits your needs and purposes. With that in mind, please read and carefully consider the Disclosure Statement and this agreement for psychotherapy services in my practice.

You have the right to be treated with positive regard and respect. You have the right to the privacy afforded you by confidentiality. You have the right, as well as the responsibility, to ask questions about your therapy and to participate in developing the goals of your work. It is important to your therapeutic work, and what that may advance in your life, that any preferences, concerns or issues that arise regarding your therapy be brought into the therapeutic conversation with your therapist to optimize the bene it to you.

Psychotherapist Responsibilities

It is the psychotherapist's responsibility to provide a confidential setting in which you may explore and expand your understandings of and influence in your life and relationships. It is also the psychotherapist's responsibility to provide you with service that is professional and respectful, including regard for your values, beliefs, life experiences and relationships. You will find that as a part of the psychotherapeutic process your beliefs, perceptions, attitudes, and behaviors may be challenged as a matter of course.

Informed Consent

Psychotherapy is understood to be a choice you've made among available options. Other options include other therapists and counselors, other therapies, groups, self-help resources, along with other modes of treatment. Your personal growth and the rate at which you make the desired changes in your life are your responsibility. It is important to understand that participation in therapy is not an assurance that desired outcomes will be realized and that there may be risks as well as benefits to engaging in a psychotherapeutic process. Since therapy often involves a focus on unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, anger, guilt, loneliness, embarrassment, helplessness, etc. which may, paradoxically, lead to the development of skills and abilities that contain and help reduce intense feelings of emotional distress.

While you maintain the right to terminate your therapy at any time, it is understood that premature termination may result in the return or worsening of the symptoms and concerns for which you sought therapy. Termination is a process and works to your bene it when you engage with your therapist regarding emerging thoughts of concluding your work. You have the right to choose who you will work with and you are welcome to request referrals when moving on. If I am unable to resolve your concerns or issues regarding your therapeutic work with me, you may refer to the PDF "What to Expect from your Licensed Professional" http://www.doh.wa.gov/Portals/1/Documents/Pubs/670125.pdf , which will help make clear the Washington State Department of Health, Health Professionals Quality Assurance Division guidelines regarding therapist responsibilities and conduct.

Solo Practitioner

I am a solo practitioner providing services in Washington State via telehealth exclusively at this time. I consult regularly with other seasoned therapists. Your identity will be protected.

Confidentiality

Therapeutic conversations are confidential and will be disclosed only with your written consent, except for con idential consultation with other clinicians. In addition, you have been provided with a copy of my Notice of Privacy Practices which describes how I may use and disclose your personal health information (PHI).

Highlighted here are some of those disclosures: 1) to report suspected abuse, neglect or exploitation of any person, whether child, developmentally disabled person, or dependent adult; 2) to interrupt threat of serious bodily injury or threatened suicidal behavior; 3) to intervene against threatened harm to another (which may include knowledge that a client is HIV positive and is unwilling to inform others with whom he/she/they is/are intimately involved); and 4) when required by court order or other compulsory process.

Other exceptions to con identiality include, but are not limited to, reimbursement systems provided by your insurance company. It is understood that insurance companies routinely require disclosure of a) a diagnosis, b) dates and types of service for reimbursement, and c) may conduct an audit of client records, and therefore, complete confidentiality cannot be assured when you choose to use insurance bene its.

Email, Texting, Social Media

While you and I may decide to use email, or texting from time to time, as an administrative convenience for things such as scheduling or cancelling appointments or billing issues, I do not communicate about confidential therapy issues by email or text nor do I interact with clients, current or former, via social media.

Records

I keep written records of our sessions. I will not disclose your record to others unless you or your legal representative direct me to do so or the law authorizes or compels me to do so.

NOTE: If you are planning to participate in individual, family, or couples therapy, it is important to note that any participant in individual or conjoint therapy, or legal guardian of a child engaged in individual, or family therapy may decide to request records or have records subpoenaed for court actions. Such legal scrutiny runs counter to the therapeutic process and is seriously advised against by this therapist.

Appointments

Therapy services are by appointment only, which you may schedule for 50 minutes, 51-74 minutes, or 75-90 minutes. From time to time in recognition of increased operating costs, I do increase my rates. If you have already been working with me at that time, I will provide you with advance notice of any such increase.

It is important to conclude sessions in a timely manner, even when material remains to be addressed. You may leave phone or email messages for me anytime, day or night. I pick up messages regularly and your call will be returned at the earliest opportunity, or if after hours, on the next business day. In the event of an emergency, you are advised to call either 911 or the Crisis Line at 206-4613222 for more immediate assistance.

PLEASE NOTE: In the case of couple therapy, it is important that sessions include both partners, unless an alternate plan has been jointly agreed upon or established by the therapist. I reserve the right to cancel the session if either partner does not attend as planned, in which case the full fee will be charged.

Fee Agreement – please read and initial boxes to indicate agreement

[ ] I understand that my fee for telehealth therapy is 1) $175 for a 50-60 minute therapy session, 2) $225 for a 61-75 minute therapy session, 3) $260 for a 90 minute therapy session. I agree to pay the fee/s in full.

[ ] I agree to give 24 hours' notice when cancelling an appointment and understand that in the absence of this notice, I will be charged the full fee for the time scheduled. I understand that missed sessions are not covered by insurance.

[ ] I understand that any unpaid balance on my account bears interest at the rate of 10% per annum and that any services provided beyond what my insurance plan covers is my sole responsibility.

[ ] I understand that brief telephone calls, up to 10 minutes, are not billed; however, telephone conversations, telehealth video chats, or email exchanges taking longer than 10 minutes will be billed an hourly rate ($175) at ¼ hour increments. Email shall be used solely for establishing contact, arranging appointments, sorting out billings/payments, not for therapy.

[ ] I understand that I am responsible for paying the full fee, even if I have insurance that I am relying on to cover therapy sessions. I agree to pay in a timely manner any amounts not paid by insurance.

[ ] I understand that, if my therapist is an out-of-network provider (not contracted with my insurance carrier), I will pay the full fee at each session and I may request a statement of services received and accrued charges to submit for insurance reimbursement that will come directly to me.

My signature indicates: 1) my agreement to the terms described in this document; 2) my permission for my therapist, Jennifer E. Harris, to claim reimbursement from my insurance company for services rendered if applicable; 3) I have reviewed and understand my therapist's "Disclosure Statement" and "Notice of Privacy Practices" and 4) I know that I can access and review "Unprofessional Conduct" online at – http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130.180.

Client Signature	Date
Partner or Spouse Signature (for couple therapy)	Date
Parent Signature (with medical decision-making rights)	Date
Jennifer E. Harris, MS LMFT	Date