Therapy Disclosure and Informed Consent
Rachel Ewing, LMFT (MA: 1864, CA: 94702)

Education and Experience:
I received my Master's in Counseling Psychology from the California Institute for Integral Studies in 2013. I am a licensed marriage and family therapist in both California and Massachusetts. I became licensed in California in 2016, and Massachusetts in 2022. I have been providing supervision to new clinicians since 2017.

General Information:
Sessions will last 50-55 minutes and most clients come weekly or bi-weekly. The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very brave step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Termination: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic

relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Client's Rights, Privacy and Confidentiality:
You have the right to choose a therapist who best suits your needs. You have a right to respectful treatment, and you may terminate therapy at any time. You have the right to confidentiality in treatment. Exceptions to confidentiality are as follows: (1) when there is a reasonable suspicion of child, dependent or elder abuse or neglect; (2) when a client presents a danger to self or others, or is gravely disabled; (3) when a client is involved in legal action and the court subpoenas evidence relating to our sessions; (4) when the Department of Health issues a subpoena associated with regulatory complaints; (5) when you specifically request in writing to release certain information to a third party (e.g., your primary care physician, teachers, family members, etc.) This permission can be revoked at any time; (6) and when a client seeks insurance, and I am required to release relevant information about the service I am providing.

In addition to the above situations, I regularly consult with colleagues regarding my work to receive feedback and suggestions. This helps me ensure that I provide you with optimal care. During these consultations, neither your last name nor other unique identifying information will be used.

Families: Limits of Confidentiality for Families: During family therapy, Rachel Ewing, LMFT views the family as the "client". In order for treatment-related information about the family to
be released, a written consent form must be signed by all members of the family. During treatment of a family, Rachel Ewing, LMFT abides by

additional limitations to confidentiality. Information learned in an individual session with one member of a family may potentially be shared with the family as part of the treatment process (no secrets policy). This policy is to help therapists treat the entire family while preventing conflicts of interest between parties.

Therapists will exercise clinical judgment regarding the need to bring information gained elsewhere into family sessions.

Children/ Adolescents: In order to provide up-most clinical care I consider the child or adolescent my primary client and will maintain their confidentiality in treatment. I collaborate regularly with parents and caregivers in order to support the family as a whole, but may maintain specifics discussed in session as confidential in order to support your minor's growth and ability to meet your goals. Federal law prohibits the disclosure of substance abuse information to a third party, including the legal guardian of a minor, with informed consent of the client (unless the situation involves a medical emergency, child/elder abuse reporting, or imminent risk of physical harm to self or others).

Fees and Scheduling:

My rate for individuals is $200/session and for families is $250. If you cancel within 24 hours or do not attend a scheduled session, there will be a $50 cancellation fee. If you are late, our time together will not be extended. All sessions must be paid for in advance. I will inform you in advance of my time away from the office and provide you contact information for another trusted colleague if requested. I have pro-bono spaces in my private practice to be provided at my discretion. This will be agreed upon prior to beginning of the therapy process.

Contact information and Resources:
You may contact me via email at rachelewinglmft@gmail.com or leave a message at (206)856-1337. I will return your messages as soon as possible, typically within 48hrs. Please note these forms of communication are not fully protected, and if you do communicate via email or phone, you do so at your own risk to your confidentiality. I do not accept phone calls, texts or emails while on vacation.

In case of mental health or safety emergencies, call 911, the Mass Emergency Services Program (ESP) at 877-382-1609, or visit the nearest emergency room.

Consent to Telehealth Services:

1. I understand that my health care provider wishes me to engage in a telehealth session.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Consent to use the Telehalth by Simplepractice Service:

Telehealth by SimplePractice is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to- date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

<u>Consent to Treatment</u>:

I, the client, understand that if I have any questions or would like additional information, I may feel free to ask during the initial session and any time during psychotherapy process. I understand that confidentiality cannot be assured for electronic communication like cell phones and e-mails. I do not hold Rachel Ewing responsible or liable for breach of confidentiality if I choose to communicate with my psychotherapist by these electronic means.

I understand that my therapist aims to maintain strict confidentiality. I understand that records of our sessions and communications must be kept by law, unless I request otherwise. By initialing here _____, I hereby request that Rachel Ewing **does not** keep records beyond basic identification, session dates and times.

By signing below, I acknowledge I am of sound body and mind and participate in therapy voluntarily; I have read and agree to the terms of the Disclosure Statement. I acknowledge that I have been given a copy of this document for my records. I acknowledge that I have had the opportunity to clarify the conditions under my consent to treatment. I understand that by signing below I am consenting to treatment with Rachel Ewing, LMFT according to the terms described in this document. I understand that payment is due at the time of service.

_____	_____	_____
Adult Client/ Guardian Name	Signature	Date

_____	_____	_____
Client Name	Signature	Date

_____	_____	_____
Minor Client Name	Signature	Date

_____	_____
Rachel Ewing, LMFT	Date