

# Your Song Counseling

## INFORMED CONSENT FOR THERAPY SERVICES

### GENERAL INFORMATION

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 positive 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.

### PROFESSIONAL PROFILE

I see individuals from variety of backgrounds, and with a wide spectrum of concerns. This includes conducting adult and older adult assessments for provisional diagnosis, individual counseling, facilitating support groups, and crisis intervention.

Education, Licensure and Specialties:

Bachelor of Arts in Liberal Studies with Women's Studies emphasis from University of Montana  
Masters of Science in Health and Human Development with Marriage and Family Counseling option from Montana State University

Licensure and certification:

Licensed Mental Health Counselor by the state of Washington

(Counselors practicing for a fee in Washington State must be registered with the Department of Licensing.

I am registered and also received state licensure, which requires additional education, training and supervision. My license number is LH60040909)

Certified Geriatric Mental Health Specialist by the state of Washington

Bilingual in English and Japanese

Knowledge of and experience with minority-status related stress, cultural adjustment issues, stress related to working in social service/healthcare field and raising bilingual and/or bicultural family

Ongoing continued education and training in stress; communication; anxiety; depression; trauma; chronic illness; grief and loss; end of life; bipolar spectrum; caregiving; mild cognitive impairment; dementia

### METHODS AND TECHNIQUES USED IN THERAPY

Philosophy of treatment consists of using psychotherapeutic approach. The beginning of treatment involves initial evaluation and assessment. Following the assessment, appropriate treatment plans will be

established with the identified individual. Modalities utilized in treatment consists of a combination of psychoeducation, acceptance and commitment therapy, cognitive and behavioral therapy, solution-focused therapy, positive psychology, problems-solving approach, motivational interviewing - whatever applies best to the identified concerns.

## **DURATION AND FREQUENCY OF THERAPY**

My normal practice is to schedule one 50-minute session every other week at a mutually agreed time, although sometimes sessions may occur more frequently. I do my best to accommodate your schedule, but please be aware that those time slots are limited and may not be available initially. Flexibility is needed on both ends.

## **COLLETERAL**

Another person (e.g. spouse, partner, sibling, parent, friend) may be invited as a collateral when I believe that they would be helpful in an adult's treatment, however it is not a requirement. This is NOT a couples or family therapy.

## **CONFIDENTIALITY**

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to kill self or otherwise conducts self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items (3) and (4).
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Rules of confidentiality can on rare occasions create dilemmas. For instance, say that perhaps during therapy you tell me you have a new friend, or romantic partner or boss, and it turns out that some years ago that person was a client of mine. Despite my desire to be open with you, I cannot tell you that I know that person, because I would be breaking the confidentiality of my work with the person. If you have any questions about confidentiality, please discuss them with Your Song Counseling.

State of Washington Disclosures

The State of Washington requires that I provide you with the following information:

You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the Department of Licensing for the protection of public health and safety. Credentialing of an individual with the Department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake Post Office Box 47857

Olympia, WA 98504-7857

Phone: 360-236-4700

E-mail: [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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Signature

Date