

Therapist Disclosure

Center for Child and Family Therapy
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Psychotherapy Information Disclosure Statement

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy. There are also certain limitations to those rights that you should be aware of. Any questions or concerns regarding the contents of this Disclosure should be discussed with me prior to signing it.

My Background and Qualifications

I have earned my Masters degree in Marriage and Family Therapy from Alliant International University in San Diego, California. My areas of training and expertise include working with military families, adults, adolescents, and children over the age of 7. I have been licensed since February 2010. Areas of concern I work with include, but are not limited to: depression, anxiety, substance abuse, ADHD, PTSD, trauma, behavioral concerns, school related problems, and parenting.

My theoretical orientation can be described as strengths-based, focused on helping an individual develop the resiliency and skill needed to handle mental health problems or stressors. I am mindful that you live within a network of many relationships and understand the need to examine those relationships for help and support. And I pay careful attention to the age and stage of your life and how you have come to an understanding of your life's story to date.

Confidentiality to Couple's Therapy

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couple's therapy with me.

If you and your partner decide to have some individual session as part of couple's therapy, what you say in those individual sessions will be considered to be part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish to keep a secret from your partner.* I will remind you of this policy before beginning such individual sessions.

Records and Record Keeping

I use EHR 24/7, Electronic Health Records by Office Ally to store all client records and billing. This business and software is HIPPA compliant. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes and records constitute my clinical and business records, which by law, I am required to maintain. You have the right to request that I correct any errors in your file. Records are the sole property of me. Should you request a copy of your records, such a request must be made in writing. I reserve the right, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will keep your records for 5 years after we end therapy unless I am contractually obligated by your health insurance to keep them longer. If you have questions either contact your health insurance company or myself.

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with your attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in your legal matters. I will generally not provide records or testimony unless compelled to do so. If I am subpoenaed and required to attend court proceedings you will be charged my hourly rate of **\$220.00 per hour**, which, in most cases, will not be reimbursed by your insurance company, therefore you will be responsible for this amount. _____ *initial here*

Other fees

Any other services, such as letter writing, will be **\$50.00**. Any time spent of other services over 30 minutes will have an additional charge. _____ *initial here*.

Billing

The name on the billing statement will be Center for Child and Family Therapy. Any type of payments need to be made out to CCFT. Once I become paneled with your insurance company, then the billing statement and payments need to be made out to Somer L. Covington.

Risks and Benefits of Therapy

Psychotherapy is a process in which you and I discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so you can experience your life more fully. It provides an opportunity to better, and more deeply understand one's self, as well as, any problems or difficulties you may be experiencing.

Psychotherapy is a joint effort between you and I. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. You should be aware that any decision on the status of your personal relationships is your responsibility.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should address any concerns you have regarding your progress in therapy with me.

Communication with Your Therapist

I can be reached through the office phone at (360) 698-9258. At times I will be available to take your call. At other times, it will be necessary to leave a message with my voice mail, which is operational 24 hours per day and is confidential. I typically do not check my voicemail on weekends or days off. I am willing to communicate with you electronically through secured, encrypted, and HIPPA compliant email. I have found email to be more effective than calling and leaving me a voicemail. If you would like to communicate via e-mail, I can be reached at somer@ccftherapy.com

Client e-mail Informed Consent

1. Risk of using email

- a. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b. E-mail senders can easily misaddress and it may not be secure and therefore confidentially may be breached, which I am not liable for.
- c. Back-up copies of e-mails may exist even after the sender and/or the recipient has deleted his or her copy.
- d. E-mail can be used as evidence in court.

2. Conditions for the use of e-mail

I cannot guarantee, but will use reasonable means, to maintain security and confidentiality of e-mail information sent and received. I am not liable for improper disclosure of confidential information that is not caused by my intentional misconduct.

- a. E-mail and texting is not appropriate for urgent or emergency situations. I cannot guarantee that any particular e-mail and/or text will be read and responded to within any particular period of time.
- b. All e-mail will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
- c. Clients/parents/legal guardians should not use e-mail or texts for communication of sensitive medical information.

3. *Client Acknowledgement and Agreement for e-mail*

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and myself. I consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with client by e-mail. _____ (initial)

Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than 10 minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on the prorated basis for that time. If a fee raise is approaching I will remind you of this well in advance. _____ initial here

Consultation

I sometimes consult with other professionals about my clients. This helps me provide high quality therapy. These professionals are also required to keep your information private and confidential. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.

State Requirements

Therapists practicing counseling for a fee must be licensed with the Department of Licensing and the Department of Health for the protection of the public health and safety. Licensure of a therapist does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment. The full law and regulations can be found in RCW 18.19.

Client Consent to Psychotherapy

By signing below, I acknowledge that I have reviewed and fully understands the terms and conditions of this Agreement. I have discussed such terms and conditions with Somer L. Covington, LMFT, and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Somer L Covington, LMFT.

Signature of Client

Date

Signature of Parent/Guardian (relationship to client)

Date

Somer L. Covington, LMFT

Date

- Copy accepted by client
- Copy accepted by additional person