THERAPIST DISCLOSURE

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Purpose of Disclosure Statement

This statement provides information about me and my treatment methods to better help you understand if I best suit your needs. Every client has the right to choose a practitioner and treatment modality that best suits his/her needs. Please read the following information and discuss any concerns with me or the office staff.

Education/Training/Experience

I received my Masters of Social Work degree from the University of Denver. I have been a therapist practicing in the mental health field since 2007. I am a Licensed Independent Clinical Social Worker (LICSW) and trained to practice social work.

I adhere to the codes of ethics of the National Association for Social Workers (NASW) and the professional standard of Washington State Department of Health. In your best interest and following the NASW code of ethics, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend to or socialize with any of my current and past clients. Even though you might invite me, I will not attend your family gatherings. I can never have a romantic relationship with any client during or any time after therapy. I cannot have a business relationship with any of my clients other than the therapy relationship.

Treatment Orientation and Methods

I offer services designed to help people to identify goals and to access their internal strengths. Together we can concentrate on the steps needed to meet your individual and/or family's goals. I help people use their internal and external strengths, offering suggestions, thinking of alternatives, and teaching skills to help facilitate growth. I urge you to make most of the planned activities, appointments, and assignments, including active involvement on your part and full participation of all those who are involved.

My scope of practice includes solutions focused therapy, cognitive behavioral therapy, acceptance and commitment therapy, dialectical behavioral therapy, play therapy, family therapy, and group therapy. My focus is working with children, adolescents, and adults on many issues relating to the family's mental health, parenting, behavior and social problems, depression, anxiety, stress, anger management, inattention, as well as recovery from physical, sexual, and/or emotional abuse.

I have found it is essential for me to have a working knowledge of a client's family, social, cultural, educational, and emotional experiences to effectively treat an individual or family in therapy. My treatment of children and pre-teen is typically Play Therapy. The theoretical grounding of Play Therapy is that children use play to communicate/process their experiences and difficulties more effectively than they can through language. I also believe that a critical aspect of play therapy for young children, particularly children who have experienced loss or trauma, is the relationship that is established with me.

Electronic Health Records

I use EHR 24/7 Electronic Health Records by Office Ally to store all client records. Additionally, I use Office Ally for billing. This business is certified HIPPA compliant. 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. 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.

Cancellation Policy and Credit Card Authorization

We agree to meet at my office and to be on time. If I am ever unable to start on time, I ask your understanding and that you will be charged the rate for the shorter session. If you are late, we will be unable to meet for the full time because I likely have another appointment after yours.

I am rarely able to fill a cancelled appointment with less than 24-hours notice and I understand circumstances come up that prevent giving 24 hours notice. There is a $25 charge for cancelling an appointment due to illness with less than 24 hours notice. Please call as soon as you know you (or your child) is ill and unable to attend the appointment.

For all other cancellations with less than 24 hours notice the fees are as follows: $25 for first cancelled appointment for any reason, $50 for the second cancelled appointment for any reason. For all additional appointments that are cancelled with less than 24 hours notice, the full fee for the session will be charged. Please note that your insurance WILL NOT cover these charges. If you cancel with less than 24 hours notice twice in a month, all future appointments will be cancelled and you are responsible for initiating rescheduling. We will talk about the circumstances for missing appointments at your next session and work together to find a reasonable solution. _____ initial here

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 you receive will be Therapy by Jenny, LLC and payments need to be made out to Therapy by Jenny, LLC.

Communicating With Your Therapist

I would like to communicate with you electronically, preferably through email. Email is not secure and encrypted which can possibly be read by others. I have found email to be more effective than calling me and leaving a voicemail. 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.

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 email 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

If you would like to communicate via email, I can be reached at jennyb@ccftherapy.com
Please initial:
_____Agree to communicate via email _____(email)
_____Disagree to communicate via email _____

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

Consultants
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. The two professionals that I consult with are Terry Boyle, MFT and Dr. Tony Stanton, PhD.

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.

I have read all of the above information and have received clarification as needed. I agree to the terms as stated above. I hereby enter into therapy with this therapist and to cooperate fully and to the best of my ability, as shown by my signature below.

_____ _____

Responsible Party/Client Signature Therapist Signature

_____

Date

❑ Copy accepted by client ❑ Copy accepted by additional person