THERAPIST DISCLOSURE STATEMENT & CLIENT INFORMED CONSENT

Cassie Salewske, MA LMHC NCC
Healing Tree Counseling and Wellness, LLC
1812 E. Madison Street, Suite 101, Seattle WA 98122
www.healingtreeseattle.com
206-595-8621

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully and initial each page.

I. THERAPIST DISCLOSURE TO CLIENT

- **Credentials**: I am a Licensed Mental Health Counselor in Washington State (#LH00011128), a National Certified Counselor (#240643), and a Washington Administrative Code Approved Supervisor.
- **Education, Training, and Experience:** I received a Bachelor of Arts in English from the University of Oregon, with a minor in Women's Studies. I completed my Master of Arts in Teaching at Pacific University, and was a teacher, tutor, and mentor for six years. I received my Masters of Arts in Mental Health Counseling through the College of Education at Seattle University. I have been a practicing therapist since 2004, specializing in working with the LGBTQ population, but experienced with a wide variety of clientele.
- **Professional Memberships:** I am a member of the Washington Mental Health Counselor Association (WMHCA) and the National Board for Certified Counselors (NBCC).
- **Services Provided:** I provide psychotherapy for individuals (adults, and adolescents aged 13 and older) and groups. I am also trained and certified to conduct hypnotherapy sessions, and Reiki treatments (separate disclosures are required for each). I provide supervision to Associate counselors and social workers who are working toward licensure in the state of Washington. I provide consultation to other mental health professionals, and independent mental health evaluations.

II. WORKING RELATIONSHIP

- Confidentiality: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.

- Health Care Coordination: It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, you should get a physical examination from a physician as soon as possible. It would be best to tell your medical provider that you will be working with me so we might begin to coordinate your health care. With your written authorization, I may obtain your medical records so I have a better understanding of your overall health.

- Risks and Benefits: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Counseling is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

■ Free Introductory Session: I offer a free introductory session for all new psychotherapy clients (not applicable for Hypnotherapy or Reiki clients). We can schedule this session by phone or email. I will ask that you complete the following paperwork prior to our meeting: Therapist Disclosure/ Informed Consent, Notice of Privacy Practices, and the New Client Intake. During the first session, we can review your paperwork, discuss the reasons why you are seeking counseling, and talk about your goals. Additionally, I can answer any questions you might have about therapy. If we decide we might be a good fit, we will then schedule another appointment. Participating in an introductory session does not obligate you to continue counseling with me. Please note that this is for *new clients only;* returning or prior clients are not eligible.

■ Appointments: We will schedule our appointments via email or phone, or in person at the end of a session. Please notify me via email or phone, at (206) 595-8621, as soon as possible if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Likewise, I will notify you via phone if I should need to cancel our appointment.

When you arrive for an appointment, please remain in the waiting room and I will promptly meet you. Our sessions will be 45-50 minutes long, and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

I will have to charge you the full session fee if you do not give me 24 hours notice of any cancellations. You will not be charged if I cancel our appointment. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment.

■ Fee for Services: My standard fee is $120.00 per 45-50 minute session. This is the same fee charged for any missed or late canceled appointments. In certain circumstances, I might arrange a reduced fee for you, which we will finalize in writing on a separate Sliding Scale Fee Agreement form. Additional fees might include: preparation of requested documents, or copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services.

■ Payment for Services: I accept cash, check, and debit/credit card payments. Checks should be made payable to **Cassie Salewske**. Payments are due directly to me at the time of service (at the end of each session). You may also fill out a payment pre-authorization form to allow automatic card payments on the date of your appointment. If payments are not made in a timeframe we have agreed upon, then I may notify debt collectors. I will charge a $30 fee for any returned checks.

■ Insurance: I do not currently accept insurance, but I can provide you with a receipt that you can submit to your insurance company for reimbursement. This is a relatively easy process. I am happy to assist you in finding the appropriate forms for your carrier, but I will not bill, or make submissions for reimbursement to your health insurance provider.

■ Record-keeping: I will keep a confidential file containing your private health information (PHI) in my office. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording "what happens in a session." I make an effort to summarize what we discuss in each session, but I make no effort to capture sessions verbatim. Washington State law requires the retention of records for seven years after last contact.

■ Emergency, Urgent, or Other Contacts: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within 24 hours.

You may also email me with your message; however, if you need to cancel an appointment within 48 hours of the scheduled time, I need to be contacted by phone. Please remember that anything you send over email is not confidential.

I am not able to provide on-call crisis or emergency services. If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or the Seattle Crisis Clinic at (206) 461-3222. The Crisis Clinic has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information.

If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.

■ Therapy Relationship and Professional Boundaries: It is my intention to maintain a warm, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship; this includes contact on social networking sites, like Facebook. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.
2) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting.
3) I will not, at any time, accept any gifts from you. I may accept a card or note from you.
4) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate a visible or audible greeting, I will reciprocate, but I will not attempt further communication unless you request it.
5) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any business and financial relationships. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.
6) I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.
7) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

■ Therapeutic Work, Duration, and Termination: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person.

If more than 60 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

■ Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Cassie Salewske, MA LMHC NCC
Healing Tree Counseling and Wellness, LLC
1812 E. Madison Street, Suite 101, Seattle WA 98122
www.healingtreeseattle.com
206-595-8621

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Cassie Salewske, MA LMHC NCC and I understand it.

_____ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

_____ I agree to follow the terms in the Disclosure Statement.

_____ I give my consent for treatment as outlined in this Disclosure Statement.

_____ If requested, I have a copy of this Disclosure Statement with my signature.

_____ I understand that my therapeutic relationship with Cassie Salewske, MA LMHC NCC may be discontinued if the terms in this agreement are not fulfilled by either of us.

_____
Client Name (please print)

_____ _____
Client Signature Date

This form will be retained in the mental health record.