

THERAPIST DISCLOSURE

Lisa H. Kelly, MSW, LICSW, PT
Washington License No. LW61121984

Center for Child and Family Therapy

Purpose of Disclosure Statement

This statement provides information about myself 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 Master of Social Work from University of Southern California in 2017 and have a BS in Physical Therapy from Northwestern University and a BA in Psychology from Smith College. I hold a professional certification from the University of Denver in Animals and Human Health which requires demonstrated skill and expertise in the clinical implementation of animal assisted therapy. I am a Licensed Independent Clinical Social Worker (LICSW) and Licensed Physical Therapist (PT). I am not able to give legal, medical, financial or professional advice other than what I am licensed to provide.

I am an active member of the National Association of Social Workers (NASW), Association for Play Therapy (APT) and American Physical Therapy Association (APTA) and I adhere to the codes and ethics of all the above and the professional standard of Washington State Department of Health. In your best interest and adhering to 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 cannot be a therapist to someone who is already a friend. I cannot have a business relationship with any of my clients, other than the therapy relationship.

Treatment Orientation and Methods

My experiences as a physical therapist have shaped my belief that an integrated mind-body approach is essential in therapy. I offer services designed to help people to identify goals and to access their inner strengths, together we can concentrate on the steps needed to meet your individual and/or family's goals. I believe that each of us has the resources to accomplish our life goals. I help people use their internal and external strengths, offering suggestions and alternatives to help facilitate growth. I urge you to make the most of the planned activities, appointments, and assignments, including active involvement on your part and full participation of all those who are involved. Change will sometimes be easy and quick, but more often it will be slow and difficult and will need repetitions and a commitment to keep trying.

I expect us to plan our work together. In our treatment plan, we will list areas to work on, methods we will use, the time and money commitments and some other things. I expect us to agree on a plan that we will both work hard to follow. From time to time, we will look at our progress and goals to assess if we are meeting our benchmarks or need to change our treatment, goals, or methods. Most of my clients see me weekly or bi-weekly for 3-6 months. After that, we meet less often for several more months. Therapy then usually comes to an end. The process of ending therapy, called "termination", can be a very valuable part of our work. When you ask to stop therapy at any time, I ask that you agree now, to meet for at least one more session, to review our work together.

There are some risks as well as benefits of therapy. You should think about these when making any treatment decisions. One risk might be that for a time there may be an uncomfortable level of negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother you for a while. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital or couple relationship. Sometimes, a client's problems may worsen after the beginning of treatment. Risks like these are hopefully temporary and should be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out as you would like. All of these should be weighed against the cost of not changing and continuing as you are. I do not take on clients, I do not think I can help.

My scope of practice includes play therapy, family therapy, solution focused therapy, mindfulness, sensory integrative therapy, and cognitive behavioral therapy. When appropriate, I will also incorporate animal-assisted therapy, utilizing the human-animal bond to promote well-being for both parties. My focus is working with children, adolescents, and adults on many issues relating to the mental health, parenting, behavior and social problems, depression, anxiety, stress, anger management, as well as recovery from physical, sexual, and/or emotional abuse.

I have found it essential for me to have a working knowledge of a client's family, social, cultural, educational, and emotional experiences in order to effectively treat an individual or family in therapy. My treatment approach for children and pre-teens is typically Play Therapy. The theoretical grounding of Play Therapy is that children use play to communicate/process their experiences and difficulties more effectively through play than they can through language. For further information about "why" play therapy is effective, please refer to: <https://www.a4pt.org/page/WhyPlayTherapy>. 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 the therapist. In order to establish this relationship, consistency in maintaining therapy appointments is imperative.

Electronic Health Records

I use traditional paper charts 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 may take notes during the 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. Records are the sole property of me. You do have the right to request that I correct any errors in your file. 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.

Communicating with your therapist

I am willing to communicate with you electronically, preferably through e-mail. My email service is secure, encrypted and HIPPA compliant. However, if your email is not secure and not encrypted then others could possibly read it. I have found e-mail to be more effective than calling me and leaving a voicemail. If you would like to communicate with me via email, I can be reached at lisak@ccftherapy.com. If you do not have access to the internet on a regular basis you can call the office (360) 698-9258 and leave a voicemail and I will get back to you during my normal business hours.

Emergency phone calls of less than 10 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 e-mails from you in a given week, I will bill you prorated basis for that time. If a fee raise is approaching I will remind you of this well in advance.

I do not check my voicemail and e-mail on weekends or days off. If you should experience a mental health crisis outside of business hours, please call 911 or the Crisis Hotline: 888-669-5460.

_____ initial here

Confidentiality of E-mail, Cell Phone and Faxes Communication; Client Consent:

It is very important to be aware that email and cell phone communication, including texting, can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong fax number.

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. E-mail and texting are not appropriate for urgent or emergency situations. I cannot guarantee that any e-mail and/or text will be read and responded to within any particular period of time. All e-mail will usually be printed and filed into the client's medical record. Texts may be printed and filed as well. Clients/parents/legal guardians should not use e-mail or texts for communication of sensitive medical information. If you would like to secure our email conversations, please let me know and I can encrypt our email communication.

I acknowledge that I have read and fully understand the e-mail 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 the client by e-mail. _____ initial here

If you would like to communicate via e-mail, I can be reached at: lisak@ccftherapy.com

Please initial:

_____ Agree to communicate via e-mail _____ client e-mail
_____ Disagree to communicate via e-mail

24 Hour Cancellation Policy

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (one day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee may be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

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 know that you will be charged proportionately. If you are late, we will be unable to meet full time, because I likely have another appointment after yours.

If you do not follow this cancellation policy twice in one month, all future appointments will be cancelled from our system, and you are responsible for initiating rescheduling. If you frequently do not follow our cancellation policy, we will talk at your next session about your circumstances for missing sessions. If you miss three sessions according to this policy, you will receive notice indicating services with me will end and with this notice you will be provided with referrals to other providers.

If there has been no contact/communication between either of us for 60 days, the current treatment period will be terminated. You can restart therapy any time, but you will need to go through our intake process again. _____ initial here

Billing

The name on the billing statement will be Lisa H Kelly. Any types of payments need to be made out to: **Lisa H Kelly.**

Credit Card Authorization and Other Fees

Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the \$150.00 hourly rate, unless indicated and agreed upon otherwise. For copies of records, I reserve the right to charge \$1.17 for the first 30 pages; .88¢ per additional pages; and a \$26.00 clerical and handling fee (per WAC 246-08-400).

I reserve the right to add a 1% finance charge on overdue balances after 60 days, and the right to send overdue bills to a collection agency after 90 days of non-payment. _____ initial here

Confidentiality with Families and Couples

In couple and family therapy, or even when different family members are seen individually, without the client present, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless agreed upon. If this is the case, I will use my clinical judgement when revealing such information. I will not release records to any outside party unless I am authorized to do so by ALL adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult 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. I will provide an additional fee sheet related to court and/or any proceedings. You will not be reimbursed by your insurance company, therefore, you will be responsible for all fees prior to my attendance in any court matter. _____ initial here

Consultation

As a LICSW I will have the opportunity to consult about my clients with other licensed counseling professionals; the client's name or other identifying information is never disclosed. The client's identity remains anonymous, and confidentiality is maintained. This helps me provide high-quality therapy.

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 implies the effectiveness of any treatment. The full law and regulations can be found in RCW 18.19.

Consent

I have read 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.

Signature of Client

Therapist Signature

Signature of Parent/Guardian

Date

Copy accepted by client

Copy accepted by additional person