THERAPIST DISCLOSURE **K. Helena Hauge, LMHC**
Center for Child and Family Therapy Washington License No. LH00006918

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 and Experience

I hold a master's degree in psychology from Chapman University with primary emphasis on Marriage, Family and Child Counseling. I am a Washington State Licensed Mental Health Therapist and trained to mental health counseling (not law, medicine, finance, or any other profession). I am not able to give you advice from these or other professional viewpoints. I am a mental health supervisor. I adhere to the codes of ethics and the professional standard of Washington State Department of Health. 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. I cannot have a business relationship with any of my clients other than the therapy relationship.

Treatment Orientation and Methods

Psychotherapy is a process by which a therapist assists you or your family in understanding beliefs, feelings, thoughts, and relationships that are areas of concern, gaining insights into human behavior and gaining new information and applying it to enrich and enhance your everyday life. To facilitate this process, it is important for you to set specific therapeutic goals, which will serve to focus our work together, While I can assist you, you must set your goals for therapy for them to be effective. Each individual is unique, and it is my responsibility to tailor treatment to your specific circumstances. At the same time, you are responsible for your decisions, how you make use of the services that I provide, and for making changes in your life. I believe that you bring strengths, experiences, and resources with you that can be invaluable in assisting you to reach your goals, and I will work with you to make use of them.

My treatment methods include but are not limited to client education and insight, cognitive-behavioral therapy, relaxation & guided imagery, behavioral therapy, and family systems therapy. The delivery of these methods is accomplished via individual, couples, family and play therapy. At times, I may provide home assignments such as journal writing, reading or other tasks outside the therapy session.

The length of time that individuals and families participate in therapy varies with the extent and type of issues that need to be addressed, and the speed in which individuals and families are able to effect change and/or resolve issues. Considering this, it is not possible for me to determine the length of the therapy at the beginning of the process. It is also not possible for me to determine which methods may be most effective or what specific results you may attain at the beginning of therapy. Instead, we will maintain and ongoing dialogue as to the progress and outcomes of your treatment.

There are some risks as well as many 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 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.

Confidentiality with Couples and Family Therapy

In couples or family therapy, or when different family members are seen individually, with-out the client present, even over a period of time, confidentiality does not apply among family members. Do not tell me anything you wish to keep a secret from your family members because this will probably be discussed in our joint sessions.

Electronic Health Records

I use Office Ally for billing and scheduling. This business and software is 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 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 your record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. If you have questions, please ask me.

Billing

The name on the billing statement you receive will be *Center for Child and Family Therapy* and payments need to be made out to *Center for Child and Family Therapy (CCFT)*.

Communication and Emergencies

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 voicemail, which is operational 24 hours per day and is confidential. I am willing to communicate with you electronically through email. I only check my confidential voicemail and email during my business hours. I do not check my voicemail and email on weekends, days off, or vacation time.

Client e-mail Informed Consent

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
e. E-mail does not contain contextual information normally acquired through in-person meetings, which can lead to misunderstandings. If we have a misunderstanding, lets resolve this over the phone or in-person.

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

If you would like to communicate via email, I can be reached at helena@ccftherapy.com

Please initial: _____ Agree to communicate via 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 here

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 from our regular therapy fee $150 per hour, for that time. If a fee is approaching, I will remind you of this well in advance.

_____ initial here

Appointment and Cancellation Policy

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

I require *24-hour* notice for any canceled appointment. I am rarely able to fill a canceled session with-in 24 hours, so you will be charged for the missed appointment. If you do not show up and you do not contact my office by phone within 24 hours of your appointment, you also will be charged a fee for the missed appointment.

If you are late, we will be unable to meet for the full time because it is likely I will have another appointment after yours. Your insurance **WILL NOT** pay for this. The charges are as follows:

$25 for the first missed appointment
$75 for the second missed appointment
$150 for the third missed appointment

If you miss THREE appointments in a row or no show TWO appointments in a month, all future appointments will be canceled, and your current treatment session will be terminated. If you want to start a new treatment session you will be responsible for initiating the intake process. We will talk about the circumstances for missing appointments at your next session and work together to find a reasonable solution. _____ initial here

If there has been NO contact/communication and/or appointments between either of us for 45 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

Other Fees

Any other services, such as letter writing, etc. will be calculated and prorated at $150 per hour which will be discussed ahead of time. However, a letter of attendance for a school is available upon request for no charge.
_____ initial here

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. Fees for telephone or any other consultation for legal matters will be billed at the regular therapy hour $150 per hour. For any court appearances and or other legal matters are billed at $250 per hour. Concerning court appearances, the time starts when the clinician leaves the office until the court, judges, or attorneys dismiss them and they return to the office (portal to portal). This includes appearance by phone. You will not be reimbursed by your insurance company; therefore, you will be responsible for all fees.
_____ 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.

Consent

By signing below, I acknowledge that I have read all the above information and have received clarification as needed. I agree to the terms as stated above. I hereby enter into therapy K. Helena Hauge, LMHC and to cooperate fully and to the best of my ability, as shown by my signature below.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (relationship to client) Date

_____ _____
K. Helena Hauge, LMHC Date

❑Copy accepted by client ❑Copy accepted by additional person