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Client Consent and Disclosure Form

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As a Licensed Marriage and Family Therapist in the State of Washington (LF00002109), I am providing the following disclosure of information, policies, and procedures so you are able to be fully informed about me and offer your consent to treatment.

Education, Training, and Experience. I received my Master of Arts in Marriage and Family Therapy from George Fox University in 2001. I received my Bachelor of Science degree in Human Development from Warner Pacific College in 1998. Yearly, I participate in continuing education in specialized areas to be able to provide quality treatment for my clients and as a condition of my licensure in the state of Washington. Throughout both my undergraduate and graduate work, I had the opportunity to apply my knowledge and skills to counseling children, adolescents, and families at a community mental health agency, juvenile detention center, and various school systems. My work there focused on providing comprehensive support services in the areas of mental illness and recovery from trauma related to sexual assault and violence. Lately, I have focused on advancing my clinical skills in my private practice by working with children, adolescents, individual adults and couples with a variety of issues.

Therapeutic Orientation. As a systemic and solution-oriented therapist, I focus on your natural resources and resiliencies to help you make powerful and positive changes in your life. I believe that people have an innate need to move toward growth and healing. My goal is to provide an accepting and understanding climate that helps facilitate your growth and healing. As you teach me about yourself, we will consider your emotional, behavioral and spiritual life as well as the environment that surrounds you daily. I will help you to look at your past, present, and future to identify problems and solutions. I truly love the process of collaborating together to help you and your family discover and live a more meaningful, satisfying and authentic life.

Confidentiality. All information you disclose in treatment is confidential unless you specifically request a release of this information in writing. It is important however, that you are aware that the law provides certain exclusions from confidentiality that include, but are not limited to: reported child, elder and dependent adult abuse; when a client makes a serious threat of violence towards a reasonably identifiable victim; when a client is dangerous to him/herself or the person or property of another; or when there is a court order. For my own professional growth and development and to ensure quality service to you, I participate in small consultation groups with other therapists. I may discuss your situation but will do so without revealing your name or other identifying information so as to maintain confidentiality.

Fee Information and Cancellation Policy.

Initial Family/Individual Session (50 minutes): $165
Family/Individual Session (50 minutes): $130
2-hour session available upon request: $240

Credit cards, cash and personal checks made payable to "Integrity Counseling" are accepted. When we schedule an appointment, I set aside that time exclusively for you. I would like a 24-hour advance notice if you must cancel or reschedule any appointment. It is my policy to charge a fee of $100 for any missed appointments or one that is cancelled with less than 24-hour notice.

Insurance Reimbursement. If you have a health insurance policy, it will often offer some coverage for mental health treatment. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you, and not your insurance company, are responsible for full payment of my fees. You should be aware that submitting claims to your insurance company requires a mental health diagnosis and carries a certain amount of risk to confidentiality, privacy, and to future capability to obtain health or life insurance. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank.

Emergencies. I attempt to respond to my messages within 24 hours. If you need help sooner or if there is a life-threatening emergency, call Clark County Crisis Line (360.696.9560), call 911, or go to the nearest hospital emergency room.

Laws and Client Rights. *WAC 308-109-040:* (WA Registration #RC 39893) Counselor practicing for a fee must be registered or certified within the department of health for protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. *Health Insurance Portability and Accountability Act (HIPAA):* My Notice of Privacy Practices provided at intake informs you of HIPAA, a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This notice carries more detailed information regarding your rights. *Washington State Department of Health's brochure for counseling clients* is provided at intake. It contains information about client and counselor rights and responsibilities, confidentiality, and an assurance of professional conduct. If you wish to complain about any improper conduct you can call the state Department of Health, Health Professions Quality Assurance Division, PO Box 47869, Olympia, WA 98504.

Consent. I have read and understand all the information provided in this disclosure statement. I have read Integrity Counseling Notice of Privacy Practices and Washington State Department of Health's brochure for counseling clients. I hereby give my consent for treatment.

_____ _____

Client's Signature Date

_____

Client's Printed Name

If a client is under 13 years of age:

_____ _____

Child's Name Date of Birth

_____ _____

Parent/Legal Guardian's Signature Date

_____

Parent/Legal Guardian's Printed Name

_____ _____

Olya Pavlishina, LMFT Date