**Caitlin Connolly, MSW, LICSW**
**1229 Cornwall Ave. Suite 209 Bellingham, WA 98225**
**Tel.: (518) 241-5812**

## Counselor Disclosure Statement and Client Agreement

### Disclosure Statement

Hello and welcome. This statement is for the purpose of your rights and responsibilities for our therapeutic relationship. I am a Clinical Social Worker and Psychotherapist in the private practice sector. This statement discloses my education, training, credentials, my therapeutic and theoretical approach, fee for services, the cancellation policy, emergencies, and your rights, privacy, and responsibilities while involved in this service.

The WAC 246-810-031 and RCW 18.19.060 require disclosure of the therapist and the following information in written form to be provided to clients before therapy begins. If you have any questions or concerns, please let me know.

### Training, Education, and Licensure

- Active Independent Clinical Social Worker License (LICSW), Credential # LW60341266
- Master of Social Work (MSW): State University of New York at Albany (SUNY) Albany, New York
- Bachelor of Arts (BA): Social Work State University of New York at Plattsburgh (SUNY), Plattsburgh, New York
- Eye Movement Desensitization Reprocessing Trained, seeking EMDRIA Certification
- Member of National Association of Social Workers (NASW)
- Washington State Approved Supervisor for Licensure candidates

I continue to pursue training and educational opportunities to enhance my clinical skills and growth.

### Client Rights and Responsibilities

My counseling services are to provide you with a strengths-based, solution-focused, client-centered, and compassionate approach. My counseling style is supportive, educational, and therapeutic. My duty is to provide the highest level for standards of practice and to follow the Social Work Code of Ethics. The core values as well as what I integrate into my practice include respect, dignity and worth of the person, service, importance of human relationships, integrity, competence, and social justice. You have the right to choose a therapist that best meets your needs and reasons for therapy. I am available to discuss any questions or concerns you have either before or upon completion of therapy. You also have the right to refuse or terminate treatment at any time for any reason. I keep a record of the service provided to you; you may also ask for a copy of the record.

### My Approach

I provide adults, couples, groups and family therapy. My work encompasses many different therapeutic approaches and techniques. My style of therapy is based on discovering what works for you with a client centered and non judgmental approach while offering support and encouragement. Some of these therapeutic and theoretical approaches include: Cognitive-behavioral therapy, Dialectical Behavioral Therapy, Solution-focused therapy, Humanistic therapy, EMDR, Psychoeducation, Motivational Interviewing, Strengths based and Narrative therapy. My belief is that each one of us is

the expert of our own lives and thus has the tools to develop a more sustainable transformation grounded in compassion and self love.

## Additional Information

Clients may leave me voicemails at (518) 241-5812. I will return your call as soon as possible. I am open to phone calls, if they exceed 15 minutes in duration; I will charge the hourly (50 minute session) rate as agreed upon in this agreement and the Sliding Rate Fee Schedule, between you and I.

### Confidentiality and Records

All sessions, forms completed, the client file record, and client information are privileged information and confidential. I am obligated by federal and state laws to follow Health Insurance Portability and Accountability Act (HIPPA) while keeping your Protected Health Information (PHI) secure, private, confidential, and safe. The client makes a decision about whether or what information may be released to a thirty party by a written consent form authorizing the Release of Information (ROI).

I will keep your information private and confidential however I have to abide by the following exceptions:

- At times, I may share some pieces of your story within a consultation format with other therapists. I am required to keep client information confidential including identifying information while limiting and keeping as much as your personal information to a minimum as possible. The purpose of consultation is to obtain accurate recommendations to assist you in the therapeutic process.
- The State of Washington requires by law that past or present, suspected abuse or neglect of a child or vulnerable adult be reported to the appropriate authorities.
- The State of Washington requires that the appropriate authorities be informed if a client has threatened harm to self or others. If the threat is deemed serious, I am legally required to notify the appropriate authorities and potential person being threatened and inform them of the threat.
- Information that may not be held confidential if it jeopardizes my safety, a crime against me, or a crime within my office premises. This includes damage to property, accidental and non-accidental injuries.
- If I am court ordered to provide information, I may be required to provide information in the presence of a judge.
- In the event of an emergency for myself, my emergency contacts may be given your needed information.
- Information may be released due to a client's death or incapacitation to personal representative or the beneficiary of a clients insurance policy about a clients life by signing an ROI for the purpose of disclosure.
- Your information will be released if you make a complaint with the Washington State Department of Health against me.
- If you use an insurance carrier for services, I am required to provide your information and they can access your record anytime. If you choose to use insurance, you will be required to sign a Release of Information (ROI) authorizing this communication.
- Your identifying information may be disclosed to a debt collection agency if you fail to pay for services by our agreement. Due to lack of payment, it may become necessary to utilize the debt collection process while limiting and keeping as much of your personal information to a minimum as possible.
- If you are a parent or legal guardian of a minor under the age of 13 years old or older, certain portions of the minor's record may not be accessible to you under law. These records as such pertaining to mental health services (the age of 13 and older), substance abuse/chemically dependency services (the age of 16 and older), sexually transmitted diseases (the age of 14

and older), or abortions (the age of 14 and older), unless a written authorization was provided by the minor child allowing disclosure.

**Complaints**

If you have concerns about your experience or involvement in treatment, please discuss this with me. I value being transparent, and having open, honest conversations about issues that arise. If you feel that I have been unethical or unprofessional, you may contact the Washington State Department of Health, HSQA Complaint Intake. The mailing address is P.O. Box 47857 Olympia, WA 98504-7857 or you may call them at 360-236-4700. You may also access forms and information at www.doh.wa.gov/hsqa.

**Fees for Service**

All fees are due before the initiation of each service session, unless other arrangements have been made. The fees are for a per hour, 50 minute therapy session as well as 10 minutes for documentation. When receiving insurance reimbursement, the flat rate of $125.00 per hour applies. If you pay cash, the rate of $100 per hour applies. If you pay with credit card or debit card, the rate of $125.00 applies. Credit and debit card processing fees may apply. You credit card information may stay on file. There will be a $35.00 charge for returned checks. If you are experiencing a financial hardship, I offer a Sliding Rate Fee Schedule. For all couples, relationship, and family therapy session with two or more individuals in a session, the rate of $15 more than the individual rate applies. Please be aware that I charge clients the full fee for no show, missed, or canceled sessions unless I am given at least 24 hour notice or there is an agreed upon arrangement made ahead of time. You will be responsible for the fee if I receive notice less than 24 hours from the start of the appointment. At this time, I am not accepting insurance but if you are currently with another insurance carrier, you will get a receipt for services, which you can submit to your insurance company, and they may or may not reimburse you for services. If you would like to be reimbursed, it is recommended that you check with your insurance company prior to starting services to find out if services are reimbursable or not. If insurance is being billed, all co-payments and coinsurance fees are due before the initiation of each service session in full. If insurance is being billed and the insurance company does not pay the bill, the client will be responsible for any services provided that were not covered by the insurance company at the rate billed. If without prior written agreement, if payment has not been received for 90 days, the amount owed will be provided to a collection agency with the least personal information provided as requested from the debt processor. Request for Copy of Client File to Authorized Persons is $10.00 plus $.50/page. These fees do not apply to court appearances or assistance in legal proceedings. I do not attend, involve, or participate in court or legal proceedings. All record requests must be provided in writing. Under some circumstances, I may deny access of the record. Otherwise, the information will be released within 14 business days. The fees are subject to change at any time.

I have read and understand all Fees for Service information. Based on our agreement, my individual counseling fee per session will be_____, our couple or family counseling fee per session will be_____, starting on _____, day of _____, 20 _____

**Professional Boundaries**

I would like our therapeutic relationship to be comfortable, respectful, and professional where you as my client are my priority to ensure I have your best interest in mind. My intent is with positive regard and compassion for you in this process. Because I respect you, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

I will not, at any time, have a relationship with you outside of my office, even after we have ended our therapeutic, professional relationship. This is a professional boundary. I will not accept any social network “friend” requests and I will not communicate with you through social media websites or applications.

- Because my business does have an internet involvement, (listings on Yelp, Facebook, etc.), it is possible for you to place reviews, of which are unsolicited on those sites of my business if you

choose too. It is imperative to your treatment that you communicate your intent to do so prior to actually writing a review. This is to keep communication between us as your input and feedback, whether positive, negative, or ambivalent, it is best for us to discuss in person as it is likely very important for your treatment.

- I will not, at any time, engage in any form of physical, sexual, or inappropriate interaction or contact with you. This excludes handshakes and the like, and this is only by your own initiation. None of these are expected from you.
- I will not accept or receive any gifts from you.
- If we see one another in public or outside of the professional setting, I will not initiate any form of contact with you as this is to respect your rights and confidentiality. If you initiate contact with me, I will respond respectfully and politely, but exclusively what you offer.
- I will not have a relationship with you beyond my scope of professional treatment services and the collection of fees for such services.

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If you are experiencing an emergency, please call 911 or the crisis line at (800) 584-3578 or go to the nearest hospital emergency department.

An intake and treatment plan as well as the other accompanying documents will be developed upon your agreement.

Effective date of this notice: November 4,2017

Changes to this notice may change at any time. If I make changes, I may make the new notice term effective immediately. If changes are made, I will notify you and you may request a revised notice by contacting me.

**Client Signature, Acknowledgment, Agreement, and Consent for Treatment**

I have received, read and understand this disclosure statement, and accompanying client documents in my client file. I have had the opportunity to ask any questions regarding this material and I understand fully this agreement. My participation is voluntary, and I am personally responsible for my experience. I consent to therapy with Caitlin Connolly, MSW, LICSW, according to the terms listed here.

_____

Client Name(s) DOB Date

_____

Client Signature DOB Date

_____

Parent/Legal Guardian Signature (if under 13) DOB Date

_____

Therapist Signature Date