

I - INFORMED CONSENT FOR PSYCHOTHERAPY

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is both a highly personal, while still being a contractual agreement. Given this, it is essential that we reach a clear understanding about how our relationship will work, as well as what we each might expect. This informed consent will provide a clear framework for that therapeutic relationship. Feel free to discuss any of this with me.

Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a step by deciding to seek therapy that is positive, brave, and maybe even a bit intimidating. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

My Education, License, and Business Entity

Danny Laesch, LMHCA

M.A., Counseling Psychology, Gonzaga University, 2021

B.A., Religion and Ethics, University of Puget Sound, 2014

Licensed Mental Health Counseling Associate in Washington State, MC61213342

My business name is Connecting Branches Counseling and is a sole proprietorship.

Payment:

Please make any checks out to: Growing Fern Counseling. On all of our financial interactions such as billing records, charges, and receipts, you will see this designation: Growing Fern Counseling, PLLC.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

II - CONSENT FOR TELEHEALTH CONSULTATION

Connecting Branches Counseling

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.

- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

III – NOTICE OF PRIVACY PRACTICES

EFFECTIVE AUG 2022

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Privacy is an important concern for many people who come to this office. It is also complicated because of the many federal and state laws and our professional ethics. Because the rules^[1] are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, please do not hesitate to ask. We will discuss this form during our first meeting, and I would be happy to answer any of your questions then, or as they may arise during treatment.

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A. INTRODUCTION: TO MY CLIENTS

This notice will tell you how I handle your medical information. It tells how I use this information here in this office, how I share it with other professionals and organizations, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask for more explanations or more details.

B. WHAT I MEAN BY YOUR MEDICAL INFORMATION

Each time you visit me or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health

or conditions, or the tests and treatment you received from me or from others, or about payment for health care. The information I collect from you is called "PHI," which stands for "protected health information." This information goes into your medical or health care records in my office. In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your relationship and other personal history.
- Reasons you came for treatment: Your problems, symptoms, and treatment needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of treatments and other services that I think will best help you.
- Progress notes: Each time you come in, I write down some things about how you are doing, what I notice about you, and what you tell me.
- Records I get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information.

There may also be other kinds of information that go into your health care records here. I may use PHI for many purposes. For example, I may use it:

- To plan your care and treatment.
- To decide how well my treatments are working for you.

- When I talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to me.
- To show that you actually received services from me, which I billed to you or to your health insurance company.
- For teaching and training other health care professionals.
- For medical or psychological research.
- For public health officials trying to improve health care in this area of the country.
- To improve the way I do my job by measuring the results of my work.

When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

C. PRIVACY AND THE LAWS ABOUT PRIVACY

I am required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires me to keep your PHI private and to give you this notice about my legal duties and my privacy practices. I will obey the rules described in this notice. If I change my privacy practices, they will apply to all the PHI I keep. I will also post the new notice of privacy practices in my office where everyone can see. You or anyone else can also get a copy about my privacy policy by asking me or by finding it on my website at: www.connectingbranchescounseling.com

D. BREACH NOTIFICATION

When I become aware of or suspect a breach, as defined in Section 1 of the breach notification overview, I will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. I will keep a written record of that Risk Assessment. Unless I determine that there is a low probability that PHI has been compromised, I will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview. I will provide any required notice to clients and HHS. After any breach, particularly one that requires notice, I will re-assess my privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches (see Attachment I for more details).

E. HOW YOUR PROTECTED HEALTH INFORMATION CAN BE USED AND SHARED

Except in some special circumstances, when I use your PHI in this office or disclose it to others, I share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So I will tell you more about what I do with your information. Mainly, I will use and disclose your PHI for routine purposes to provide for your care, many of which do not require

prior written consent or authorization. For other uses, I must tell you about them and ask you to sign a written authorization form.

1. Uses and disclosures that DO NOT require your prior written consent or authorization

In almost all cases I intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for my services, or some other business functions called “health care operations.” In other words, I need information about you and your condition to provide care to you.

a. The basic uses and disclosure that DO NOT require prior written consent or authorization

For treatment. I use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of my services.

I may share your PHI with others who provide treatment to you. For example, I may share your information with your personal physician or psychiatrist. If you are being treated by^[1]_[SEP] a team, I can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all^[1]_[SEP] can decide what treatments work best for you and make up a treatment plan. I may refer you to other professionals or consultants for services I cannot provide. When I do this, I need to tell them things about you and your conditions. I will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, I can also share your PHI with them. These are some examples so that you can see how I use and disclose your PHI for treatment.

For payment. I may use your information to bill you, your insurance, or others, so I can be paid for the treatments I provide to you. I may contact your insurance company to find out exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, I may use your PHI to see where I^[1]_[SEP] can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send.

Client Incapacitation or Emergency. I may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn’t required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are

unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

b. Other uses and disclosures that also DO NOT require prior written consent or authorization.

Legal mandates. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect. I have to report suspected child abuse, elder and/or dependent adult abuse.

Child Abuse: If provider has reasonable cause to believe that a child has suffered abuse or neglect, provider is required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

Vulnerable Adults: If I believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

Safety concerns. Disclosure of your PHI may be required to avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of yourself or to the health and safety of other(s). Any such disclosure will only be made to someone able to prevent the threatened harm from occurring.

Judicial or legal proceedings. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for worker's compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena. I am legally obligated to respond to the subpoena and may have to provide the requested information to the court. However, such information is also likely to be privileged under WA law, and I will not release information without first consulting with you or your legally appointed representative. This does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Law enforcement. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

2. Uses and disclosures that require your authorization

If I want to use your information for any purpose besides those described above, I need your written permission on an authorization form. I don't expect to need this very often. If you do allow me to use or disclose your PHI, you can cancel that permission in writing at any time. I would then stop using or disclosing your information for that purpose. Of course, I cannot take back any information I have already disclosed or used with your permission. I will obtain an

authorization from you before using or disclosing PHI in a way that is not described in this Notice.

3. Uses and disclosures where you have an opportunity to object

I may provide some information about you with your family or close others who you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. I will ask you which persons you want me to tell, and what information you want me to tell them, about your condition or treatment, as long as it is not against the law.

4. An accounting of disclosures I have made

When I disclose your PHI, I may keep some records of whom I sent it to, when I sent it, and what I sent. You can get an accounting (a list) of these disclosures.

F. YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION

1. Right to Receive Communication by Alternative Means or at Alternative Locations.

You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment.

2. Right to Request Restrictions.

You have the right to ask me to limit what I tell people involved in your care or with payment for your care, such as family members and friends. I don't have to agree to your request, but if we do agree, I will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.

3. Right to Inspect and Copy.

In most cases, you have the right to look at the health information I have about you, such as your medical and billing records. You must make the request to inspect or copy such information in writing. You can get a copy of these records, but I may charge you. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. I may provide you with a summary of your PHI as long as you agree to that in advance.

4. Right to Amendment.

If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to me. You must also tell me the reasons you want to make the changes.

5. Right to Privacy Policy.

You have the right to a copy of this notice. If I change this notice, I will post the new one in my office or you can find it on my website: www.connectingbranchescounseling.com

6. Complaints.

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me, Danny Laesch, M.A., my supervisor, Dr. Katie Olvera, and/or with the Secretary of the U.S. Department of Health and Human Services.

All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

7. Right to Accounting.

You generally have a right to receive an accounting of disclosure of your PHI. Upon your request, I will discuss with you the details of this accounting process.

8. Right to Restrict for Care Out-of-Pocket.

You have the right to restrict certain disclosure of PHI to a health plan when you pay out-of-pocket in full for my services.

9. Right to be Notified.

You have a right to be notified if: a). there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; b). that PHI has not been encrypted to government standards; and c). my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

G. IF YOU HAVE QUESTIONS OR PROBLEMS

If you need more information, have questions about the privacy practices described above, or have other concerns about your privacy rights, you may contact me, Danny Laesch, M.A., LMHCA. at 217 417 4905 or via email at danny.laesch@gmail.com

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

Me:

Danny Laesch, M.A., LMHCA, 808 S. Elm St., Spokane, WA, 99204.

To my supervisor:

Dr. Katie Olvera, South Bay Suites in Fairhaven
1140 10th Street
Bellingham, WA 98225

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with appropriate address upon request. Please note: you have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint. The effective date of this notice went into effect on July, 2016.

Attachment I: Breach Notification

What is a breach? The HITECH Act added a requirement to HIPAA that psychologists (and other covered entities) must give notice to clients and to HHS if they discover that “unsecured” Protected Health Information (PHI) has been breached. A “breach” is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include: stolen or improperly accessed PHI; PHI inadvertently sent to the wrong provider; and unauthorized viewing of PHI by an employee in your practice. PHI is “unsecured” if it is not encrypted to government standards.

A use or disclosure of PHI that violates the Privacy Rule is presumed to be a breach unless you demonstrate that there is a “low probability that PHI has been compromised.” That demonstration is done through the risk assessment described next.

WHAT TO DO IF YOU LEARN OF OR SUSPECT A BREACH

A. Risk Assessment

The first step if you discover or suspect a breach is to conduct the required risk assessment. (You must take this step even if the breached PHI was secured through encryption.) The risk assessment considers the following four factors to determine if PHI has been compromised:

The nature and extent of PHI involved. For example, does the breached PHI provide client names, or other information enabling an unauthorized user to determine the client’s identity?

To whom the PHI may have been disclosed. This refers to the unauthorized person who used the PHI or to whom the disclosure was made. That person could be an outside thief or hacker, or a knowledgeable insider who inappropriately accessed client records.

Whether the PHI was actually acquired or viewed. Factors 2 and 3 can be illustrated by comparing two scenarios. In both scenarios, your office has been broken into and your locked le

cabinet with paper client records has been pried open. In Scenario A, you suspect that a burglar was simply looking for valuables because cash and other valuables (but no client les) have been taken. In Scenario B, you suspect the husband of a client in the midst of a contentious divorce because no valuables have been taken; only the wife's le appears to have been opened, and the husband has a history of similar extreme behavior. In Scenario A, the likelihood that a burglar was rummaging through les seeking only valuables, indicates a relatively low risk that PHI was actually viewed. In Scenario B, the identity of the suspected "breacher" suggests a very high risk that the wife/client's PHI was viewed and compromised. The extent to which the risk to the PHI has been mitigated. For example, if you send the wrong client's PHI to a psychologist colleague for consultation, it should be easy to obtain written confirmation from the colleague that they will properly delete or destroy the PHI on the wrong client. By contrast, if your laptop has been stolen you have little assurance that the thief will respect your client's confidentiality. If the risk assessment fails to demonstrate that there is a low probability that the PHI has been compromised, breach notification is required — if the PHI was unsecured.

B. Notice to the Client

If notice is required, you must notify any client affected by a breach without unreasonable delay and within 60 days after discovery. A breach is "discovered" on the first day that you know (or reasonably should have known) of the breach. You are also deemed to have discovered a breach on the first day that any employee, officer or other agent of your practice (other than the person who committed the breach) knows about the breach.

In most cases that members have brought to the APA Practice Organization's attention, there is a clear answer to the question, "Do I have to give notice?" For example, in the most common scenario of the stolen laptop with unencrypted PHI, the answer is always yes. But if you are uncertain, you can contact our Office of Legal and Regulatory Affairs at praclegal@apa.org. You may also want to contact your professional liability insurance.

The notice must be in plain language that a client can understand. It should provide:

- A brief description of the breach, including dates
- A description of types of unsecured PHI involved
- The steps the client should take to protect against potential harm
- A brief description of steps you have taken to investigate the incident, mitigate harm, and protect against further breaches; and
- Your contact information.

If you do not have all of the above information when you first need to send notice, you can provide a series of notices that fill in the information as you learn it. You must provide written notice by first-class mail to the client at his or her last known address. Alternatively, you can contact your clients by e-mail if they have indicated that this is the preferred mode of contact.

C. Notice to HHS

For breaches affecting fewer than 500 clients, you must keep a log of those breaches during the year and then provide notice to HHS of all breaches during the calendar year, within ^[1]_[SEP]60 days after that year ends. For breaches affecting 500 clients or more, there are more complicated requirements that include immediate notice to HHS and sending notifications to major media outlets in the area for publication purposes. HHS provides instructions on how to provide notice for breaches affecting more than 500 clients on its website at:

<<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html>>

IV: OFFICE POLICIES AND DISCLOSURE STATEMENT

EFFECTIVE AUGUST 2022

Please read carefully.

Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, this document reviews basic information about psychotherapy, summarizes my background and my therapeutic approach, and provides details about my office policies. Please read this information carefully and ask me to explain anything that you don't understand. This document, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it before we begin our therapy together.

This document addresses the following topics:

- My therapeutic approach
- My education, licensure, and business entity
- Fees and payment policies
- Cancellations
- Emergency contact information
- About confidentiality
- The risks and benefits of therapy
- Referrals to other providers
- My statement of principles and complaint procedures

MY THERAPEUTIC APPROACH

An important goal at the start of our work is to build a connection, and we'll spend time in our first session exploring our ability to do this by getting to know you and your current concerns. I take a nonjudgmental, open approach during this assessment so I can do my best to really understand you. If you feel like I'm "getting it," and you feel like we're connecting, then I'll suggest that we continue to work together. However, if we're not a good fit, I'm happy to connect you with someone who might be more appropriate for you and your needs. As we move forward in our work, I use an approach rooted in existential curiosity, with occasional, informal check-ins

about your personal feelings of progress. Additionally, I invite you to share these feelings whether or not you are prompted.

Throughout all of my work, I tend to take a collaborative, active, conversational, and sometimes direct approach. This may include offering in-the-moment feedback or encouraging you to consider looking at something a bit differently. I empower my clients to be direct with me, as well. This is your experience, and you have the right to feel as if you're getting the most you can out of our time together. I might also provide readings or activities to do in between our sessions. I find that additional work outside of the therapy room leads to much richer discussion in the room. It also supports your autonomy by giving you an opportunity to work on things on your own.

Typically, I will meet with clients one time per week. As clients get closer to their therapeutic goals, we may find that sessions should be scheduled less frequently. Termination can occur at any time you chose, but the goal is to end our work when you feel as if you no longer need therapy and have met your goals.

MY EDUCATION, LICENSURE AND BUSINESS ENTITY

Daniel (Danny) Laesch, M.A.

M.A. in Counseling Psychology, Gonzaga University, 2021

B.A. in Religion and Ethics, University of Puget Sound, 2014

Clinical Mental Health Counseling Associate in Washington State, MC61213342

MY SUPERVISOR'S EDUCATION, LICENSURE, AND BUSINESS ENTITY

Katie Olvera, Psy.D.

Psy.D. in Clinical Psychology, University of Indianapolis, 2012

M.A. in Clinical Psychology, University of Indianapolis, 2009

B.A. in Psychology, Purdue University, 2007

Licensed Psychologist in Washington State, PY 60352628

My business name is Connecting Branches Counseling. Please make any checks out to: Katie Plewa Olvera Counseling, PLLC. On all of our financial interactions such as billing records, charges, and receipts, you will see this designation: Katie Plewa Olvera Counseling, PLLC.

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for a \$100 fee if cancellation is less than 24 hours. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you will lose the of that session time.

The standard meeting time for psychotherapy is 50 minutes.

FEES & PAYMENT POLICIES

For individual therapy, my fee is \$225 for the initial intake evaluation and \$165 per 50-minute individual session thereafter. A sliding-scale fee may be negotiated. Fees are usually collected in full at the end of each session. Cash, credit/debit cards, or personal checks are acceptable for payment, and a receipt will be provided to you at your request.

PAYMENT AGREEMENT

- All services may be paid with cash, check, or credit card prior to the start of the service. Please make all checks payable to KPO Counseling.
- If utilizing insurance for payment, I give Daniel Laesch, M.A. permission to bill my insurance company for services. Billing services are rendered and managed by Billing Simplicity, LLC.
- If my insurance rejects a submitted claim for any reason, I am responsible and will pay the full fee for the service(s) rendered. The full fee of services is based on the amount that insurance covers – or, for self-pay clients, it will be the agreed-upon session amount.
- There will be a \$30.00 charge for all returned checks.
- Appointments start on time. If I am late, I may use the remaining time of my appointment but not beyond that. I will be required to pay for the entire cost of the visit.
- KPO Counseling, PLLC does not provide any refunds.
- I have an obligation to pay my account in full 60 days from the scheduled date of service. If I do not pay my account in full within this time period, I acknowledge my credit card will be charged for the remaining balance + 3% processing fee.

Extended sessions: Occasionally we may schedule longer sessions. For example, this may occur if we invite a family member or partner to join in our session. On a rare occasion, we may decide to extend a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes, I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis.

Insurance: If you plan to use insurance to pay for our sessions, I encourage you to educate yourself about what your particular plan covers (and what it does not cover) so that you are not surprised by unexpected bills. You are responsible for all co-pays, co-insurance, and meeting

your deductible. If I am not a preferred provider on your plan, you can explore whether your insurance plan offers out-of-network benefits that would cover a percentage of my fee. If you find that you have out-of-network benefits, I ask that you pay me directly, and I will provide you with a receipt to submit to your insurance company for reimbursement. Many of my clients choose to pay privately because it offers them more control and privacy. *When mental health services are billed to an insurance company, the provider is required to submit a diagnosis, which then becomes part of your medical record.*

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

EMERGENCY CONTACT INFORMATION

In the event of an urgent life threatening situation, please contact the Crisis Care Line at 1-800-584-3578 (24 hours a day, 365 days a year, toll free), 911, or go directly to the emergency room.

ABOUT CONFIDENTIALITY

It is your legal right that our sessions and my records about you be kept private. That is why I ask you to sign a “release -of- records” form before I can talk about you or send my records about you to anyone else. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the “Notice of Privacy Practices” (copies available on my website).

Email. Voicemail and phone are the only secure methods of communication that are HIPAA compliant. Email and texts can be intercepted or viewed by third parties. Additionally, if you use your work email address, your employer could have access to it. Some clients prefer the convenience of email communication and texting despite their lack of security. I am asking you to determine your own preference for security versus convenience in communication. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Social Media & Telecommunication. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc) within a five-year period post termination. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Professional consultation. Professional consultation is an important component of an effective psychotherapy practice. As such, I will regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

LMHCA Supervision.

As an LMHCA in Washington State, I am licensed by the state to provide mental health services. Upon completion of a masters degree, masters internship (1500 hours), national boards, and LMHCA licensure approval, an LMHCA in the state of Washington is required to have an additional 3000 hours supervised practice in order to attain full licensure, i.e., an LMHC.

I am working with Dr. Katie Olvera, who is a practicing psychologist and licensed clinical supervisor in the state of WA. She and I meet regularly to discuss client progress, approve intake, and progress notes, and any questions or concerns that have arisen in the course of diagnosis and treatment. As such, she will also have direct access to your medical information and my notes. This does not impact the HIPAA protection by which your documents are treated.

Records & Record Keeping. In terms of records and record keeping practices, I will take notes during or after our session. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I will maintain records for at least seven years following termination of therapy. After seven years, your records may be destroyed in a manner that preserves your confidentiality.

THE BENEFITS AND RISKS OF THERAPY

Therapy is a process in which we will discuss a myriad of issues, experiences and memories for the purpose of creating positive change. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, school, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Risks: Therapy may also involve some discomfort, including remembering and discussing unpleasant feelings and experiences. The process may evoke strong feelings such as sadness, anger, or fear. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility. If your symptoms worsen, it is often a sign that

we are going “too fast” in the therapy, so please let me know so we can adjust our work accordingly. Finally, even with our best efforts, there is a risk that therapy may not work out as you had hoped.

REFERRALS TO OTHER PROVIDERS

I do not work with clients that I do not think I can help. If you could benefit from a treatment I cannot provide, I will help you with a referral. Based on what I learn from you, I may recommend you seek a medical consultation or other resource. If I do this, I will discuss my reasons with you, so that you can decide what is best. If for some reason therapy is not going well, I might suggest you see another therapist or another professional. As a responsible person and ethical therapist, I cannot continue to treat you if my treatment is not working for you.

MY STATEMENT OF PRINCIPLES AND COMPLAINT PROCEDURES

It is my intention to fully abide by all the rules of the National Board of Certified Counselors (NBCC), by Federal laws, and by those of my state license. Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please share your concerns with me. Our work together will be slower and harder if your concerns with me are not addressed. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I have treated you unfairly or have even broken a professional rule, please tell me. If I am not able to resolve your concerns, you may report your complaints to the

Washington State Department of Health
Behavioral Health Professions
111 Israel Rd. S.E.
Tumwater, WA 98501,

call them at 360-236-4700,

Or visit them online: <https://doh.wa.gov/licenses-permits-and-certificates/complaint-and-disciplinary-process/health-professions-complaint-process>

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first

discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

THANK YOU

Thank you for your patience in carefully reading the Office Policies and Disclosure Statement. If, after reading this form, you decide against entering a therapeutic relationship with me, please contact me no later than 48 hours prior to our scheduled appointment time. If you have any questions prior to our first appointment, don't hesitate to call or send me an email.