Kerry Billingham, MS, LMHC

Individual & Family Therapist

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INFORMED CONSENT FOR COUNSELING SERVICES

THERAPIST CREDENTIALS: I am a master's level Licensed Mental Health Counselor (LMHC) in the State of Washington. LMHC #6901. I work under the supervision of an approved supervisor.

EDUCATION: I earned my Master's Degree in Counseling Psychology with an emphasis in cultural and feminist therapy from Northeastern University in Boston, Massachusetts. I earned my Bachelor's Degree in Psychology with a minor in Social Work at the University of New Hampshire in Durham, New Hampshire.

EXPERTISE: I am a Mental Health Professional (MHP) and a Child Mental Health Specialist (CMHS). I am Licensed in the State of Washington. This means I was supervised by a licensed clinician for 3600 hours, passed the National Board of Certified Counselors examination, and completed a master's degree and approved internship post graduation. I am also certified in Dialectical Behavioral Therapy.

THERAPEUTIC APPROACH: I have been trained in a variety of psychological and systemic approaches for working with individuals and families. I consistently use a client centered and family systems approach while integrating cognitive behavioral, emotion-focused, and dialectical behavioral therapy techniques to draw on strengths and problem-solve to enhance self-direction and empowerment. I have also been trained in Trauma Focused Cognitive Behavioral Therapy.

RISKS OF THERAPY: There are few known risks associated with these treatment modalities. However, some people report a heightened emotional awareness which can bring on stronger emotions. In some cases, people feel more depressed and have thoughts of suicide. Also, as you grow and learn things about yourself, your relationships with others may change.

CLIENT RIGHTS: Clients have the right to: 1) be treated with respect and dignity in the therapeutic atmosphere; 2) confidentiality and privacy; 3) refuse or terminate counseling at any time; 4) not be discriminated against; 5) obtain a copy of client records or request to amend a record; 6) to file a formal complaint against the therapist. If the client desires to terminate the counseling contract, it would be helpful if this were discussed with me in advance so that I may ensure proper closure, including referrals where appropriate, and so that any misunderstandings may be resolved.

TREATMENT: I typically see clients once a week unless sessions are arranged otherwise. Clients may schedule appointments as needed according to their therapeutic goals. Treatment may last anywhere from short term (10-12 sessions) to long term (up to several years), depending on client symptom relief and perceived change. Counseling is a process of change and will not happen overnight. A client may choose to continue maintenance counseling as desired unless it is

determined that sessions are no longer helpful or otherwise unnecessary. I help clients develop a treatment plan to track their progress in life domains and create goals that are meaningful and measurable.

CONFIDENTIALITY: I maintain the confidentiality guidelines of the Washington Administrative Code (WAC), the Health Insurance Portability and Accountability Act (HIPAA) and the American Counseling Association (ACA). See attached copies for detailed information. I will not disclose any personal or identifying information to anyone outside the therapist-client relationship without a client's written authorization. Exceptions to confidentiality include: 1) evidence suggests physical, sexual or emotional abuse and neglect of a child, a disabled individual, or the elderly, 2) the client presents with suicidal ideation and refused to comply with safety commitments, 3) the client reports a plan to harm a specific-named individual, 4) where permitted by or required by law (i.e., insurance agreement, legal subpoena), 5) consultations with my DBT consult group and with my supervisor. These conversations with my consultants/ supervisor will take place in an area and in a manner in which they will protect your privacy. My duty to provide confidentiality will survive the death of a client unless otherwise authorized by the client prior to death. In the event that a client and I have unplanned contact in a public setting, verbal acknowledgement will be left up to the client's discretion.

RECORD KEEPING POLICIES: I will maintain documentation of all consents, authorizations, notices of privacy practices, Office Policies and Procedures, trainings, and patient requests for records or amendments to records. I will document complaints received and their disposition. Client records will be kept locked in my office or in a locked file cabinet offsite. I will keep client records for seven years from the date of the last treatment session. With respect to the records of a minor, I will keep those records for at least seven years or until the patient is twenty-one years old, which ever is longer. Thereafter, I may destroy client records. When records are destroyed they will be done so in a manner that protects client privacy and confidentiality. If you do not want records kept, please inform me and I will discuss with you how to do this.

COVERAGE IN MY ABSENCE OR DEATH: There may be times when I take a week vacation. If you feel you would like to meet with another clinician in my absence, I will talk to you about having access to one of my colleagues in the office. In the case of my death, the custodian of your records is a designated colleague in my office.

CRISIS CONTACT INFORMATION: If a client is in crisis and unable to reach me, please call the Seattle Crisis Clinic Line at 206-461-3222 or toll free 1-866-427-4747 or TDD Line access 206-461-3219. If you have life threatening emergency, call 911 immediately. I will designate an on-call therapist for coverage in the case of my own personal emergencies or vacation.

CLIENT REPONSIBILITIES

FEES AND BILLING PRACTICES: My fee for a 90 minute intake assessment is $175. For a 30 minute session is $105. For a 55 minute session is $125. For a 75 minute session is $155. Fees are to be paid at the beginning of the session unless discussed otherwise. Fees for phone consultation are $20 per conversation lasting over 15 minutes. I have the right to make exceptions as needed. I accept cash, check, or credit cards. There is a $5 discount per session if you pay in cash. I take exact change only, as I do not keep a cash box or safe on the office premises for change. If a client is unable to pay the service fee, I have the right to terminate

therapy and refer the client to a low cost counseling center. There is a $25 fee for any returned checks.

CANCELLATION POLICY: I have a 24 hour cancellation policy. If you are sick or otherwise unable to make it to the scheduled appointment, you must contact me at least 24 hours before the appointment. Failure to due so will result in being charged the full session rate. This fee will be due at the beginning of the next session.

CORRESPONDENCE: If a client chooses to contact me via cellular phone, email, or fax, s/he understands complete client privacy and confidentiality will be at risk due to intercepted calls, technological hackers, or accidentally dialed fax numbers. Clients are responsible for advising me if there is not a safe phone number or address to be contacted, otherwise, I have the right to attempt contacting clients according to the information provided by the client on the registration form.

ACCOUNTABILITY: Clients are expected to actively participate in each session in order to achieve significant progress or change. If a client does not maintain complete honesty and disclosure of critical information with me, I will be unable to assist them with making positive life changes.

CLIENT AGREEMENT

By signing this form below, I acknowledge I have read and understand the above therapist disclosure, consent to receive counseling services, client responsibilities and treatment contract. I have received copies of the HIPAA privacy practice guidelines. I agree to abide by the above client responsibilities and to actively participate in the counseling environment. I understand that if I withhold important critical information from my therapist, I will be interfering with my own counseling progress and I will potentially jeopardize the therapeutic process. I understand my rights as a client. I have been given the opportunity to ask questions. I understand this is a legal document and contract. I have been given a copy of this contract.

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Client name Client signature Date

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Client name Client signature Date

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Client name Client signature Date

_____

Client name Client signature Date

For treatment of a child under the age of 13:

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Parent/legal guardian name Signature Date