Christina Spears-Bartunek, MS, LMHC 206-535-4433

 **Clinician Disclosure Information and Informed Consent**

You have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You also have the right to terminate your treatment at any time for any reason. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services.

 Confidentiality, your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

 • If you give me written consent to have the information released to another party.

 • In the case of your death or disability I may disclose information to your personal representative.

• If you waive confidentiality by bringing legal action against me. • In response to a valid subpoena from the court or from the Secretary of the Washington State Department of Health for records related to a complaint, report, or investigation.

• If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person.

• If, without prior written agreement, no payment for services has been received after 90 days, the account contact information which may include account name, address, phone, email, social security number, and the signature page of the consent for services may be submitted to a collection agency.

• If I have any other legal duty, obligation, or right to report. I may also be required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44 and RCW 18.19.180(3), suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

 If you have any questions regarding your confidentiality please let me know, and I would be happy to discuss it with you. For additional information regarding your confidentiality rights, please carefully review the attached HIPAA and Washington State Notice of Rights and Privacy Practices. Insurance Providers Insurance companies and other third-party payers may require that I provide them with information regarding the services I provide to you. This information may include the type of service provided, the dates and times of service, your diagnosis, treatment plan, a description of impairment, progress of therapy, and case notes. If you do not want me to provide your confidential information to your insurance company, let me know so we can talk about alternatives.

**Consultation**: I seek ongoing consultation from colleagues in order to provide you with the best services possible. I may disclose information about your counseling session in which case I will withhold your name and other easily identifiable information. I have an agreement with Wendi Nancarrow-Carter, LCSW to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated.

 **Education, Training and Experience** I am a licensed Mental Health Counselor in Washington State (#00004447). I received my Masters in Science in psychology from Western Washington University and my Bachelors in Science in psychology/biology from University of Washington, and have over 30 years of clinical experience. Cognitive Behavioral, Solution Focused and Mindfulness counseling methods are primarily used but occasionally another theoretical method may be applied if considered appropriate. Any methods used are consistent with generally accepted theory and practice.

**Financial Requirements** The cost of each 55 minute therapy session is $135. The cost of an initial intake session is $150. Fees are to be paid by check, cash or credit/debit cards at the end of each session. Co-pays, coinsurance and unmet deductibles are also due at the time of service for health plans that I am a member of. Please review those fees before your first session. Appointments may be suspended until payment of services is made in full if you accrue an outstanding balance due. Cancellations or rescheduling appointments must be made 24 hours in advance of your appointment time. If it is not cancelled or rescheduled within this time frame, you will be responsible for paying a **$75 fee**. Insurance does not cover missed appointments.

 **Electronic Communications and Social Media Policy** I will use cellular phones to communicate with my clients. In such cases, I will limit the information I store in any portable communication device to the least necessary. Please be aware that such forms of communication do have inherent risks to client confidentiality. I will typically communicate with clients via email and text for the communication of scheduling, canceling, and billing for appointments only. Professional ethics standards do not allow me to communicate with clients via personal social media.

I provide video session via a HIPAA compliant website, doxy.me. All rules and safety measures of confidentiality are recognized and upheld in the remote setting.

**Emergencies** If you are experiencing an emergency or crisis, please call 911 or the Crisis Line (206)461-3222. In such situations, you may also go the nearest hospital Emergency Room.

**Termination of Services** You have the right to terminate services with me at any time during the treatment. Typically, termination of care is a mutually agreed upon decision based upon progress in growth and reaching one’s therapeutic goals: this decision occurs between the client and clinician. If you should miss three or more scheduled appointments without contacting me prior or do not participate in therapy for 60 days or more, I will consider my services to be ended by default and no longer hold any responsibility for your mental health care.

**Limits of Service** I do not assess fitness for custody, act as an expert witness, act as a fact witness or go to court as your advocate. By signing this document, you agree not to subpoena me or otherwise request my presence or services as a witness to any action on your behalf.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, loneliness and helplessness. On the other hand, psychotherapy has been shown to have benefits for people. It often leads to better relationships, solutions to specific problems and significant reduction in feelings of distress. There are no guarantees of what you will experience.

 **State of Washington Disclosures** The State of Washington requires that I provide you with the following information. Counselors practicing for a fee must be registered or licensed with the Department of Licensing for the protection of public health and safety. Credentialing of an individual with the Department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. A copy of the acts of unprofessional conduct can be found in RCW18.130.180. Complaints about unprofessional conduct can be made to: Health Systems Quality Assurance Complaint Intake HSQAComplaintIntake@doh.wa.gov I maintain a referral list of other Counselors with a range of specialties. I will provide you this list if I feel your needs are beyond the scope of my expertise, or you ask for such information. Consent for Treatment

 By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions. By signing this document, you are attesting to your consent to participation in counseling services provided by Christina Spears-Bartunek, MS, LMHC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature date

Print name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Christina Spears-Bartunek, LMHC