Gera McGuire, MA, NCC, LMHC
Mailing Address: PO Box 44 Black Diamond, WA 98010
Office Address: 1174 Myrtle Avenue, Suite 106, Enumclaw, Washington Phone: 360-469-4179

Informed Consent and Counselor-Client Services Agreement Form

INTRODUCTION

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

The law requires that I obtain your signature acknowledging that I have provided you this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them in entirety and very carefully. We can discuss any questions that you have about the procedures and practices. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process of substantiate claims made under your policy; or if you have not satisfied any financial obligations that you may have incurred.

YOUR THERAPIST'S EDUCATION AND TRAINING

Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. I obtained my Bachelor of Arts degree in Psychology from Hiram College in Ohio and my Master's Degree in Counseling from Edinboro University of Pennsylvania and began working as a counselor in 1994. I have counseled and supervised counselors in various settings with varied populations including mental health agencies, schools, hospital settings and in private practice. Additional education that I have received has been through the Philadelphia Child Guidance Center for family therapy as well as Columbia University in New York for Complicated Grief Therapy. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Gera McGuire, MA, NCC, LMHC is a Nationally Certified Counselor with licensure in the state of Washington as a Mental Health Counselor. My license number is WA Lic. # 60422606.

YOUR THERAPIST'S TREATMENT MODALITY AND THERAPEUTIC ORIENTATION

My modality is eclectic, drawing from ecosystemic structural family therapy, cognitive behavioral therapy, and complicated grief therapy.

PROFESSIONAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the practitioner and client, and the problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. For therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

I am not able to propose an appropriate course of treatment for you until we have spent some time together. As soon as I can identify an appropriate course of treatment, however, I will discuss it with you.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

There may be times in which I will challenge your perceptions and assumptions and offer different perspectives. 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. During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy and realize that there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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 a 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; or
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, 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, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

APPOINTMENT SCHEDULING AND CANCELLATION POLICIES

Your first 2 or 3 sessions are set aside for information gathering as an initial evaluation. During this time we can decide if you would like to partner with me to provide the services that you need.

Sessions are typically scheduled to occur for 45-60 minutes on a weekly basis. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours (2 business days) advance notice of the cancellation. If an appointment is missed, or canceled with less than 48 hours' notice, you (not your insurance company) will be charged the full fee for that missed session. Typically, insurance companies do not provide reimbursement for cancelled sessions. Exceptions may be made if you are sick or have an unavoidable emergency. I will try to find another time to reschedule your appointment.

If you have 3 no shows, we will discuss your participation in treatment and decide if you wish to continue with services. I will send a formal letter to your home addressing this concern.

MINORS & PARENTS

According to Washington State Law, the age of consent is 13. "Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent." RCW 71.34.530

Clients aged under 13 should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete.

For clients aged 13 and older most communications with parents will require the child's authorization.

RATES

Initial Evaluation (90791) $175.00
Individual Therapy (16-37 minutes) (90832) $100.00
Individual Therapy (38-52 minutes) (90834) $125.00
Individual Therapy (53-67 minutes) (90837) $175.00
Each additional 30 minutes add $100
Family/Couples Therapy (90847) $150.00
Group Therapy (90853) $25-75 per session
Late Cancel/No Show $40.00
Preparation for Court Appearance or Court Appearance $175/hour
Monthly Late Fee (outstanding balances only) $ 25.00

PROFESSIONAL FEES

Payment is expected in full at the time of your session. I accept cash or personal check. There is a Check Returned Fee of $25.00.

In addition to weekly appointments, I charge for other professional services you may need, such as report writing and preparation for court appearances. I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party at the rate of $175.00 per hour.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If I am required to invoice you monthly as a result of an outstanding balance, a $25.00 fee will be late fee will be assessed.

Payment plans will be negotiated in rare cases and will each be assessed a $25.00 monthly processing fee. If the identified client is a minor with the primary payer residing at a different address and is requesting to be invoiced for all co-payments, a written agreement will be created with the financially responsible party. As previously stated, any outstanding balance at the end of the month (regardless if a written agreement is present) will be assessed a $25.00 late payment fee.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

If you request a copy of your record, I may charge you a reasonable fee in accordance with WAC 246-08-400.

DELINQUENT ACCOUNTS

You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay a monthly late fee of $25. If it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due, plus accrued monthly late fees, any and all collection expenses of 30-50% of any balances owing, and any attorney's fees.

THERAPIST AVAILABILITY AND EMERGENCIES

You may leave a message for me at any time on my confidential voicemail at 360-469-4179.

If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room, and/or call the King County 24-hour Crisis Line at 866-427-4747. The main voicemail is where I also provide

on-call information in the event I am on vacation or unexpectedly called away. I will do my best to return your call.

TERMINATION OF THERAPY

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

INSURANCE

I am currently in network for a few insurance companies and considered out of network for others.

Please inform me if you wish to utilize your health insurance to pay for services. I will discuss the procedures for billing your insurance and provide you with a receipt that you will submit to your insurance company if you so choose. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you, the amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier and submitting all the receipts for services for reimbursement. Please discuss any questions or concerns that you may have about this with me.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the

information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

STATE OF WASHINGTON DISCLOSURES

The State of Washington requires that I provide you with the following information.

You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be credentialed or licensed with the Department of Health 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 RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

ACKNOWLEDGMENT AND 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 Gera McGuire, MA, NCC, LMHC.

_____ _____
Client Signature Date

_____
Print Name

_____ _____
Gera McGuire, MA, NCC, LMHC Date