INFORMED CONSENT FOR TREATMENT

Betsy L. Hicks, MA, LMFT
Lacey Couple & Family Therapy Services, PLLC
677 Woodland Square Loop SE Suite 11 Lacey, WA 98503

This document when signed is a formal agreement between us for therapeutic services. You have the right and the responsibility to choose your provider and treatment modality that best suits your needs. Please ask if you have any questions or concerns pertaining to this document or treatment.

ABOUT ME (EDUCATION/TRAINING & PHILOSOPHY OF TREATMENT)

I hold a master's degree in Marriage and Family Therapy from Pacific Lutheran University and have been trained to work with individuals, couples and families. Overall, I practice from a general systems perspective incorporating a systemic approach, helping clients look at all aspects of their life-current and past-to help identify what influences may be contributing to current issues. Experiences, family patterns, and beliefs, help shape who we are and how we view the world. When possible I prefer to work with the entire family. At times people may experience an event or a significant life change and individual therapy may be preferred. I aim to help clients gain insight and discover broken communication and/or behavior patterns so we can work together on improving relationships and building positive interactional patterns and communication. I further aim to help families/couples/individuals discover the various influences that may be impacting their lives. Additionally, I draw heavily from Narrative Therapy and Solution Focus techniques to help clients envision the life they want and realize what steps they want to take to live the life they wanted. For couples work, I am primarily utilizing Emotional Focus Therapy and Gottman methods.

License in Washington State

Licensed Marriage and Family Therapist (LMFT) License # LF60649745

Education

Pacific Lutheran University-Masters (MA) in Marriage and Family Therapy
University of Washington-Bachelors (BA) in Psychology

Professional Membership

Pre-Clinical Fellow of American Association for Marriage and Family Therapy
Pre-Clinical Fellow of Washington Association for Marriage and Family Therapy

CONTACT INFORMATION

Phone number: 360-588-2181. As I may be in session with another client, I may not always answer my phone. Please leave a detailed message and I will return your call as soon as possible. At the very latest I will respond within 48 hours. Please be advised this phone number does not accept or send text messages. Email: Laceytherapy@gmail.com I will try to respond the same day, but at the very latest I will respond within 48 business hours.

INTERNET/MEDIA POLICY

I do have a business Facebook page where I post inspirational/motivational psycho-educational articles. It is not intended to be therapy. please be aware your engagement could compromise the confidentiality of the therapeutic relationship. I do not accept friend or contact requests from current or former clients on any personal social or professional networking/media sites.

NUMBERS TO CALL IN THE EVENT OF AN EMERGENCY OR UNABLE TO REACH ME:

Emergency number: 911

Crisis numbers: Thurston County 1-360-586-2800 Pierce County 1-360-586-7764

CLIENTS RIGHTS/RESPONSIBILITY/CONFIDENTIALITY

You have the right to non-discriminatory treatment and to be treated with dignity. You have the right to have your records protected. Furthermore, you have the right to obtain a copy of your records. I will need a written request and a fee will be charged for copies. If the clients are seen as a couple or a family, no information will be released without the written consent of all parties. Exceptions to the right to obtain your

record include the therapist concluding that the release may cause harm to you or someone else, or if it is legally advisable. You also have the right to confidentiality and the right to request restrictions on disclosures of your protected health information- with exceptions as noted in **limits to confidentiality (Appendix A.)** With written authorization, you have the right to authorize the release of your protected health information and the right to rescind your release of protected health information. (To withdraw your consent you need to have it in writing and understand that information already disclosed cannot be undone or recovered.) As a client you have the right to refuse treatment, and obtain referrals to other therapists and/or agencies. You have the right to discuss complaints with me or with anyone of your choosing, including other therapist. You have the right to a copy of this informed consent.

I encourage you, and it is your responsibility, to ask questions when you have concerns, be honest, follow the treatment plan, attend therapy appointments, and inform me of any changes (contact information, or information that would impact you and our therapeutic process such as employment, significant relationships, etc.) It is your responsibility to make payments prior to therapy session.

BENEFITS AND RISKS

Individual, couple, and family therapy have all been shown to have benefits for many people. However, there can be risks associated with therapy. Growing, making self-discoveries and changes is a process and can cause discomfort and experience unexpected feelings such as frustration and guilt. During the therapeutic process clients may experience setbacks which may be inevitable.

Some of the possible benefits of therapy are increased satisfaction with relationships, resolution of issues, and a greater understanding of self, relationships, and cultural influences. Other possible benefits may be reduced stress and anxiety. Furthermore, an individual, couple, or family, may develop greater coping skills and a clearer sense of their values and goals.

PROPOSED COURSE OF TREATMENT

The first session is 80 minutes to complete and review intake forms and consent forms as well as to allow adequate time to go over concerns. Sessions are typically once a week for 50 minutes. Typically there are 8-12 sessions for treatment, but this may vary greatly depending on the unique needs of the client(s).

The first few sessions, as we get to know each other, are intended to explore the issues that have brought you into therapy and for me to hear and understand each person's perspective.

Together we will explore what goal(s) best meet your needs and discuss a treatment plan for how your goals can best be achieved. It is your right to request changes or revisions to your goals. We will regularly evaluate progress that is made, and make sure the goals are still appropriate and allow for revisions in a collaborative effort. There are various techniques I may use during therapy to include communication skill building techniques, genograms (looking at family history), and clinical assessments. It may also be helpful to incorporate other relevant people into the therapeutic process to help support you/your family in reaching set goals. It is important to note that no one would be contacted nor would information be disclosed without your written permission.

FEES/INSURANCE

Payment is due at time of session. My standard fee for therapy is $150.00 per 50 minute session. The first session (which is 80 minutes) is $200.00. Subsequent 80 minute sessions are $210.00. I am out of network with insurance companies and I do not file for insurance. I can provide you with a receipt and your health plan *may* provide reimbursement. Please check with your insurance company regarding coverage and filing procedures. Payment may be made by cash, check, Visa, or MasterCard. If cancellations are necessary please provide-at minimum-a 24 hour notice. There is a $75.00 cancellation fee for appointments cancelled less the 24 hours. There is a $100.00 fee for a 'no show' to an appointment. Payment will be charged same day to your credit card on file. The fee for a written check with non-sufficient funds is $30.00. On a limited basis I offer a reduced fee for services. For further information please ask prior to services. If there is a matter where you need a brief/crisis consultation with me, you may call to discuss the issue. Should the call exceed 10 minutes or calls become frequent, the fee charged is a proportionate amount of your typical session fee.

COURT ISSUES

Because therapy requires a safe, confidential environment, involvement in legal or court proceedings fundamentally alters the therapeutic relationship. Therefore, I do not provide forensic evaluations, custody recommendations, or expert witness testimony unless required by law.

If I am subpoenaed or requested by you or your legal representative to attend a deposition, court hearing, or other legal proceeding, you agree to compensate me for all time involved—even if I am called to testify by another party.

Hourly Rate: Time spent on legal preparation, record review, travel, waiting at court, depositions, and testimony is billed at $350.00 per hour (this rate is separate from your standard psychotherapy fee and is not covered by insurance).

Minimum Charge: Court appearances and depositions carry a 4 hour minimum charge, payable in advance.

Retainer: A non-refundable retainer of $1500.00 must be received by this office no later than 7 business days prior to the scheduled court date or deposition. Any unused portion will be refunded, or additional time will be billed accordingly.

Cancellations: If a court appearance or deposition is canceled or postponed with less than 72 hours notice, the minimum fee will still apply to compensate for blocked office and clinical time.

Client Responsibility: You are financially responsible for all professional time, legal consultation fees, and administrative costs incurred in response to legal actions regarding your case, regardless of which party issued the subpoena

COMPLAINTS

Unprofessional conduct can be defined under the revised code of Washington State (RCW 18.130.180) If you feel you have been discriminated against or otherwise treated unethically or unprofessionally you may contact the WA State Department of Health, PO BOX 47869, Olympia, WA 98504, (360) 236-4700.

COLLABORATIVE SHARING

At times I meet with consultation groups so that we might gain a better understanding of how we can work with clients more effectively. If I discuss my cases with my professional colleagues all names and unique identifying information will remain concealed. The other professionals with whom I work with are bound to the same standards of confidentially and ethics as I am.

INACTIVE STATUS AND FILE CLOSURE POLICY

To ensure the highest quality of care and maintain accurate records, Lacey Couple and Family Therapy Services maintains an active-client policy. If therapist has had no contact from you for a period of 30 consecutive days, your file will be considered inactive and will be closed. File closure simply means you are no longer considered an active client of this practice; it does not prevent you from seeking services in the future. If your file is closed and you wish to resume therapy at a later date, you may contact me to determine current availability. Please note that resuming care may require completing updated intake paperwork, a new assessment, and is subject to current fee schedules and clinician availability.

Your signature acknowledges that you have agreed to treatment and have read and understood the information in this informed consent. It also acknowledges that you have received the limits of confidentiality form.

Client Signature _____ Date_____

Client Signature _____ Date_____

Client Signature _____ Date_____

Client Signature _____ Date_____

Therapist Signature_____ Date _____

Betsy Hicks M.A., LMFT

LIMITS OF CONFIDENTIALITY APPENDIX A

All content of therapy sessions are confidential. Written consent is required for the client's verbal information and/or written records to be shared. However, listed below are the following legal and/or ethical exceptions to confidentiality:

ABUSE OF CHILDREN If a client states or suggests they are abusing or neglecting a child, or a mental health provider has reasonable cause to believe a child has been abused or neglected or had been previously abused a mental health provider is mandated by law to report this information to the proper legal authorities and/or department.

VULNERABLE ADULTS If a client states or suggest that they have abandoned, abused, financially exploited or neglected a vulnerable adult a mental health provider is mandated by law to report to proper legal authorities and/or department.

HARM TO SELF If there is reasonable cause to believe and/or a client states or suggests they have a plan or intend to commit suicide, the mental health care provider is legally required to notify the proper legal authorities and make reasonable attempts to notify the family of the client.

DUTY TO WARN AND PROTECT If there is reasonable cause to believe and/or a client discloses they plan or have intentions to harm another person, a mental health provider has an ethical duty to warn the intended victim, notify the proper legal authorities, and make reasonable attempts to notify the family of the client.

SUBPOENA/COURT ORDER If a mental health provider is subpoenaed or court ordered, information and/or records will be released that are related to a report or a complaint. Mental health provider will make reasonable attempts to notify client. If client is contesting the subpoena it is the client's responsibility to properly inform me of the contest.

PRIVILEGE WAIVED If any Washington-state agency that oversees my licensure subpoenas me as part of an investigation, I am required to comply and may be asked to disclose your personal information. If legal actions are brought against a mental health provider by a client the privilege of confidentiality is null and void.

MINORS Parent/legal guardians hold the privilege of confidentiality when the child is under age 13. Information obtained in therapy from a minor under age 13 may be shared with patents/legal guardians.

INSURANCE COMPANIES/BILLING Insurance companies may need dates of treatment and diagnoses for reimbursement. Complete confidentiality cannot be assured when using insurance.

I have read the above and fully understand the limits of confidentiality.

Client Signature _____ Date_____

Client Signature _____ Date_____

Client Signature _____ Date_____

Client Signature _____ Date_____

Therapist Signature _____ Date_____

Betsy Hicks M.A., LMFT

CREDIT CARD AUTHORIZATION

Betsy L. Hicks, MA, LMFT Lacey Couple & Family Therapy Services, PLLC
677 Woodland Square Loop SE Suite 11 Lacey, WA 98503

In order to provide you and other clients of Lacey Couple and Family Therapy Services, the best possible care, a minimum of 24 hours' notice is required to cancel or reschedule your appointments. I_____, understand the importance of notifying Betsy Hicks MA., LMFT at least 24 hours prior to the scheduled appointments that I am not able to keep.

I understand that $50.00 will be charged to my card on file, for failing to cancel an appointment prior to 24 hours of the scheduled appointment time or if I fail to show for an appointment without contacting Betsy Hicks prior to the appointed time, a No Show fee of $100.00 will be charged for the individual record of myself or the couple's record of myself and

_____

I _____, give Betsy Hicks MA., LMFT the authorization to charge my credit card $50.00 for each missed therapy session where 24 hours' notice is not given and/or $100.00 for each missed therapy session where I fail to call and show for the appointment. I will be provided a receipt for all payments upon request.

I will not dispute fees charged to this card for appointments I have not cancelled per the cancellation policy. I further authorize Lacey Couple & Family Therapy Services PLLC to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

I am requesting that this card be used for payment of either late cancellations and/or 'no show' fees:

Name on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ Code: _____

Address: _____Zip Code: _____

Client's Name (printed): _____

Client's/Card Holder Signature: _____Date: _____