CLIENT INFORMATION

Client Name: ____ Gender:_______________.
D0B:______________________ Phone:_________________________ E-mail:__________________________________.
Address:____.

City:______________________ State:__________________________ Zip:____________________________________.

Responsible Party: ____.
Address:____.
City:______________________ State:__________________________ Zip:____________________________________.

Emergency Contact Name: ___________________________________ Phone:_____________________________.
Relationship:____.

DISCLOSURE STATEMENT

Those Therapists with an LMHC, PhD, LICSW, or LMFT are fully licensed and can practice independently.

LMHCA, LICSWA, LMFTA indicate provisional licensure in the State of Washington. These therapists have completed their master's degree and are able to see clients under the supervision of a fully licensed practitioner.

"Intern" indicates that this practitioner is not licensed and is in the process of completing a master's or doctoral degree from an accredited university. This person is also supervised by fully licensed practitioners both at Family Dynamics Counseling Services and within their graduate program.

Karen Larkin Packwood, MA, LMHC, CDPT, CCTP
#LH60231558 (Initial)

Deborah Baker, MA, LMHCA, HHP
#MC6089477 (Initial)

Tobi Goering, MA, LMHC
#LH61002914 (Initial)

Margaret Stevenson, LSWAIC, MHP
#SC61017825 (Initial)

Email voicemail and texting are not confidentially secure forms of communication. However, if you prefer to be contacted by any of these methods, please initial here_______________.

Our business office is open Monday-Thursday from 8:00-8:00, Friday from 8:00-5:00, and Saturday from 9:00-6:00 with the exception of holidays. Your scheduled time with your counselor is by appointment only.

It is the intent to provide therapeutic treatment for everyone who works with a therapist at Family Dynamics Counseling Services. The therapeutic relationship ceases to exist with a client when asked to testify, sit for a deposition, or write an affidavit making recommendations to the courts. This is not something that we are skilled at, if this is your aim in seeking counseling, please request a referral to an agency which has the skills to perform such a role, please initial here______________.

According to WAC 246—810-035 (2) your therapist is allowed to keep minimal confidential notes for each session to protect your privacy. In the event of an insurance audit, the insurance company would receive a diagnosis code and minimal notations, please initial here_______________.

If it ever becomes necessary during treatment to testify, write letters, or anything court related beyond the work we would typically do when working therapeutically, please note our rates and policies below:

> $450/hour upon receipt for written letters, affidavits, recommendations.
>
> $2500 due upon receipt for any subpoena to sit for a deposition or court appearance. This is refundable up to one week prior to date and time of the required appearance, but as we will need to cancel all appointments for the day of the appearance and will need to prepare for testimony, it is not refundable after this point, as the work has been done and the appointments with other clients that cannot be rescheduled have been cancelled. Please initial here_______________.

It is required for children of divorce to have a copy of the visitation/custody settlement papers on file. These papers will need to be received prior to working with the child. Unless there is written legal documentation to the contrary, both parents will be invited to work with the therapist in supporting the child during the therapeutic process. (If divorce is not final, temporary orders will be accepted until final papers are filed.) Please initial here_____________.

Additional Mandatory Information RCW 18225.100: You have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs. You have the right to confidentiality except the reporting of suspected abuse or neglect of a child, dependent adult or developmentally disabled person. This disclosure does not grant new rights and is not intended to supersede state or federal laws and regulations of professional standards.

Please also note that if you disclose intent to harm yourself or others we are legally and ethically bound to report this to authorities.

The undersigned also authorizes: the release of information necessary for supervision, training, or other lawful purposes; the providing credit or collection of any fees due; and, that should a complaint of any nature be instituted against a provider and/ or Family Dynamics Counseling Services, Inc. or should any collection of monies due to the provider be initiated, the undersigned waives the right to confidentiality and agrees to hold the provider and/or Family Dynamics Counseling Services harmless for any and all subsequent disclosures by such. The use of a copy of this assignment to be considered as the original and shall be valid for the duration of the therapeutic relationship or length of time needed to culminate financial or legal disputes in relation to such.

By signing this document, you (the client, patient, member, etc.) are indicating that you have read and agree with the information, agree to treatment, and have been given a copy of this document. This document is the sole agreement between client, counselor, and Family Dynamics Counseling Services and supersedes any other agreements or contracts whatsoever.

The Washington State Department of Health may be contacted to obtain a list of or copy of the acts of unprofessional conduct listed under RCW 18.130.180 at Health Professional Quality Assurance, PO Box 47860, Tumwater, WA 98501, (360) 236-4700.

Severability: If any portion of this agreement is deemed to be unenforceable, the remainder is still valid.

CLIENT SIGNATURE:____ DATE:_______________.

Name of Responsible Party (for child under 18):____.

Relationship to Client:____.

SIGNATURE OF RESPONSIBLE PARTY:________________________________ DATE:_______________.

SIGNATURE OF PROVIDER:____ DATE:_______________.