Teri Wood, M.A., PLLC, LMHC
Child & Family Therapist
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Disclosure Statement

Welcome. I am a Washington State licensed mental health counselor. My master's degree was earned at Antioch University in Seattle. My post graduate studies were with University of Washington and Wellspring. I attend on-going educational trainings relevant to my practice. I have been offering services in the mental health field for 30+ years. My therapeutic approach is based on what you report as your needs/goals and/or what we discuss in session. I am systems based with eclectic and other components borrowed from Play, Art, Cognitive Behavioral, and Animal Assisted therapies. Humanistic, Existential, and Attachment therapy are also borrowed from. I work with individuals, couples, parents, family, and group therapies.

You have the right and responsibility to receive appropriate care, respect and confidentiality – with some exceptions as stated below. It is appropriate for you to raise questions at any point in the therapy process. You have the right to receive treatment that is non-discriminatory, and sensitive to differences of race, culture, language, sex, age, national origin, disability, creed, socio-economic status, marital status, and sexual orientation. It is your right as a client to choose the therapist and therapy modality which you feel is a good fit. You have the right to terminate therapy at any time. In order to have healthy closure, it would be important for us both to participate in the process. In cases where I feel you may benefit from another therapeutic perspective; I will give you referrals.

The counseling process involves me gathering information about the presenting problem(s) or concern(s) and forming an opinion about the type of treatment/modality that would be most helpful. Information collected may include, but not limited to, developmental, psychosocial, family and school/work history. Behavior symptoms may also be included in assessments/evaluations. The number of sessions will vary with the potential complexity of the situation; you are free to check in with me regarding duration and scheduling.

The state of Washington requires me to provide the following disclosures: WAC 308-190-040: *"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."*

It is important to be aware that counseling/therapy can be extremely helpful but is not guaranteed. As active participant/s / family/ies you get what you put into it with your commitment to change. Counseling/therapy is primarily voluntary. If you feel that I and not a good match for you, or a particular concern you are seeking help for, it's hoped that you will bring this to counseling and openly discuss it. If we find termination of services is imminent, a referral list of 3 options will be given to you during a closure session. You will be responsible for any outstanding balances at that time. You have the right for further explanation of these policies at any time.

By signing this disclosure statement, you are agreeing to be responsible for full payment of all relevant fees.

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Emergency or Crisis Information:

Teri Wood, MA, PLLC is a private practice therapy model that does not offer crisis response services or after hours coverage.

In case of life-threatening issue/s-EMERGENCY please call 911, go directly to the Emergency Room/Department.

In case of a CRISIS please call:

- **King Country Crisis Line 1-866-427-4747**
- **Snohomish County Crisis Line 1-800-584-3578**
- **TTY 206-461-3610**
- **Crisis Text 741-741**
- **Teen Link (6p – 10p only) 1-866-833-6546**
- **National Suicide Hotline 1-800-273-8255**
- **Runaway Switchboard 1-800-786-2929**

Confidentiality: Issues discussed in the course of therapy are primarily confidential. Information regarding your treatment is addressed in the laws of the state of Washington, which require certain information to be released in specific situations, such as (RCW 18.225.105):

(1) With the written authorization of [client/family] or, in the case of death or disability, the person's personal representative;
(2) [Client/family] waives the privilege by bringing charges against me
(3) In response to a subpoena from the secretary. The secretary may subpoena only records related to a complaint or report under RCW **18.130.050**;
(4) As required under chapter **26.44** or **74.34** RCW or RCW **71.05.360** (8) and (9); or
(5) To any individual if I have reason to believe that disclosure will avoid or minimize an imminent danger to the health or safety of the individual or any other individual; however, there is no obligation on my part to disclose.

Also:

- Abuse or suspected abuse or neglect of a child or elder, yourself or other/s.
- In the case of actual, possible or imminent harm to yourself or others.
- You/your family waives the privilege by bringing litigation against me.
- I may disclose your health information if a court issues an appropriate order. Please consult your attorney for clarification.
- Billing and payment retrieval attempts/companies.
- In cases where I have a Duty to Warn.
- If you bring a complaint against me with the State of Washington, Department of Health, your information will be released.

Appointments: Unless otherwise discussed, our appointment times are scheduled for 50 minutes.
When I will be out of office for extended periods of time, to the best of my abilities, I will give you notice and attempt to provide an alternate contact and/or counselor in my absence. By signing this disclosure statement, you are committing to prioritize your appointments with me.

If you cancel or miss 3 sessions in a row you will need to call the front desk and find a new available time slot or be put on my wait list.

Consulting: To enhance my professional skills I consult with other mental health counselors, therapists and psychologists. I may consult about your case but will refrain from using your name.

Electronic Communication/s: I cannot guarantee confidentiality using electronic communications. There is a risk of 3rd party access to electronic communication/s. I cannot guarantee immediate or prompt replies. **To authorize me to correspond with you by EMAIL, initial: ______; by TEXT, initial: ______.** By placing your initials in either/both space(s), you are giving informed consent to bear entirely the aforementioned privacy risks, and you are agreeing to not hold me responsible in any way if you elect to communicate with me by text and/or email and a security breach occurs. You may decline to initial either/both space(s) above, thereby requiring me to communicate with you solely by secure means such as in my office or by limited phone contact).

Insurance: There are several reasons that you may choose **not** to use insurance. Insurance companies require a Diagnostic Statistical Manual (DSM)-5 diagnosis for treatment, and many cover/reimburse me for a limited set of mental health diagnoses. Treatment has to be medically necessary. Your diagnosis and treatment become part of your medical record. Some employers use medical records when making employment decisions. Once you have been given one or more diagnosis, it may also affect your access to insurance and your cost if you change plans. Please be aware that any form of claim submitted to an insurance company will involve disclosure of confidential information that carries a risk to privacy and/or future capacity to obtain health insurance, life insurance, or even a job. Medical data has also been reported to have been legally accessed by law enforcement and other agencies. Using insurance may limit the number of sessions you are allowed.

I am *not* able to guarantee reimbursement from insurance companies. **You are responsible for understanding your insurance plan/s** limits and allowances.

Insurance Release of Information (ROI): By signing this disclosure statement, you are authorizing me to release any medical information necessary to your insurance carrier for the purpose of processing your insurance reimbursement claim.

Medications: I am not a doctor. I do not prescribe, endorse or include medications as this is outside of my scope of practice.

No Legal Services: I intend to provide you and/or your child with services for therapy not litigation. I am prohibited by law to speak to any custody or parenting legal matters. I do not intend to become involved in legal disputes such as, but not limited to, personal injury lawsuits, divorce proceedings, parent reports, Guardian Ad Litem reports/interviews, dependency hearings or custody/parenting battles, etc. These can compromise you or your child's ability to be honest during treatment. If you request, or I am required to participate in litigation the party/ies responsible for my participation agrees to pay me $400.00 per hour, beginning at one minute. I require $400.00 fee upfront for the first hour, regardless of any other fee agreements in this disclosure statement. You will also be responsible for my travel time, reports, and other case-related costs.

Fees: Payment is due at the time of service unless otherwise specified.

- My standard rate is $140 per 50-minutes
- $120 for 50-minute "hour" discount rate for cash payment (you can ask about this in the first session)
- $100 per 50-minute "hour" discounted rate when paying in advance for 5 (five) consecutive appointments
- $400 per hour for legal fees (see above)
- $140 for **late cancelations and not calling or showing for scheduled appt (not covered by insurance):**
    - **If you cancel and appointment less than 48 hours prior to appt.**
    - **If you are more than 20 minutes late and you've forfeited you appointment that day**
    - **If you don't cancel and do not show for your appointment**

- $25 per 15 minutes on the telephone (not covered by insurance). I do not currently provide tele-mental health
- $75 for treatment summaries, FMLA, or other document (not covered by insurance)
- $30 for any returned checks
- Any bank fees related to payment for my services
- $10 plus copy fees = service fee for any records exceeding 5 pages or for repeated extended pages
- $400 per hour for legal services as noted above

All fees are subject to change.

Lack of payment is reason for me to terminate this contact and counseling. Three referrals will be provided to you in person.

You are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement.

By signing this disclosure statement, you are agreeing to be responsible for full payment of all relevant fees.

Social Media and Dual Relationships: I do not participate in social media with known client's or family.

In the Community: Should we see each other outside of the office, I leave it up to you if you wish to acknowledge or address me.

Risks of Treatment: Sometimes problems in relationships develop as an individual engages in therapeutic services and begins to change. In addition, as we talk about emotions and experiences, you may begin to feel discomfort.

Washington State Law requires that the following language appear on every disclosure statement:
"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment." "The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct."

Concerns:
If you have any concerns about the treatment you, your child and/or family are receiving from me, please feel free to discuss this directly with me. If you feel I have been unethical in my treatment, or behavior, you have the right to contact the Department of Health: Health Services Quality Assurance Division, P.O. Box 4757, Olympia, WA, 98054; (360) 236-4700 or via email: HSQAComplaintintake@doh.wa.gov.

Records in my care, such as charts, releases of information and other paperwork related to you will be destroyed, shredded or burned after 5 years from your last attended session with me. In case of my death all records will be destroyed, shredded or burned.

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Consent:

By signing this Client Information, Disclosure Statement, and Consent Form as the Client or the Guardian/s of said Client, I/we acknowledge that I/we have read, understand and agree to the full terms and conditions contained in this form from Teri Wood, M.A., PLLC.. I/we have been given appropriate opportunity to address any questions or request clarification of anything that is unclear to me/us. I am/we are voluntarily agreeing to receive mental health assessments, treatment and services for me/us (or my child if said client is less than 13 years of age or court ordered to have a legal guardian – paperwork required) been provided contact numbers and complaint information. I/we understand the confidentiality policy and restrictions. I/we fully understand and will abide by the cancellation and late policies. I am/we are able to provide documentation pertaining to any custody/guardianship (for consent of treatment) concerns upon request. By signing I am/we are stating that I am/we are of competent mind and take responsibility for my/our decisions. Where applicable: I am/we are the legal guardian of the child/person mentioned below and have full permission to sign on their behalf for behavioral health services. I/we have been given a copy of this Disclosure Statement.

I/we also understand that some of my/our personal information may be released to my/our insurance company/ies or EAP in order to bill them for behavioral/counseling services. By signing below, I am/we are consenting to the release of that information. If my/our insurance company/ies or EAP refuses to pay for the services provided, I/we understand that I am/we are fully responsible pay for the services, and I/we agree to do so. If I/we refuse to pay for the services, I/we understand that some of my/our personal information may be released to a collections agency in order to collect the overdue fees.

By signing this disclosure statement, you are agreeing to be responsible for full payment of all relevant fees.

I am 13 years or older OR I am the legal guardian/custodial parent of client and give my consent to receive services for myself and/or my child via Teri Wood, M.A., Pllc.

Client Name (PRINT): ____ Date: _____/_____/_______

Client Signature (13 & older) : ________________________________ Date: _____/_____/_______

Parent/Guardian Name (PRINT): ______________________________ Date: _____/_____/_______

Parent/Guardian Signature: ____________________________________ Date: _____/_____/_______

Parent/Guardian Name (PRINT): ______________________________ Date: _____/_____/_______

Parent/Guardian Signature: ____________________________________ Date: _____/_____/_______

Counselor: ____ Date: _____/_____/_______