



ART and SHELTER©

### **Client Informed Consent/Disclosure Agreement**

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully. Once you sign this, it will constitute a binding agreement between us as well as your consent for us to begin treatment/counseling. Thank you for choosing me as your counselor and art therapist.

#### **My credentials**

I am a Licensed Mental Health Counselor with the state of Washington (License #: CL 60166810). I am also a registered Art Therapist with the Art Therapy Association (Member ID#: 13621).

#### **My counseling philosophy and services**

I believe in a team approach to counseling. Together we will work toward your goals. I will assist you in exploring your present and past issues and struggles using art materials and techniques to guide you. The final goal of your counseling will be for you to one day have the necessary coping skills to handle the struggles that brought you in today without my assistance. While it is impossible for me to guarantee the outcome of your counseling and the art therapy experience you receive, I will do my professional best to help you resolve your life issues while staying within accepted ethical guidelines. To better serve you, I may take notes during our sessions and may ask if I can take photographs of your artwork for review with my supervisor, who oversees my work as an independent counselor in private practice.

#### **Client rights and important information**

You are in complete control of your counseling and number of sessions needed. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information. You have the right to terminate therapy at any time, but please discuss this decision with me first. You also have the right to see your client file and to obtain a second opinion from another therapist at any time. If you need a referral to another therapist I would be happy to assist you.

#### **Counseling limitations and risks**

My counseling services are limited to the scheduled sessions we have together. There are some risks to Counseling and art therapy. You may experience uncomfortable levels of sadness, anger, frustration, etc. as you explore your personal history. Therapy can help people gain new understanding and coping strategies to deal with these feelings. With new skills, people often gain insight about their past, have a reduction in stress, and experience improved relationships. To better serve you, our relationship will remain purely professional and not be considered a

friendship. In a professional relationship (such as ours), it is important for you to remember that you are experiencing me only in the professional role. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of a local hospital or call the Crisis Clinic at (206) 461-3222.

**Confidentiality:** No recording devices are allowed in the counseling office (including cell phones use). All notes and photographs of art work are kept in a safe and secure place and you may ask me where I keep these records should you be curious or feel comforted in knowing this.

Generally, the information provided by and to a client during therapy sessions is legally confidential if the art therapist is a registered or licensed professional counselor. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed professional counselor is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Washington without the consent of the person to whom the testimony sought relates.

I will keep confidential anything you say to me with the following general exceptions:

- 1) Required by law (Washington Statute RCW 70.02.020; 70.02.310)
- 2) You direct me to tell someone else and sign a written release;
- 3) I determine you are a danger to yourself or others
- 4) I have reason to suspect child abuse or neglect
- 5) I am subpoenaed by a court to disclose information.

Please be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. Payment terms

### Art Therapy/Counseling Fees

In return for a fee of \$85 per session for individuals and \$115 per session for couples/families, I agree to provide counseling and/or art therapy services for you. Sessions are 50 minutes in duration. Sessions will start on time, and end 10 minutes before the hour. The fee for each session will be due and must be paid at the conclusion of each session, and can be paid by cash, credit card, or check. I will provide you with a receipt for all fees paid. In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session you missed. I also may charge fees for phone calls with you exceeding 15 minutes in length and will notify you of these charges, if applicable. Should I become involved in any legal matter such as giving testimony, depositions, etc., the fee is \$200 per hour for preparation, review of materials, travel time, and any other time involved. All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days in advance of such changes. There is a \$20 fee charged for each returned check.

In the event you are dissatisfied with my services for any reason, please let me know and I will try to resolve your concerns. If you have any questions, please feel free to ask me.

You have the legal right to report your complaints to the State of Washington Department of Health, which has the general responsibility of regulating the practice of registered counselors, licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy.

Any questions, concerns, or complaints regarding the practice of mental health professionals by both licensed and unlicensed persons in the field of psychotherapy may be directed to:

Washington State Department of Health  
Health Systems Quality Assurance  
Complaint Intake  
P.O. Box 47857  
Olympia, WA 98504-7857

Or go to this website for more details:

<http://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess.aspx>

I have read the preceding information; I understand and agree to the terms stated in this two page document. I understand my rights as a client and I have received a copy of this document.

I have also received a copy of the HIPAA laws and statements.

Client's Full Name (printed) \_\_\_\_\_

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Name and Date of Birth \_\_\_\_\_

Parent's Signature (constitutes permission to treat child if child is younger than 13)

\_\_\_\_\_ Date: \_\_\_\_\_

Art Therapist Signature \_\_\_\_\_ Date: \_\_\_\_\_