Disclosure Statement

Contact Information:

Mailing Address: 1501 N 200th St, Suite 105, Shoreline, WA 98133
Phone: 206.569.4937
Email: fred@avagabondsjourney.com

Washington State Counseling License: #LH60525325

Training and Degree: In 2012, I received a Master of Arts in Counseling Psychology from The Seattle School of Theology and Psychology. This was after completion of an internship at Atlantic Street Center, a social service agency in the Rainier Valley that specializes in working with families of color in poverty. After graduation, I continued to work there for the next two years, working with children, adolescents, and their families, primarily in the school setting, addressing issues of trauma, depression, and anxiety. During this time I also served two years as an assistant instructor of counselors-in-training in The Seattle School's Practicum program, facilitating small group and individual interpersonal development. I continue this work currently as a Practicum instructor. Additionally, I am trained by Seattle Pacific University as a mathematics/science teacher having served 12 years as a certified instructor of middle school/high school students, during which time I received my Master of Science Education degree from Western Washington University.

Counseling Orientation: The counseling process involves the formation of an alliance with your child to explore the nature of the issues that bring them to counseling. This relationship is the primary context for change. Processing with children usually involves some form of play since play is primarily how a child communicates and works out their inner world. While adolescents require less play, it still is an important part of reducing anxiety and facilitating conversation.

My approach to working with your child is not primarily behavioral; in other words, not simply to reduce "bad" behaviors. My primary work is to determine what your child is communicating by their behavior and to assist them in finding a healthier way to communicate or to deal with their distress. Although we will spend much time exploring the issues that bring your child to counseling, we will also look at relationships with significant people in their life, both past and present. My approach explores the intricacies of these relationships and their influence on their specific difficulties in an effort to find and address the sources of problems. Consequently, it is essential for the family to be involved in the process. This can be vulnerable, but is not about blame or fault, but about collaborating with you to discover the resources you have to help your family and your child to thrive.

It's important to recognize that progress in counseling is not linear. It can be a disruptive process as your child deals with parts of their life that have never been addressed or are difficult for them to understand. Their symptoms or concerns may increase for a time. This is often a normal part of the counseling path. However, if you are unsure of the direction of our work, I welcome your questions and feedback.

Finally, I believe that certain problems can have a physical component. In such cases, I will advise medical consultation.

Billing and Insurance Information:

	Individual	Parent Consult	Family
53-minute session:	**$130**	**$130**	**$150**

(A 53-minute session will be listed as an hour for invoicing.) Occasionally, you may wish to schedule longer or shorter sessions. Please discuss with me how payment is structured for these sessions.

Your regular fee will be charged, on a prorated basis, for any additional professional services rendered at your request, such as **phone contacts *over 10 minutes*** and consultations with other professionals. **Court time** and related preparation will be billed at the rate of **$250 per hour**, including travel and wait time, even if I am called to testify by another party. Fees are adjusted annually on January 1 and will not increase more than $10 per year. I accept cash, personal checks (made out to "A Vagabond's Journey Counseling"), and credit cards (see below). Returned checks will be charged $35. ***Payments are to be made at the beginning of each session.***

Credit Card Authorization and Purpose: This *required* authorization will be used to process payment for your session unless you prefer to use cash or check. It will also be used in the event that you forget to bring cash or check to your session OR you fail to give adequate notice of missing an appointment. In such a case you are authorizing me to charge your credit card for any therapy related fees. ***If for some reason you cannot pay for the session at our meeting time, we will not hold the session.*** However, you will still be responsible for payment for the session; *it will be regarded as a missed appointment* (see below).

Missed, Cancelled, or Late Appointments: You will be charged for a missed or cancelled appointment if you have failed to provide a minimum notice of **48 hours**. See the chart below:

Notice Given	>48hrs	48hrs>notice>24hrs	24hrs>notice>12hrs	<12hrs
Charge	$0	$35	$65	$130

There are a variety of ways to notify me, though by phone is preferred. Texts are the least preferred because they can be dropped or delayed. ***Illness is not an exception to this rule.*** If you are late, I will stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. **If late, *those using insurance*** will be charged a fee as follows:

Delay	<5min	5-14min	15-24min	>25min
Charge	$0	$30	$50	$130

Inclement Weather: I will make reasonable and safe efforts to make it to the office in case of inclement weather (e.g., snow). If I make it to the office, I will assume that our appointment will be held and payment is your responsibility. If you are unable to attend in person, you may consider keeping your appointment by phone.

Insurance and Third Party Payments: I am currently a provider for **Regence, Cigna,** and **First Choice Health** (includes Kaiser PPO) and will submit claims accordingly. Otherwise, I do not file insurance claims for you or receive direct insurance payments, except for **Regence, Cigna, First Choice Health,** and **Premera** (out-of-network). If you wish to use your insurance, you must arrange for the provider to reimburse you directly. I am happy to provide you with a monthly statement that provides the required insurance codes. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to your provider, as well as knowing the benefits and limits of your policy. Please note that if you use insurance, a diagnosis will be required. **Note: Insurance and other third party payers will not pay for missed or late appointments. Complete payment for services rendered and missed appointments is your responsibility.**

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner, and you may terminate therapy at

any time. In the event that you elect to end our time together, I strongly recommend a minimum of one final meeting to discuss your progress and your goals for the future (see "Termination of Treatment" below). According to WA state law, ***minors age 13 and above must consent to treatment***. They also have the right to limit the disclosure of information to their parents/guardians. The Release of Information signed at the outset of treatment will define contact with parents.

Intake Process / Initial Consultation Services: During the intake process, I will explore with you the nature of your concerns and will determine whether I can work with the problem as presented or a referral to another clinician would be more appropriate. The regular fee will be charged for the consultative services I provide during the intake process. You understand that until a plan of treatment has been developed and agreed upon by both counselor and client, all services provided are consultative in nature, and I will assume no obligation to provide continuing services to you. In the event I recommend services elsewhere, I will provide you with referral assistance. **Note: Use of insurance requires the submission of a mental health diagnosis.**

Social Networking and Internet Searches: At times I may conduct a web search on clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss it with me. I do not accept friend requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

Confidentiality: There is a legal privilege in the state of Washington protecting the confidentiality of the information that you share with me. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality.
There are legal **exceptions** to confidentiality. In the following situations, the information you have shared with me may be shared with others (please see the enclosed HIPAA form for a more complete list):

1) The Uniform Health Care Information Act may provide for disclosure of information to another health care provider who is serving you.
2) You may give written permission to share confidential information. If you wish to disclose to a third party, you must sign a *consent to release* form.
3) If you reveal that you are contemplating, planning, or have acted out a crime, I must report this.
4) If you reveal that you are planning to harm yourself or others, I must report this.
5) If you are a minor, I may discuss with your parents or guardians some of the information from counseling. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
6) If you and your spouse are both seeing me for marriage counseling, I may, at my discretion, discuss information with your spouse that you have revealed to me, unless you specifically indicate that certain information is confidential.
7) If you reveal that a child or adult has suffered abuse or neglect, I have an obligation (as do all professionals) to report this information.
8) If information you have revealed to me is subpoenaed, disclosure may be required by law.
9) As required under chapter 26.44 RCW.

When it is possible, we will discuss any exceptions to confidentiality as they arise.

Clinical Supervision/Consultation: I regularly engage in clinical consultation, the goal of which is to increase my skills and improve my service to you. This allows me to gain other perspectives and ideas that may help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

State Information: Counselors practicing counseling for a fee must be registered or licensed with the department of health for the protection of the public health and safety. Licensing of an individual with the

department does not include recognition of any practice standards, nor does it necessarily imply 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 counselors who would commit acts of unprofessional conduct. If you believe that I have been unethical in our work and still believe so after discussing your concern with me, you may contact the state:

Department of Health—Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.664.9098

Scheduling Appointments: Appointments are generally made on a regular, weekly basis. In some cases, I will suggest more frequent appointments. Parent consultation sessions are scheduled separately from your child's session times in order to prevent interrupting your child's course of treatment. Appointment times are not automatically held open for you from week to week. It is your responsibility to reschedule at each session.

Termination of Treatment: You may terminate treatment at any time without legal or financial obligation beyond payment for services already rendered and unpaid missed appointments. Please give a minimum of one week's notice. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that might need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment, and you do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated. Should you make contact with me at a later date requesting additional services, I may choose to see you on a consultative basis, or I may recommend that you seek services elsewhere. I also may terminate the treatment if I determine the therapy process to be unproductive and/or if I determine that you would be better served by other health or mental health practitioners. I will provide 30 days notice of intent to terminate to allow you to make other treatment arrangements.
Thank you for your interest in counseling with me.

TREATMENT AGREEMENT

I have read and understand the information in this form. Further, I have read the written statement entitled "Notice of Privacy Practices Regarding Protected Health Information." If there is anything I do not understand, I can ask my child's counselor. I continue my consent to treatment for my minor according to the policies presented in this form. *A signed copy of this form is available on request.*

_____ _____
Child/Adolescent's Name (Please Print) Birth Date

_____ / _____ _____
Parent/Guardian's Signature (for clients under 18) Relationship to Client Date

_____ _____
Adolescent's Signature (for clients 13 and over) Date

_____ _____
Therapist Signature Date

fred@avagabondsjourney.com 206.569.4937 Parent/Guardian Initials _____

EMERGENCY CONTACT

If you are ever experiencing an emergency, including a mental health crisis, please call:

- General Emergencies – 911
- Crisis Line (Snohomish County) – 800-584-3578
- Crisis Line (King County) – 866-427-4747
- Teen Link – 866-833-6546 (Evenings 6-10pm)
- Domestic Violence – 800-562-6025

If you need to contact me about an emergency, the best method is:

- By phone (206.569.4937).
- If you cannot reach me by phone, please leave a voicemail.

Please note that SMS (normal phone text messages) are not designed for emergency contact. SMS text messages occasionally get delayed and on rare occasions may be lost. So, please refrain from using SMS as your sole method of communicating with me in emergencies.

Credit Card Payment Authorization Form

Sign and complete this form to authorize A Vagabond's Journey Counseling to debit your credit card as listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with A Vagabond's Journey Counseling and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. A receipt of credit card processing will be sent to the email provided below or, if you choose, by text to your mobile device.

Please complete the information below:

I, _____, authorize A Vagabond's Journey Counseling to charge my credit
(full name; please print)

card account indicated below. Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at the agreed upon counseling fee.

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC/Discover, 4 digits on front of AMEX) _____

I authorize A Vagabond's Journey Counseling to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____

fred@avagabondsjourney.com 206.569.4937 Parent/Guardian Initials _____

Emergency Notification

In case of emergency, notify:

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

OR

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

_____ / _____ _____
Parent/Guardian's Signature (for clients under 18) Relationship to Client Date

_____ _____
Adolescent's Signature (for clients 13 and over) Date