Disclosure Statement

Contact Information:

Mailing Address: 19504 8th Ave NW, 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 Seattle's Rainier Valley that specializes in empowering families of color. 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 continued this work for four years 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. I have been in private practice since January 2015.

Counseling Orientation: The counseling process involves the formation of an alliance with you to explore the nature of the issues that bring you to counseling. This relationship is the primary context for change. Although we will spend much time exploring the issues that bring you to counseling, we will also look at your relationships with other significant people in your life, both past and present. My approach explores the intricacies of these relationships and their influence on your specific difficulties in an effort to find and address the sources of problems.

In particular, the Biblical foundation underlying my counseling leads me to believe that you are made to relate in a satisfying and self-giving manner. In relationship is the potential for both immense joy and deep struggle, and thus your interactions with others are of particular interest in our work together.

It's important to recognize that progress in counseling is not linear. It can be a disruptive process as you deal with parts of your life that you have never addressed. Your 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.

In addition, clients who are most successful in their work with me

1) appreciate honest discussion and investigation of their personal histories
2) value their counseling time, maintaining a consistent appointment schedule of once a week sessions
3) build resourcefulness through outside assignments, (e.g., reading, journaling, or other creative outlets)

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

Billing and Insurance Information:

	Individual	Couple/Family
53-minute session:	**$140**	**$160**

All appointments are scheduled for an hour. (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 5 minutes*** and consultations with other professionals (*These services are generally not covered by insurance*). **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). If the card charges are declined, this must be remedied before the next session can be scheduled and a $35 charge will be added if not remedied after two days.

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	$140

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 private pay for the portion of the hour that cannot be billed to insurance:

Delay	<5min	5-14min	15-24min	>25min
Charge	$0	$30	$50	$140

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, we will meet via video telehealth unless your insurance does not cover it.

Insurance and Third Party Payments: I am currently a provider for **Premera**, **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 **Cigna, First Choice Health,** and **Premera**. 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).

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 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** for an hour. In some cases, I will suggest more frequent appointments. Appointment times are automatically held for you from week to week. It is your responsibility to notify me of any changes in your schedule that prevent you from attending. Rescheduling when other openings in the week are available can prevent cancellation fees.

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 counselor. I continue my consent to treatment according to the policies presented in this form. *A signed copy of this form is available on request.*

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

Insurance Authorization:
I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services. I agree to pay according to the above terms.
Client/Primary Subscriber signature required for insurance.

_____ _____
Client Signature Date

_____ _____
Primary Subscriber Signature Date

_____ _____ _____ _____
Insurance Company Subscriber ID Group # Date of Birth
(Be prepared to provide a copy of your insurance card, front and back.)

Communications Policy

CONTACTING ME

When you need to contact Fred DuMez-Matheson for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

By phone (206.569.4937): You may leave messages on voicemail, which is confidential. I will check these messages on a regular basis. Please limit your phone contacts to appointment scheduling and emergencies; barring prior arrangement, our work will take place face-to-face. There may be circumstances in which it is appropriate to conduct one or more scheduled sessions by phone or video. Unscheduled telephone conversations initiated by a client will result in a fee being charged on a prorated basis according to the client's established fee schedule.

By e-mail (fredmathesontherapist@gmail.com): If you wish to communicate with me by normal email or normal text message, please read and complete the Communication by Email, Text Message, and Other Non-Secure Means form included with these office policies, as **my e-mail is not secure**. My e-mail address is available to simplify contacts from new clients, to facilitate scheduling of appointments, and to send files such as PDFs or other digital documents. However, e-mail is not a viable means of communicating other information to me. Please note that e-mails will be printed and placed in your file. I do not respond in depth to e-mails from clients. If you require urgent contact, you may choose to schedule a session sooner than your previously scheduled appointment time, if available.

Please refrain from making contact with me using social media messaging systems such as Facebook, Twitter, or LinkedIn. These methods have very poor security and I am not prepared to watch them closely for important messages from clients. It is important that we be able to communicate and also keep the confidential space that is vital to therapy. Please speak with me about any concerns you have regarding my preferred communication methods.

RESPONSE TIME

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within 48 hours (weekends are excepted from this timeframe). I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town.

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.

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Fred DuMez-Matheson, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Fred DuMez-Matheson
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Fred DuMez-Matheson about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Fred DuMez-Matheson to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Client Signature Date

_____ _____

Second Client Signature (if applicable) Date

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 as primary payment or in the event that you forget to bring another form of payment to your session. Credit cards will also be debited in the event that you fail to give adequate notice 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 services rendered or 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 _____

Specific Symptoms

Please rate your experience of the following specific symptoms using the key below. It is a lengthy list, but it can help you and your therapist to identify specific problems.

Never = 0; Seldom =1; Often = 2; Always = 3

_____ Difficulty concentrating
_____ Vision or hearing problems
_____ Stealing
_____ Feeling helpless
_____ Eating binges
_____ Feeling hopeless
_____ Lying to others
_____ Sexual preoccupation
_____ Feelings of worthlessness
_____ Injuring self *List:* _____
_____ Memory loss/blackout
_____ Crying
_____ Weight gain/loss
_____ Anger
_____ Worrying
_____ Feeling afraid
_____ Withdrawing socially
_____ Feelings of self-doubt
_____ Nervous around others
_____ Seizures
_____ Missing classes
_____ Lack of energy
_____ Feeling uptight
_____ Lack of interest
_____ Guilt feelings
_____ Feeling out of control
_____ Suicidal thoughts

_____ Irritability
_____ Racing thoughts
_____ Decreased need for sleep
_____ Impulsivity
_____ Difficulty sleeping

_____ Shortness of breath
_____ Trembling/shaking
_____ Nausea
_____ Chest pain
_____ Panic attacks
_____ Dizziness/Faintness
_____ Sweating
_____ Numbness
_____ Fear of dying
_____ Palpitations
_____ Sensation of choking
_____ Hot flashes/chills
_____ Fear of "going crazy"

_____ Muscle tension/ache
_____ Frequent urination
_____ Easily startled
_____ Restlessness
_____ Trouble swallowing
_____ Dry mouth
_____ Feeling "on edge"

_____ Recurrent dreams
_____ Hallucinations
_____ Physiological reaction to trauma reminders
_____ Difficulty recalling aspects of past trauma
_____ Intrusive recollections
_____ Difficulty feeling emotions
_____ Avoidance of certain memories
_____ Distress to trauma reminders
_____ Flashbacks
_____ Lack of sense of future

_____ Physical symptoms *(e.g., headaches, digestive) Have you seen a health care provider for these?* _____

_____ Sexual functioning problems *Have you seen a health care provider for these?* _____

_____ Other: _____ _____ Other: _____

Emergency Notification

In case of emergency, notify:

Name: _____

Address: _____
_____
_____

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

Relationship: _____

OR

Name: _____

Address: _____
_____
_____

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

Relationship: _____

In the event of an emergency in which I _____am unable to
(Print Full Client Name)
communicate for myself, I grant Fred DuMez-Matheson, LMHC permission to contact the individuals listed above to inform them of my emergency and where I might be transported or otherwise taken care of.

Client Signature: _____

Date: _____