Kelly Peck Counseling, LLC

1944 Pacific Avenue, Suite 309, Tacoma, WA 98402

Phone: (253) 227-7639 Fax: (253) 572-9958

DISCLOSURE, CONSENT FOR TREATMENT, CLIENT RIGHTS AND FINANCIAL AGREEMENT/FEE POLICY

The following information addresses the rights and responsibilities for our therapeutic relationship. Please read thoroughly before you sign it and consent to treatment. I am happy to address any questions or concerns you might have about my policies and/or the treatment process.

Consent for Treatment

Disclaimer by the State of Washington: "Counselors practicing for a fee must be registered or licensed with the Department of Licensing 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 imply the effectiveness of any treatment."

Qualifications/Education/Experience

- Licensed Mental Health Counselor through the State of Washington, Licensure # LH00005875.
- Master's Degree in Clinical Psychology at Chapman University in 1990.
- Bachelor's Degree in Psychology at Central Washington University in 1985.
- Over 30 years of experience working with children, adolescents, adults, couples and families with a wide range of issues from mild to severe, as well as previous experience in field of probation law enforcement.
- I am committed to furthering my knowledge and expertise by regularly participating in specialized training and receiving ongoing clinical consultation.

Treatment Orientation

My primary approach to counseling focuses on clients' strengths and ability to make positive changes in their lives. I believe that one of the essential ingredients for therapeutic change is trust between the therapist and client. Clients are encouraged to set their own goals for therapy and to be full and active participants in their own treatment. Guided by the client's needs and issues, I use a variety of tools drawing from many therapeutic approaches, such as Psychoeducation, Client-Centered, Behavioral, Cognitive-Behavioral (including Trauma Focused Cognitive Behavioral Therapy), and Solution-Focused strategies.

Client's Rights and Responsibilities

- You have the right to be treated with respect and dignity.
- Be informed about your condition and to participate in decisions affecting your care
- Refuse treatment.
- Develop a plan of care that meets your unique needs.
- Receive care that is free of sexual exploitation or harassment and is sensitive to your race, national origin, sexual orientation, age, sex, religion, creed, marital status, and disabled veteran status.
- Receive care that does not discriminate against you due to any physical, mental or sensory disability or because or HIV/AIDS.
- Review your medical record and/or request a copy of your record.
- Voice questions, concerns or complaints about any aspect of coverage, care or service with me.
- Expect all concerns and complaints will be addressed in a professional and non-punitive manner.

Confidentiality

All information that you share in the session is kept strictly confidential. Specific information can only be released with your prior written consent. The legal exceptions to the rules of confidentiality are as follows:

- If you disclose intent to do serious harm to yourself, I have a legal obligation to contact crisis resources and/or make reasonable attempts to notify your family.
- If you disclose intent to do serious harm to someone else, I have a legal obligation to warn the intended victim and report the information to legal authorities.
- If I receive first-hand communication about the victimization of a minor or a vulnerable adult, I am legally required to report the information to the appropriate authorities.

- If I receive a subpoena from a court of law.

If you are over the age of thirteen (13) and under the age of eighteen (18), information will only be shared with your knowledge and your and your parent or guardian's written consent (does not include legal exceptions listed above).

Crisis Information

I do not provide ongoing crisis services. If intensive or after-hours crisis services are needed during the course of therapy, I will help facilitate linkage with crisis services, such as referrals to the local crisis center or referrals for hospital admittance. If you have concerns about this policy, please discuss this with me so any questions or concerns you may have can be clarified.

If you are in an emergency situation, please call 911, or call the 24- hour Crisis Clinic at 1-800-576-7764 or go to the nearest hospital emergency room.

Fee Policy

- The fee for the initial 60-minute diagnostic interview/assessment is $165.00. If you decide that my treatment services are not a good fit for you and you decide not to proceed with therapy, appropriate referrals to other therapists and/or resources will be given to you as needed. If you decide to return and proceed with therapy, the fee for the first session will be expected at the end the session or your insurance will be billed for the first and subsequent sessions.
- The fee for individual, family/marital/couples therapy sessions following the initial assessment is $140.00 for a 45-minute session, $165.00 for a 60-minute session and $85.00 for a 30-minute session.
- The fee for consultation is $140.00 for a 50-minute session (plus time and mileage if required to travel).
- **There is a $50.00 fee for canceling or missing an appointment without providing at least a full 24 hours in advance.** Emergency needs are an exception, so please discuss this with me to avoid a charge. To change or cancel an appointment, please call 253-227-7639. A message may be left 24-hours a day, seven days a week. I check my messages frequently and will return your call as soon possible.

Financial Policy

- **Your fee/insurance co-payment is expected at the time of service.** You are responsible for your bill including any amount that your insurance carrier does not pay. I do not carry month-to-month balances.
- If you have insurance you are responsible for determining the limits and conditions of your coverage. Your primary insurance will be billed weekly for their portion.

Court Testimony

Should I become involved in any legal dispute (i.e., divorce, custody, worker's compensation, accident claim, etc.); I will **NOT** be available to provide expert testimony in court. This decision is based on the premise that my evaluations will be seen as biased in favor of my client due to our therapeutic alliance and/or because the testimony could negatively affect the therapeutic relationship which I must put first.

Insurance Assignment and Release

I hereby authorize the release of any medical or mental health information necessary to process all insurance claims. I hereby authorize my insurance benefits to be paid directly to Kelly Peck, MA LMHC and I am financially responsible for any services not covered by my insurance carrier.

With my signature below, I acknowledge that I have read and understand this disclosure statement. I consent to therapy with Kelly Peck, MA, LMHC according to the terms of this document.

Client Signature	Date	Parent/Guardian Signature	Date
Client printed name		Parent/Guardian printed name	
Clinician Signature	Date		