

**Notice of Private Practices and Counselor's Disclosure****License:**

Washington State Licensed Mental Health Counselor Associate, #MC60299843

**Education/Experience:**

I have worked in the mental health field since 2008 in Western Washington. I have been privileged to collaborate in a variety of setting ranging from crisis intervention to one on one treatment. The bulk of my career has been working with at-risk youth and families struggling with an array of issues; each with their own unique story to tell. What I have learned from collaborating with clients is that each of us has such a beautiful story that I hold with the utmost respect.

For graduate school, I acquired a Master's degree in Psychology Counseling at The Seattle School. During my time there, I worked with a number of community services agencies. I have worked in a variety of settings from client homes to their communities. I also facilitated a snowboard program through the agency to teach teens to snowboard. I have also had the opportunity to work with adults in a one on one office setting. Each agency and client has taught me and impacted both who I am and my approach in therapy. My desire is to serve my clients by exploring what they hope and desire for themselves.

**Affiliations/Memberships:**

Northwest Alliance for Psychoanalytic Study	COR Northwest
International Association of Eating Disorders/ IAEDP	NEDA

**Therapeutic Philosophy/Methods:**

My training is in a broad range of areas, but I concentrate in the following: sexual trauma, PTSD, eating disorders, depression, anxiety, life transitions, and relationship problems. I also have experience with addiction, couples work, grief/loss, intimacy, sexual struggles and self-esteem. I work with women, men, adolescents and couples. My technique is grounded in psychodynamic theory, including relational psychoanalysis, object relations, emotional based therapy and cognitive behavioral therapy. I believe working with the problem requires addressing the complexities that the problem presents in relationships. Relationships can be a source of great joy as well as a place of intense pain. Part of our work will be to examine how your style of relating inhibits you from the utmost satisfaction in your current relationships. We will explore your problem and focus on finding its source and solution. We will take the insight gained about your past and apply it to the present with the mutual goal of restoring hope in you and bringing freedom in your life. We will do so through conversation and with the use of other tools as deemed helpful or necessary. Some problems result in physical conditions, and therefore medical consultation may be advised. I believe body, mind and soul are connected, and when one part of you suffers, all areas in your life are affected. Your health and happiness are important to me. I am dedicated to working through the entire therapeutic process with you.

**Rate/Payment:**

The rate for treatment is \$110 for individual 52 minute session and \$120 for couples for 52 minute session. However, financial difficulties can be taken in to account and a sliding scale could be agreed upon before treatment begins. Sessions typically last for 52 minutes with exception of the initial interview this is a free 20 minute consultation during which the client and I will determine if counseling with me is the proper fit. The client has the option to continue after the 20 minute consultation as the remainder of the first paid session.

Payment is due at the end of each session by either cash or check. Credit Card is available with a 2.75% fee. Your rate, as agreed upon will be: \$110 per session unless other agreed \$\_\_\_\_\_. If the client needs

to cancel or reschedule the appointment, it needs to be done before 48 hours of the appointment otherwise the amount of the session will be charged. There is a \$30 fee for any returned checks. A credit card will be kept on file during intake process for no show/late cancel charges. I do not file insurance claims for you. If your provider is covering any or all of the costs, then you need to make arrangements to be directly reimbursed. You are responsible for filling out any paperwork. My payment should not be affected. I will fill out any necessary parts as indicated by your insurance company and provide you a monthly bill with the required information for reimbursement. If I am required to go to court for any reason I require a \$2000 up front cost for preparation and time in court as well as loss income during this time. If my services are not covered within the \$2000 upfront fee you will be billed upon closure of the court appearance.

If a written statement needs to be written on behalf of the client the cost is \$25 per fifteen minutes and will be paid before the document is sent.

### **Scheduling Appointments**

Appointments are generally made on a regular, weekly basis. Appointment times are not automatically held open for you from week to week. It is your responsibility to reschedule at the end of a session.

### **Confidentiality**

There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, I assure you that I strive to maintain the strictest ethical standards of confidentiality.

There are legal exceptions to confidentiality. The following situations are those in which the information you have shared with me may be shared with others.

- 1) The client gives written permission to share confidential information.
- 2) Anything that suggests a crime or harmful act towards yourself or to others.
- 3) If the client is a minor, and there is indication that she/he was the victim or subject of a crime.
- 4) The client brings charges against the counselor.
- 5) In response to a subpoena.
- 6) As required under chapter 26.44 RCW.

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

### **Consultations**

I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas as to how to best help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

### **Legal Disclaimer**

Counselors practicing for a fee must be registered or licensed with Department of Licensing for protection of the public health and safety. Registration of an individual does not include recognition of any practice standards, nor necessarily implies effectiveness of treatment. (WAC 246-810-030, WAC 246-810-031). The Counselor Credential Act is to provide protection for public health and safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

### **Unprofessional Conduct**

The brochure called "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

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

### **Contact by Phone, Text or Email**

You may send an email to [cwalson@kariswellness.com](mailto:cwalson@kariswellness.com), leave me a voicemail or send a text message at (206) 747-9604 at any time. I will check those messages on a regular basis. You will not be charged for brief phone calls; however, after 10 minutes, you will be charged my normal rate in 20 minute increments if you want to continue. Please note that these forms of communication are not fully protected and if you do communicate by phone, text or email that you do so at the risk of your confidentiality. I will do my best to respond to your communication in a prompt manner. Please do not use these avenues to deliver important therapeutic information as your session is the best place to deal with personal issues.

### **Media: Facebook, Twitter, Blogging and other means of media**

Media may be used by Karis Wellness to connect with potential clientele. Clientele may access me via these channels with the understanding that they may not be secure and are not forms of communication that are fully protected.

### **Emergencies**

If you are in an emergency and cannot reach me, please call one of the following numbers for help:  
General Emergencies: 911  
Crisis Service Line: 253-922-4035  
Pierce County Crisis Line at 800-576-7764

**I have received and understand my rights as a client. I have received and understand this Disclosure Statement and have been provided an opportunity to review and ask questions.**

Client Name (Please Print): \_\_\_\_\_

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

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

### **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### **Introduction to Clients**

This notice will tell you about how I handle information about you and your child. It tells how I use this information in my office, how I share it with other professionals and organizations, and how you can see it. I am required to tell you about this because of a federal law, the Health

Insurance Portability and Accountability Act of 1996 (HIPAA).

In most situations I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law or HIPAA. Clients who are 13 or older must sign the written authorization form.

#### Your Medical Information

Each time you or your child visit me information is collected about you or your child's physical or mental health. It may be information about you or your child's past, present or future health or condition, the treatment or services received, or about payment for health care. This information is called PHI, which stands for Protected Health Information. The information I obtain from you or your child goes into your or your child's medical record at my office. It is likely to include the following:

- Your or your child's personal history
- Reasons you or your child came for treatment: problems, symptoms, needs, goals
- Diagnoses: medical terms for you or your child's problems, symptoms, disabilities
- Treatment Plan: services that I think will help you or your child
- Progress Notes
- Records from others who treated or evaluated you or your child
- Psychological test scores, school records, and the like
- Information about medications you or your child are taking
- Legal matters
- Billing and insurance information

Medical information is used for many purposes. For example I may use it to:

- Plan your child's care
- Decide how well my treatment is working for you
- Talk with other health care professionals who are also treating you or your child, such as your family doctor or the professional who referred you to me
- Show that you actually received the services from me that I billed to you or your health insurance company

#### How Protected Health Information Can Be Used and Shared

When you or your child's information is read by me or others, it is called "use." If the information is shared with or sent to others outside this office, it is called "disclosure." Except in some special circumstances, when I use you or your child's PHI or disclose it to others, I share only the minimum necessary PHI needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed.

#### **Use or disclosure of the following protected health information does not require your consent or authorization:**

1. Uses and disclosures required by law-like *files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence-like *the duties to warn explained in the Disclosure Statement*
3. Uses and disclosures for health and oversight activities-like *correcting records or correcting records already disclosed*
4. Uses and disclosures for judicial and administrative proceedings-like *a case where you are claiming malpractice or breach of ethics*
5. Uses and disclosures of law enforcement purposes-like *if you intend to harm someone else*
6. Uses and disclosures to avert a serious threat to health or safety-like *calling Probate Court for a commitment hearing*
7. Uses and disclosures for Worker's Compensation-like *the basic information obtained in*

*therapy/counseling as a result of your Worker's Compensation claim*

### **Your Rights as a Patient under HIPAA**

1. As a client, you have the right to see your file, unless it would endanger your health or another person's health or safety. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.*

2. As a client, you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies a fee for a treatment summary may apply.

3. As a client, you have the right to request amendments to your counseling/therapy file

4. As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees @ \$.20 a page as well as a fee for my time.

5. As a client, you have the right to restrict the use and disclosure of your PHI for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

6. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement. It will be necessary for you to sign a certificate indicating that you have received, read and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement. I will be happy to explain these documents further.

In summary, HIPAA and Washington State law provide you with certain rights regarding your clinical record and disclosure of protected health information about you. These rights include:

- requesting that I amend your record
- requesting restrictions on what information from your clinical record is disclosed to others
- requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized
- determining the location to which protected information disclosures are sent
- having any complaints you make about my policies and procedures recorded in your records
- receipt of a copy of this Notice of Privacy Practices form

I acknowledge that I have received and read the **Professional Disclosure Statement** and the **HIPAA Client's Rights**. I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the **Professional Disclosure Statement** and the **HIPAA Client's Rights**.

\_\_\_\_\_  
Printed name of Client

\_\_\_\_\_  
Signature of Client Date

Credit Card; (check rate/payment section for clarification)

Visa    Mastercard    AmericanExpress    Other \_\_\_\_\_

NAME ON CARD \_\_\_\_\_

CC# \_\_\_\_\_ EXPIRATION \_\_\_\_\_

3DIGIT CODE ON BACK \_\_\_\_\_ Zip Code \_\_\_\_\_