Gila Fein, MA, LMHC
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Kirkland, WA 98033
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Mental Health Counselor License #LH 60272230

DISCLOSURE OF INFORMATION AND CLIENT AGREEMENT

The information provided in this document and written acknowledgement of its receipt are requirements of Washington state law. The purpose is to let you know what your rights are as a client as well as provide you with information about my qualifications, ways of working and office policies. Please read this document carefully, return a signed copy of the final page to me for my files and keep a copy of this document for yourself. I welcome any questions or concerns you may have regarding this agreement or my services.

Counselors practicing counseling for a fee must be licensed or certified with the Department of Licensing for protection of the public health and safety. I am a Licensed Mental Health Counselor with the State of Washington.

Your Rights As A Client In Counseling

As a client of a counselor licensed by the State of Washington, you have privileged communications under state law. With the exception of the situations listed below, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The privilege is yours, not mine, and I will not waive it without your consent. I will always act to maximize your privacy even when you waive your right to confidentiality.

I will disclose as required under mandatory reporting or as otherwise required or authorized by law. The following are exceptions to your right to confidentiality:

1. If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.

2. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective or Adult Protective Services, state agencies.

3. If you are currently in litigation, or become involved in litigation during treatment or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that process. Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know

that you are likely to be in such a legal situation, so that I can exercise due caution so as to protect your privacy.

4. If you are seeing me in couples or family therapy, and you, your partner or another family member should happen to see me in an adjunctive individual session, information shared with me in that meeting may be shared by me in joint or family sessions if I believe it to be in the best interest of the work we are doing together. Likewise, if you are a group therapy member and you share information with me outside of group, it may be shared by me in subsequent group sessions if I believe it to be in the best interest of the work we are doing together in the group.

5. I may consult with colleagues regarding our work together to gain feedback and suggestions in order to help you. If I do so, it will be without using your last name or any other unique identifying information. All discussions of this type are subject to the rules of confidentiality.

In some cases it will be useful for me to discuss your situation with others such as your physician, your former therapist, etc. In such cases, I will seek your written permission for this exchange of information.

You have the right to understand my reasons for making suggestions or using particular techniques. If you do not understand something about our work together, it is your right to ask any questions you may have. You have the right to refuse treatment or at any time for any reason, to decide that you do not wish to continue counseling. I encourage you to discuss your decision to end treatment with me. I believe this is an important part of the therapy process. If you wish, I can provide you with the names of other qualified professionals.

If you have been referred to me directly by someone else, I may, as a good business practice, acknowledge to them that you have contacted me and thank them for the referral. I will not discuss your situation with them unless I have your written permission.

Appointments and Fees

Appointments are usually scheduled once per week or once every other week. The sessions last for 50 minutes, unless we arrange in advance to meet for a longer time. Longer sessions will incur an extra charge based upon the amount of time we take. The scheduled time for your session is set aside for you. **If you miss a session without canceling, or if you cancel with less than 24-hours notice, I will bill you in full for that time.**

My standard fee is $120 per session. Payment is to be made at the end of each session unless we specifically agree on another payment schedule. I accept cash and checks. There is a $20 service charge for returned checks.

My Training and Approach to Therapy

I received my Master's Degree from Bastyr University / LIOS in Applied Behavioral Sciences and prior to that received my bachelor's degree from the University of Washington in Business Administration/Accounting. I completed my counseling internship at Valley Counseling and Training Center in Renton, Washington working with families, couples and individuals.

My therapeutic orientation is based on a psychodynamic and family systems approach. I participate in trainings and workshops on a variety of subjects as a means of continuing education for my counseling practice.

I believe that we are influenced and impacted by the people in our lives. Understanding how these relationships impact us helps us to understand our behavior.

In my work with children, I support children's creative expression in play therapy, familial work in emotional and relationship issues, and creative arts therapy. Therapy with children includes exploration and integration of feelings through use of images in the sand tray, which is reinforced by other methods of expression and discussion. Parental consultation is available monthly, and more often if requested.

I ascribe and adhere to the Code of Ethics of the American Counseling Association. I must also answer to the ethical and professional standards of the Washington State Omnibus Credentialing Act for Counselors and the Uniform Disciplinary Act for the Regulation of Health Professions.

Quality of Service/Ethical Protection

As a consumer you have certain basic rights as follows: you have the right to receive appropriate care and treatment, employing the least restrictive alternatives available; the right to be treated with respect and dignity; the right to receive therapy and family support which is non-discriminatory and sensitive to differences in race, culture, language, sex, age, national origin, disability, creed, socioeconomic status, sexual orientation; the right to confidentiality; the right to refuse proposed treatment for you or your child; the right to be free of any sexual exploitation or harassment; and the right to lodge a grievance if you feel you have been violated. Complaints about the work or ethical behavior of any counselor can be directed to:

Washington State Department of Health
Health Professionals Quality Assurance
P.O. Box 47865
Olympia, WA 98504-7865
360-236-4700

The Universal Disciplinary Code applies to our relationship. You can access it at RCW.18.130.180.

Emergencies

If you are in an emergency and cannot reach me, please call one of the following numbers for help: **Crisis Clinic: (206) 461-3222** or General Emergency**: 911**

Client Consent to Treatment

I (we) consent to mental health services by Gila Fein, a licensed mental health counseling associate, and I understand and have received all policy information including information on consumer rights/ethical protection, disclosure information, confidentiality, appointments, and payment policy.

I (we) have read the above guidelines presented to me by Gila Fein. I (we) agree to and understand these terms. I acknowledge that I am responsible for what has been mutually agreed upon in fees and that I am further responsible for all necessary collections, attorney and legal fees incurred over and above the fees discussed.

Clients assume financial responsibility for any willful accident or accidental damage done to the property or premises and release Gila Fein from liability from any physical injury sustained in an accident or during the commission of vandalism or violence.

______________________________	____________________
Client Name (Please Print)	Client Date of Birth
______________________________	____________________
Client Signature	Date
______________________________	____________________
Client Name (Please Print)	Client Date of Birth
______________________________	____________________
Client's Signature	Date
______________________________	____________________
Therapist Signature	Date