Michelle Matson Ellis
VIVERE THERAPY

INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome. Before we begin counseling it is both my desire and a requirement of Washington State law to provide you with the following information.

EDUCATION AND TRAINING

I graduated from The Seattle School of Theology and Psychology with a Master of Arts in Counseling Psychology degree on April 17, 2015. I am a Licensed Mental Health Counselor (license number LH60742082).

I completed my internship at Northwest Family Life in Seattle, Washington. In addition, I am certified in Lifespan Integration and EMDR and have extensive post-graduate training in trauma therapy and domestic violence counseling. If you'd like to see a complete list of my trainings, please refer to my website under "Orientation & Specialties."

MY COUNSELING APPROACH

I have received training and education for a wide range of counseling techniques. I am especially drawn to the arenas of Attachment Theory, Narrative Therapy, and Relational Psychotherapy.

CONFIDENTIALITY

You have the right to confidentiality of your therapy both legally and personally. All issues discussed in the course of counseling are strictly confidential. There are certain exceptions to these rights as listed below.

1. If I have good reason to believe that you will harm another person, I am required to attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team.
4. If you give written permission for me to share confidential information.
5. In response to a court order requiring disclosure.

In the event of my death or serious impairment, my colleague Jonna Petry, LMHC, will be given my clients' records and coordinate arrangements with them for further care. Her phone number is 206-795-6780.

CASE CONSULTATION AND SUPERVISION

I desire to give my clients the best possible counseling service. I may at times discuss your situation (without sharing your name) with other professionals within a confidential consult group as well as during individual and/or group supervision.

Initial here _____

FEES & PAYMENT

My fee is $160 per session. Payment is due at the beginning of each session. The first appointment is $200.

If you are billing insurance, I will bill for $160, however, some discounts are offered through your insurance. If you are utilizing insurance, you will receive a monthly bill from Omni Medical Billing Services, Inc. (206-201-3314). Co-pays will be due at the beginning of each session. Sessions begin at the scheduled time and will be 50 minutes in length.

If you are late, we will end on time and not run over into the next client's session. If you miss a session without canceling or cancel with less than 48-hours' notice (except for emergency), you must pay for that session at our next regularly scheduled meeting (regardless of whether you normally utilize insurance or not). The fee for missed appointments is $100.00. Clients are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement (WAC 246-810-031 (2) iii).

Initial here _____

DIAGNOSIS

Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. I will be referring to the DSM-5 manual, *The Diagnostic and Statistical Manual of Mental Disorders, 5th edition*, for any diagnostic issues. I will only utilize a diagnosis in the course of your treatment if I believe it will be beneficial to your therapy or to your healing or if your insurance company requires it.

AFTER HOURS OR IN MY ABSENCE

If you are experiencing an emergency when I am out of town or outside of my regular office hours, please call one of the following numbers:

General Emergencies	911
Care Crisis Response Service (a 24-hour crisis line offering emotional support, crisis intervention, and referral assistance through Volunteers of America)	800-584-3578 425-258-4357
King County Crisis Clinic (provides crisis intervention, information, and referrals to all people of King County)	800-244-5767 206-461-3222

COMPLAINTS

If you are unhappy with what is happening in therapy with me, I hope you will let me know. I will take such concerns seriously, and with care and respect. State of Washington Department of Health has a brochure entitled "Counseling or Hypnotherapy Clients" that describes client rights and responsibilities and acts that would be considered unprofessional conduct. If you believe my Supervisor or I have behaved in an unethical manner, you may complain about this behavior to the Examining Board for Psychology, Dept. of Health, Olympia WA 98504.

Clients have the right to choose counselors who best suit their needs and purposes. If you have any questions or concerns that were not answered in this disclosure statement, feel free to let me know.

WA State law requires that this form includes the following two paragraphs:

1. WAC 308-109-040: "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, or necessarily imply the effectiveness of any treatment.
2. SHB 1828: "A record of the mental health care provided to you is kept in this office. You may ask to see and copy that record. You may also ask this office to correct that record, if you believe the information within your record is in error. A copy of your correction to the office records will be placed in your record, at your request. This office will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it at this office.

ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

I have read and understand the information presented in this form and therefore consent to treatment. If requested, you may receive a copy of this form via email.

CLIENT SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

THERAPIST SIGNATURE: _____ DATE: _____