You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully and initial each page.

Counselor Registration Requirement:
Counselors practicing counseling for a fee must be registered or certified (licensed) with the Department of Health 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 imply the effectiveness of any treatment.

DISCLOSURE:

Counselor's Name: Lillie McCatty, MA, MHP, LMHC, CMHS, EM-MHS
Counselor Registration or Certification Number:
Licensed Mental Health Counselor # LH60240782
Chemical Dependency Professional Trainee #CO60291614(exp)

Type of Counseling Provided:
1. Individual
2. Family
3. Group
4. Co-Occurring

Counseling Techniques:
1. Drama Therapy (RDT) and Creative Arts Therapies
2. Play Therapy
3. Existential Therapy
4. Behavior Modification
5. Cognitive Behavioral Therapy

Counselor Education:
Master of Arts in Drama Therapy from *New York University (NYU)* 2007
Bachelor of Science in Psychology: Child and Adolescent Development *University of Evansville, IN* 2002

Counselor Experience:
Aug. 2012 – July 2014 · Mental Health Counselor III **Sea Mar Community Health Centers** *Lacey, WA*
April 2011 – Aug. 2012 · Child and Adolescent Counselor **Willapa Behavioral Health** *Raymond, WA*
Jan. 2007 – May 2010 · Therapeutic Specialist **Incarnation Children's Center** *New York, NY*
March 2003 – Aug. 2005 · Skills Trainer **Behavioral Health Resources** *Olympia, WA*

CLIENT INFORMED CONSENT:

● **Confidentiality**: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Federal and State laws set the limits on confidentiality. All information discussed in psychotherapy sessions is held confidential except in the following situations (according to state and federal law): Potential suicidal behavior; threatened harm to another; suspected abuse of a minor or an adult dependent or developmentally disabled person; court subpoena; you bring charges against the counselor; or you give written consent. Please note that I am a mandated reporter as are all individuals associated with my practice. If anyone sees or hears, in or out of session, anything that is concerning in terms of abuse or neglect we are mandated by law to

report. It is my policy to discuss any pending report with you unless I feel it may further endanger the child or vulnerable adult.

If you or your child are court ordered for counseling services through any court I will be expected to periodically make reports to the court about your attendance and progress in counseling. You signature on this document constitutes your release of relevant information for this purpose. Additionally any judge can waive your confidentiality at any time by judicial order and compel me to testify or provide documents to the court at the judge's discretion.

Also, in situations where custody issues are present the law states that both parents have access to medical records about their child unless their rights to such have been terminated. Therefore in most cases both parents can inquire and receive information about their child's counseling without specific release of information.

For professional enrichment, I utilize other professionals for case consultation. Should I discuss our work together, I will disguise all of your identifying, personal information.

Please note that in Washington State children 13 years of age and older have the ability to consent to mental health treatment without notification to parents or guardians and have the same expectation of privacy as their adult counterparts. This means that I will not be able to discuss treatment or release records of your teenager to you unless he or she consents to the contact. I do encourage all teen clients to consent to consultation with their parents and I encourage parents to talk with me about their concerns even if I am not able to talk with them about their teen's treatment.

● **Health Care Coordination**: It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, you should get a physical examination from a physician as soon as possible. It would be best to tell your medical provider that you will be working with me so we might begin to coordinate your health care.

With your written authorization, I may obtain your medical records so I have a better understanding of your overall health. This is especially important for children and adolescents as they have many things that can affect their mood and behavior including their changing and growing bodies.

Also please note that since I am not a doctor I cannot prescribe or advise on any issue relating to medications.

● **Risks and Benefits**: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Counseling is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

Again this is especially true for children and even more so for behavioral challenges. Expect that as we address behavioral concerns the problem behaviors will get worse before they get better. Please discuss the changing symptoms of your child with me as they occur.

● **Free Phone Screening**: I offer a free phone screening. This is an opportunity to discuss the reasons why you are seeking counseling, and talk about your goals. Additionally, I can answer any questions you might have about therapy. If we decide we might be a good fit, we will then schedule an intake appointment. Please have all paperwork filled out prior to the intake appointment. Participating in a phone screening does not obligate you to continue counseling with me.

● **Appointments**: We will schedule our appointments either via phone or in person at the end of a session. Please notify me via phone, at 360-259-7179, as soon as possible if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Likewise, I will notify you via phone if I should need to cancel our appointment.

When you arrive for an appointment, please ring the doorbell and wait for me to answer the door before entering. Our sessions will be 53 minutes long, and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. Insurance will not covered such missed time and the balance will be your responsibility. I cannot accommodate making up for lost session time unless it is due to my error.

Please note that younger children are sometimes not able to be therapeutically present for a full session and I reserve the right to end the session early if I determine it to be therapeutically indicated in those cases. In these cases you will not be charged a balance. If you would like to use any or all of your child's session to discuss concerns or progress with me you are welcome to do so.

● **Cancellation Agreement - All cancelations require 24 hours notice.** Any scheduled appointment where the client does not attend and does not give notice of cancelation will be considered a "no show" and will be charged the full fee of $130.00 for the session. Any cancelations that happen After 12:00pm (noon) on the day of the scheduled session will also be considered a "no show" and will be charged the full fee of $130.00 for the session. Any scheduled appointment where the client or parent gives less than 24 hours notice but notice is given before 12:00pm (noon) on the day of the scheduled session will be known as a "same day cancelation". Same day cancelations will be charged a cancelation fee equal to half the full cost of the session: $65.00. New clients will be given a courtesy one time fee waiver which can be applied to one same-day cancelation OR one no show session after which this policy will be reviewed in session or mailed to your home. Any fees will be due at the start of your next session and will not be billed to any other party. A bill will be mailed to you so you are clear about any fees that are owed. If you no show or late cancel two consecutive standing re-occurring appointments all subsiquent appointments will be cancelled, your reoccuring space will be made available to the next client on the waiting list, and you will need to call or text and schedule your next appointment. If you are a current or continuing client and have already had a courtesy fee-waiver applied to your account this policy update does *not* grant an additional fee-waiver. If a pattern of missed appointments or cancellations occur, fees in full will be required when sessions are scheduled rather than at the time of service. Insurance companies will not cover the fee for missed or canceled appointments.

● **Fee for Services**: My standard fee is $130.00 per 53 minute session. This is the same fee charged for any missed or late canceled appointments. In certain circumstances, I might arrange a reduced fee for you, which we will finalize in writing on a separate form (Fee Agreement) **before** the start of services. Additional fees might include: preparation of requested documents, court appearances or support, lengthy phone calls, or copying and sending records. Generally speaking these additional services and fees are not covered by your insurance. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services.

● **Payment for Services**: I accept cash, credit card, and personal check payments made payable to **Lillie McCatty**. Payments are due directly to me at the time of service (at the start of each session). **Please prepare your check ahead of time so that we do not have to use your session time to deal with payment details.** If you require other payment arrangements please speak to me to handle these situations on a case by case basis. If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I will charge a $30 fee for any returned checks.

● **Insurance**: I currently accept Regence, First Choice and Kaiser PPO/Flex. If I am not in network with your insurance carrier you can pay out of pocket at the time of service and I can provide you with an invoice that you can submit to your insurance company for reimbursement. This is a relatively easy process. I am happy to assist you in finding the appropriate forms for your carrier, but I will not bill, or make submissions for reimbursement to your health insurance provider at this time.

Please note that court ordered services and any services related to preparing documentation are not covered by any insurance. Marriage counseling is often not a covered service.

● **Record-keeping**: I will keep a confidential file containing your private health information (PHI) in my office. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording "what happens in a session." I make an effort to summarize what we discuss in each session, but I make no effort to capture sessions verbatim. Washington State law requires the retention of records for seven years after last contact. This file is subject to the same confidentiality standards mentioned above.

● **Emergency, Urgent, or Other Contacts**: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages weekly and return voicemails on Thursday nights or Friday mornings. **As an outpatient psychotherapist I am not in the position to provide emergency medical or suicide intervention services. Emergency services are available 24 hours a day by calling the crisis line at 360-586-2800 or by calling 911.** Please remember that anything you send over email is not confidential. Please limit email correspondence to non-clinical issues. Never use email or social media to communicate emergent or crisis information.
If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.

● **Therapy Relationship and Professional Boundaries/Ethics**: It is my intention to maintain a warm, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I subscribe to the code of ethics and professional standards of Licensed Mental Health Counselors (LMHC) in Washington State. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship; this includes contact on social networking sites, like Facebook. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.

2) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting. Sometimes children are more comfortable with a high five or similar rather than a hand shake and I will honor the type of appropriate touch that feels natural to them. I will still avoid hugging and will not allow children to sit in my lap.

3) I will not, at any time, accept any gifts from you. I may accept a card or note from you and I will accept drawings or other creative efforts from children which I will display in the office.

4) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate a visible or audible greeting, I will reciprocate, but I will not attempt further communication unless you request it.

5) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any business and financial relationships. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.

6) I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.

7) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered “privileged.” Neither your death nor mine terminates your confidentiality rights.

● **Therapeutic Work, Duration, and Termination**: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person. Closure is important to the therapeutic process. I ask that my clients agree to a closure session to adequately honor the work they have done in therapy

If more than 30 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

● **Complaints**: Therapy is a joint effort between therapist and client. In order for the therapy to work, it is vital to keep the lines of communication open. Please come and talk to me about any concerns you have at any time during our work together. I welcome feedback from clients at any and all points

of our work together. Please feel free to bring up any concerns or questions that you may have. These conversations are often a very important part of the therapeutic process. If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869 or by phone at (360) 236-4901.

● **Your Responsibilities**: I will work hard to help you accomplish your goals. In order to produce and maintain and safe and healthy working relationship I ask that you make the following commitment:

1) I will make every effort to benefit from the sessions by participating, asking questions, reporting on symptoms, and completing at-home assignments.
2) I will provide accurate information about my history and symptoms.
3) I will not attend sessions or bring my children to sessions under the influence of alcohol or other substances.
4) I will not be disrespectful nor disregard the feelings or problems of others while participating in group counseling.
5) I will not use language that is inappropriate, bigoted, or disrespectful which may hurt the feelings of others while in public areas or in group sessions.
6) I will not physically tough, allude to, or otherwise engage in behavior or speak in a manner which may be interpreted as sexual or which constitutes sexual harassment.

Please note that violation of these responsibilities is subject to termination of the therapeutic relationship at my discretion.

360.259.7179 ● lmccatty@gmail.com ● PO Box 12962 ● Olympia, WA 98508-2962

Confirmation of Informed Consent
CLIENT COPY
Lillie McCatty, LMHC
PO BOX 12962
Olympia, WA 98508-2962
www.lilliemccattylmhc.com

Please initial each statement, and sign below:

______ I have read the Disclosure Statement for Lillie McCatty, LMHC and I understand it.

______ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

______ I agree to follow the terms in the Disclosure Statement.

______ I give my consent for treatment as outlined in this Disclosure Statement.

______ I will receive a copy of this Disclosure Statement with my signature.

______ I understand that my therapeutic relationship with Lillie McCatty, LMHC may be discontinued if the terms in this agreement are not fulfilled by either of us.

____
Client Name (please print)

____ ________________________
Client Signature Date

This form will be retained by the client.

Confirmation of Informed Consent
CHART COPY

Lillie McCatty, LMHC
PO BOX 12962
Olympia, WA 98508-2962
www.lilliemccattylmhc.com

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____
Client Name (please print)

____ ________________________
Client Signature Date

This form will be retained in the mental health record.