Restoration Counseling Services
Informed Consent

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Therapy

I am a licensed Marriage and Family Therapist with a Masters degree from Seattle Pacific University. I have been trained to work with individuals, couples, and families. Through the therapy process I apply systemic and relational principles in a caring and professional manner.

Therapy is a different process for every individual and the time necessary for treatment varies depending on the kind and difficulty of the problem to the person. Each person is responsible for his or her own choices in therapy and has the option of stopping therapy at any time.

Aside from counseling with Restoration Counseling Services I have other obligations in the Bainbridge Island School District that demand my time. In particular during the winter and early spring months my hours may be more limited and flexibility may be necessary in order to continue with therapy.

World View

While I personally hold to Christian values and perspectives, I maintain that all people are valuable and should expect that their beliefs and values will be acknowledged and respected. I believe that therapy is a biological, psychological, social, and also spiritual process. Each of these areas will be explored as appropriate and to the degree that the client feels willing and able.

Crisis or Emergency

In case of crisis or emergency and I can not be reached, please call the Care Crisis Line at 988 or dial 911

Your Rights Regarding Therapy

1. You may request a change of therapy, referral to another therapist or to discontinue therapy at any time.
2. You have the right and responsibility to be informed about your treatment.
3. If you feel that in therapy I have been irresponsible, unprofessional, or unethical, you may contact the Department of Health at 1-360-664-4375, P.O. Box 47857 Olympia, WA 98504-7857 .

Financial Agreement

Fees for individual, couple, or family therapy are based on a 50 minute session. The fee agreed to pay per session is $130.00. Some exceptions to this fee can be negotiated based on financial hardship. Generally payment is made each session. Missed appointments without 24 hour notice of cancellation may be billed to the client for the full fee.

Confidentiality:

Entering into a therapy agreement, I agree to keep all of our interactions under the strictest confidence. Any consultation with other therapists and colleagues will be done in a private and professional manner. If an agreement has been made for therapy, according to ethical and legal standards, no one outside of Restoration Counseling Services has access to information about you without your consent.

There are some exceptions to confidentiality: regarding the report of child abuse, sexual abuse of a minor, abuse of an elderly or disabled person, presenting a clear danger to yourself, or others, the inability to meet one's own needs, or if I receive a court order from a judge to share information. According to the laws of the State of Washington and the AAMFT code of ethics, I am obligated to do whatever is needed to assure your safety and the safety of others.

Technology- Text and email: Though text and email are great tools, they are not appropriate for the discussion or exchange of clinical content. My communication with email or text will be limited to scheduling or billing questions. You accept that confidentiality cannot be guaranteed when text or email is used for communication.
Telehealth: There may be times that phone or video sessions are the best way for us to work. In order to do telehealth, both you and I must agree that it is an appropriate mode for your counseling. You should understand that there are many benefits to being able to do therapy in this way but there are also potential risks to be aware of. Telehealth is not suitable for everyone and may be a source of frustration or miscommunication. In order to do telehealth you must have capable electronic devices and be comfortable and competent using the electronic device. You must also have a private place where you can meet.

Limitation to confidentiality for Couples therapy: During the course of my work with a couple I may see either individual alone for one or more sessions. This is part of the work that I am doing with the couple unless otherwise indicated or arranged. Since I am working for the interest of the couple, it may be in the best interest of the relationship for me to release information learned in an individual session to both members of the relationship. This policy is intended to avoid a possible conflict of interest that might arise if an individual's interests are not consistent with the interests of the couple being treated. I will use my best judgment as to whether, when and to what extent I will make a disclosure of information from an individual session and also, if appropriate, first give the individual the opportunity to make the disclosure.

If there are issues which you are certain should not be part of the discussion in couple's therapy, you may want to consult with a different therapist who can treat you separately from the relationship counseling.

Treatment Agreement and Consent for Treatment

I voluntarily consent to treatment at Restoration Counseling Services. I understand that services may include such types of treatment as individual therapy, group therapy, family or couples therapy and may include the use of telehealth. I acknowledge that no guarantees have been made to me as to the effect of such treatment procedures and have the option of receiving explanations of treatment and any possible risks involved. I also understand that I may refuse any and all services at any time.

I understand that all clinical information will be kept confidential, except as stipulated by Washington, State statutes and the stipulations within this informed consent. I understand that should I have any complaint or grievance regarding services, I will be assisted in having the grievance procedure explained and having my grievance addressed in a timely fashion.

I understand that I am responsible for my financial obligation to Restoration Counseling Services.

Client(s) Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

As the parent/legal guardian of _____; _____:

_____; _____ I consent to therapy at

Restoration Counseling Services.

Parent or Guardian signature: _____ Date: _____

Therapist signature: _____ Date: _____