Restoration Counseling Services
Informed Consent

Kate Pippinger
(360)908-3894
Kate@restorationcounseling.us

Therapy

I am currently enrolled in Capella University's program for Marriage and Family Therapy (MFT) and have completed the coursework needed to obtain my master's degree in MFT. Once my year-long internship is complete I will be a Marriage and Family Therapy Associate, and will continue logging the client hours I need to become licensed in the state of Washington. I have been trained to work with individuals, couples, and families using the systemic and relational paradigm. I have experience and interest in marriage, parenting, foster/adoption issues, depression/anxiety and trauma issues, the Internal Family Systems (IFS) model of therapy and whole body healing modalities.

World View

My faith informs my beliefs that all people are inherently valuable and deserve to be treated with dignity and respect. I believe that within each individual is the innate ability to do what is best for themselves; their internal system, and that each one of us has the capacity to grow and change. Although there might be internal or external 'fog' blocking our insight, there is always hope. I believe that therapy consists of biological, psychological, social, and also spiritual aspects. Each of these areas will be explored as appropriate and desired.

Your Rights Regarding Therapy

1. You may discontinue therapy at any time or request a referral to another therapist.
2. You have the right and responsibility to be informed about your treatment.
3. You have the right to report any unprofessional or unethical behaviors to my immediate supervisor, Teresa Bentley (license #00000953) at tbentley400@yahoo.com, or to the Department of Health at 1-360-664-4375, P.O. Box 47857 Olympia, WA 98504-7857

Confidentiality

The information you share with me during a counseling session is confidential. I will take notes and keep a secure, written record of our time together. To provide the best service possible, I may seek consultation with other therapists who have the same obligation of confidentiality that I adhere to. As an intern, I am required to meet weekly with my supervisor; Teresa Bently, LMFT, for supervision and discussion of my caseload. I am also required to record some sessions to share with my supervisor or professor; for training purposes, but will only do so with your written consent, of which there is no obligation. Your sense of safety and privacy is of utmost importance.

Confidentiality in couples therapy: In couples therapy, the couple is the "client," which creates an equal space for both partners to feel safe. I do not keep secrets or withhold information from either partner as this jeopardizes the well-being and health of the couple and the therapeutic process. During the course of my work with a couple I may see either individual alone for one or more sessions, and the individual session is still considered part of the couples therapy. Since I am working in the best 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 give the individual every opportunity to disclose applicable information first, with guidance. If there are issues which you are certain should not be part of the discussion in couples therapy, you may want to consult with a different therapist who can treat you separately from the relationship counseling.

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

- To report suspected abuse of a child, developmentally disabled person, or vulnerable adult
- To intervene against threatened harm to oneself or someone else
- If required by court order or other compulsory process
- If the client makes a complaint with the State of Washington or Department of Health
- In the event of the client's death or disability, information may be released if the client's personal representative or beneficiary signs a release authorizing disclosure.

Email and Text Messaging: Please be aware that I cannot guarantee confidentiality when using e-mail or text messaging. For this reason I will not discuss clinical content using e-mail or text. If you choose to use email or text as a means of setting and confirming appointments, you accept that confidentiality cannot be guaranteed.

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 therapy. In order to do telehealth you must have dependable connectivity, a device that allows for optimal engagement, and a private place where you can meet.

Financial Agreement

Fees for individual, couple, or family therapy are based on a 50 minute session. The fee agreed to pay per session is $50.00. Payment accepted is cash, credit card, or checks made out to Restoration Counseling Services. Payment is made each session. ***Missed appointments without 24 hour notice of cancellation may be billed to the client for the full fee***.

Crisis or Emergency

If you are in a crisis and cannot reach me, please call the Crisis Line at 988. If you are having an emergency, please call 911.

I understand the above information and voluntarily consent to treatment by Kate Pippinger. I agree that no promises have been made as to the outcome of therapy. I understand and agree to my rights and the limits of confidentiality, and I understand that I may refuse treatment at any time. I understand my financial responsibility for services.

Client(s) Signature:____ Date: _______________

Client(s) Signature:____ Date: _______________

As the parent/legal guardian of ________________________; ________________________; ________________________; I consent to therapy at Restoration Counseling Services.

Parent or Guardian Signature: __________________________________ Date: _______________

Therapist Signature: ____ Date: _______________