River Valley

Psychological Services

Disclosure Statement

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To New Clients

Welcome to River Valley Psychological Services. This is a statement of your rights and responsibilities for our therapeutic relationships. This Disclosure Statement is designed to inform you about receiving psychological services. Please let me know if you have any questions or concerns about this disclosure statement.

Client Rights and Responsibilities:

As a client, you have the right to choose a therapist who best suits your needs and purpose. Please be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end therapy at any time.

You understand that for counseling/therapy to be most successful, you will need to be actively engaged and participate in your own healing and growth. Additionally, you understand that the work you complete outside of therapy sessions will greatly impact your progress in therapy. You understand that counseling/therapy may feel challenging and difficult at times. We will discuss these feelings and difficulties in sessions. Although I expect that you will benefit from counseling/therapy, I cannot guarantee any specific results.

Background and Approach:

I am a licensed clinical psychologist in the State of Washington (License #PY60187300). I received my doctorate degree in clinical psychology from Seattle Pacific University in 2006. My experiences range from working with adolescents, adults, couples, and families in diverse settings. I also have extensive experience working with clients with chemical dependency issues. My approach is evidence based and cognitive behavioral therapies with humanistic approach. The first few sessions are used to gather information about you/your child and to develop a treatment plan together that meets your needs. The duration of treatment is variable depending on your specific situation. Each session lasts 45 minutes.

Records and Confidentiality:

The law requires me to maintain written treatment records. You have the right to review your records and request modification of inaccurate information. In Washington State, psychologists may deny access to patient records if the health care information may be injurious to the patient's health and/or could reasonably expect to cause danger to the life or safety of the

patient (RCW 70.02.090). Information discussed in therapy session is confidential, which means it is not disclosed to anyone without your written permission. The law, however, requires the release of confidential information in certain situations such as a suspected child/vulnerable adult abuse, potential suicidal ideation/behavior, threats to harm others, and court ordered request. Certain treatment information will be disclosed to your insurance company if they are paying for your psychological services. In the case of individual therapy with a minor, I will use my professional judgment to determine what information, if any, will be disclosed to guardians.

Fees and Payment:
Please contact our office to obtain fee information for the initial session and preceding appointments. Payment is due at the time of service. If you are using insurance, the office staff will facilitate the billing process. You are responsible for understanding your insurance benefits and for making deductible and co-payments. If you need to cancel your appointment, please give at least one business day notice (does not count weekend). Please note that appointments missed or cancelled without this advance notice will be charged a full fee unless I am able to fill the scheduled hour. Insurance companies will not pay for missed or cancelled appointments and you will be responsible for these charges. Any overdue accounts will be sent to a collection agency.

Contact Information:
Our front office is open Monday through Friday from 8:30am to 5:00pm, excluding holidays. My office hours at this time are Monday through Friday from 9am to 4pm. If I am unable to take your call, please leave a message with our office staff or on voicemail. Our office staff can assist you with scheduling appointments and billing questions.

Consent for Treatment:
By your signature, you are indicating: (1) that you voluntarily agree to receive mental health assessment and mental health treatment and that you authorize me to provide such assessment and treatment as I consider necessary and advisable; (2) that you understand and agree that you will participate in the planning of your care and treatment, (3) that you may stop such treatment at any time; (4) that you have read and understood this statement and you have had sufficient opportunity to ask questions about, and seek clarification of anything unclear to you; and (5) that I provided you with a copy of this statement.

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Client/Parent/Legal Guardian Signature and Date

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Therapist Signature and Date