Vitman Counseling LLC

PROFESSIONAL DISCLOSURE STATEMENT

PROFESSIONAL REQUIREMENTS

Psychotherapy should consist of a supportive and honest relationship. It is important that you receive certain information, as dictated by the state, prior to the initial therapy session. The first part of this statement consists of information that all counselors are required to disclose to their clients; the latter part is professional information about my practice and me.

"Counselors practicing counseling for a fee must be registered, certified, or 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 a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment." WAC 246-810-030. I am a Licensed Mental Health Counselor with the State of Washington (License #LH60558559).

I welcome any questions or concerns about treatment. If for some reason you feel I have not fully addressed your concerns, you may contact the Department of Licensing at (360) 236-4700. You have the right to decide the therapist who best suits your needs and purposes. You also have the right to discontinue treatment at any time, although I would encourage your ideas or thoughts before the decision is made to allow for mutual understanding.

CLIENT RIGHTS

I will not release any information without your written permission, with the following exceptions (as required by Washington state law (RCW 18.19.180). In cases of the following your information may be disclosed: suspected child (or dependent adult) abuse; if you are a physical threat to yourself or others (i.e., suicidal or homicidal threats); or in the rare case of a court subpoena. I am involved in consultation groups with other professionals in which the general details of cases may be discussed to better meet the needs of our clients, yet without revealing any identifying information about you or your family. I would also obtain professional supervision if I felt it was in the best interest of quality care.

MY BACKGROUND AND THERAPY METHODS

Education:

Master of Arts degree in Counseling Psychology, City University of Seattle
Bachelor of Arts degree in Applied Psychology, City University of Seattle

Experience:

Working with individuals, couples, families and groups providing comprehensive outpatient counseling to adults. Experience in crisis interventions, treatment planning, mental health assessment, acculturation, depression, anxiety, personality disorders, trauma, PTSD, grief and loss, emotional regulation, behavior change, and goal setting. As best practice the weekly appointments are expected for the best outcomes. English, Serbian, Croatian and Bosnian.

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Training:

Annually, I attend professional trainings, workshops and seminars to deepen my knowledge and enhance my therapeutic skills. I also am involved in peer consultations group to improve my effectiveness at work.

Professional Affiliations:

Washington Mental Health Counselors Association (WMHCA)
American Mental Health Counselors Association (AMHCA)
American Counseling Association (ACA)

PAYMENT INFORMATION/CANCELLATION POLICY/ GOOD FAITH ESTIMATE OF COST

Client Name _____ Client DOB _____

The therapy session services are anticipated to occur weekly to ensure the best practices in therapy. My fee for individual counseling is $200 and for couples or family counseling is $280 for a 55-minute counseling session. The initial intake session is $230. I ask for payment at the time of the service. I charge a fee of $150 for appointments that are not attended without 48-hour cancellation. Major Credit Cards and Health Savings Account Debit Cards are accepted and collected at first visit. They are saved in a HIPAA-compliant format electronically. These cards are charged at each visit for co-pays, co-insurances and private pays. The cards are also charged for late cancelations (giving less than 48-hr notice) and "no-shows." Phone calls and professional or medical consultations beyond 15 minutes will be billed at the standard hourly rate. There are additional charges for any casework done as part of any legal proceedings that are stated in the Professional Fee form. Additional services that may be recommended. This estimate of your costs is only an estimate, and your actual charges may differ. You have the right to initiate the patient–provider dispute resolution process if the charges you are actual billed substantially exceed the expected charges in this estimate. This estimate of costs is not a contract and does not obligate you to obtain clinical services from me.

I do bill some insurance companies (First Choice, Premera Blue Cross, Regence Blue Shield, LifeWise and am out-of-network for some other insurance providers). In some cases, depending on your insurance, I ask for payment up front and will provide you an invoice to submit to your insurance. It should be noted that some insurance companies do not reimburse at all for out-of-network services. If you are using your insurance, by signing below you are also authorizing the release of any medical or other information necessary to process your claim. You are also authorizing payment of medical benefits to myself as your provider of behavioral health services.

LEGAL INVOLMENT

If you ever become involved in a divorce, or custody dispute or insurance case or any other legal case please understand that this therapist will not provide evaluation or expert testimony. You should hire a different mental health professional for any evaluation or testimony you require. This position is based on two reasons: 1) the statement may be seen as biased in your favor because of the therapeutic relationship; and 2) the testimony might affect the therapeutic relationship.

_____ (INITIALS)

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SAFETY

In addition, if you intend to engage in therapy over the internet in any form, email, Skype, or other cyber-methods, by signing your initials below you are consenting to the knowledge that anything over the internet may not be fully secure and that you are choosing what to share over these methods knowing the confidentiality risk.

Therapy is a process that requires the collaboration and participation of both the client and therapist. I hope that this process will be healing and transformative as we work on your identified goals.

If at any time it feels as if these necessary steps are challenging to reach or establish, we may need to take a break or wait for more active work to continue to make sure that we maintain a safe clinical space for your goals and healing. I reserve the right to determine collaboratively with clients if the therapy is appropriate for both client and therapist given history, timing, and availability of social supports.

By signing below and initialing the previous sections, you are agreeing that you read the information above and on the above two pages, understand the contents, accept the terms, and have received a copy of my disclosure information.

You are also signing that you acknowledge receipt of my Notice of Privacy Practices (HIPAA) and Social Media Policy. If you have any questions now or in the future, please feel free to ask. I am available by voice mail at the phone number listed above (unless my voice mail says otherwise). If you are in need of urgent assistance and I am not available, please call the Crisis Clinic at 1-800-273-8255.

I have read this document, and consent to therapy with Spomenka Vitman, MA, under the terms above.

Client Name _____ Client DOB _____

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Parent/Guardian* Signature _____ Date _____
*In the case of divorce, I certify that I am the primary custodial parent of this child and have legal authority to sign.

_____ (INITIALS)

Therapist's Signature _____ Date _____