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This is information that you may find useful as we work together. The State of Washington requires that psychologists provide you with Client Disclosure Information, which clarifies the rights and responsibilities we share.

Confidentiality:

Information about your treatment is confidential and privileged, and cannot be shared without your written permission. However, there are three mandatory exceptions, as stipulated in Washington law:

- If your therapist believes there is a danger that you will do harm to yourself or someone else;
- If there is evidence of child, disabled adult, or elder abuse, neglect, and:
- When directed by a court if you are involved in civil litigation or criminal prosecution.

Also, for the benefit of my clients and my own professional growth, I may sometimes seek consultation with other professionals. Should I discuss your circumstances in this professional context, I will not disclose your identity.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Professional Qualifications:

I received a Master of Arts in Psychology from Seattle University. My BA is in history from the University of Washington. I interned at Eastside Mental Health and I have also worked as an Adult Outpatient Therapist at Valley Cities Counseling, as well as Community Psychiatric Clinic. I have also been a Psychiatric Assessor for Fairfax Hospital.

Approach to Counseling:

As a therapist, my goal is to support, encourage, empower and challenge you to overcome your obstacles and create the life you want. My therapeutic orientation is existential and I have received training and supervision in this modality. My theoretical approach is person centered, cognitive behavioral and psychodynamic. I believe that growth, change, and acceptance of oneself can occur with the assistance of a genuine, caring and empathetic therapist.

Commitment to Change:

Effective psychotherapy requires commitment on your part. As with other efforts, you will get out of it what you put into it. My job is to serve as facilitator and guide, helping you explore options and discover strengths in your own way.

Client Rights and Responsibilities:

In the beginning of therapy we will work collaboratively to formulate goals specific to your therapeutic needs. I will periodically ask you to assess the effectiveness of treatment as well as evaluate your goals. Changes in treatment and goals will occur as necessary to provide the best therapeutic interventions possible for you. Typically there are emotional risks involved in seeking treatment. While I cannot guarantee it, the benefits of therapy usually outweigh the risks. You have the right to decline participation in therapy at any time. If, for any reason, I feel you would be better served by a different therapist, I will give you an appropriate referral and your treatment with me will end. If you have any further questions about the benefits and risks of therapy, please discuss them with me.

Your Rights:

As a client receiving services, you have the right to:

- Have full and complete knowledge of your therapist's qualifications and training.
- Be fully informed regarding the financial terms under which services will be provided.
- Discuss your treatment with anyone you choose, including another therapist.
- Have a detailed explanation of any form of treatment prior to it's initiation.
- Have direct access to your treatment records.
- Have pertinent information shared with another therapist, or any other party, provided you sign a Release of Information, and/or specify in writing that information be released to certain individuals.
- Question the practice and competence of your therapist, and if you desire, to file a formal complaint with appropriate professional of legal bodies.

- Request a copy of the ethics code that governs your therapist's practice.
- Terminate treatment at any time for any reason.

Fee and Payment Policies:

- Psychotherapy, extended telephone calls…… $120 per 50 minute session.
- Services will be stopped after two unpaid sessions and resume when they are paid in full.
- I require 48 hours in advance to cancel an appointment. Cancellations under 48 hours are charged at the full rate. Exceptions may be made for emergencies.
- No-shows are charged at the full rate.
- Sessions end on time, even if we are in the middle of something. This allows me to be on time for all my clients.
- Phone calls are billed at the same rate, in quarter hour segments, after 5 minutes.
- I do not provide paper work for disability, unemployment, L&I, crisis management, and court-mandated documents. Any work pertaining to legal services is charged at $140 an hour.

It is very important that you find out exactly what mental health services your insurance policy covers, and also what your deductible, copay and coinsurance are for such services. Also find out if there are a limited number of such appointments per year.

Emergencies:

In case of emergency during non-office hours or when I cannot be reached at the number above, please call the crisis clinic at 206-461-3222, the Alcohol/Drug Helpline at 206-722-3700, or police/fire at 911. I will make every attempt to be available to you in a crisis, however I cannot always be reached immediately.

Email and Text Correspondence:

I use email and texts for scheduling and rescheduling only. By signing this form, you are agreeing not to hold me responsible for any breach of confidentiality that may occur due to email or text sent to me or from me.

Telehealth

I _____ (patient's name) hereby consent to engage in Telehealth. I understand that "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using Spruce which is a system that is encrypted to the federal standard and HIPAA compatible. It is my responsibility to

choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the technology that you are interacting with. Additionally, Both parties agree not to record any TeleMental Health sessions. During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. I will ensure that I have my phone with me and the phone number is 206-237-5125. I understand that all fees for Telehealth and non-Telehealth services are the same. I am financially responsible for all services rendered, late cancellations, and missed appointments.

Legal agreement:

It is agreed between client and therapist that no lawsuit of any kind shall be brought until the arbitration procedures of the county and state where the treatment is rendered shall be exhausted and any lawsuit shall only be maintained in the county and state where the treatment was rendered. The non prevailing party at the arbitration shall be responsible for reasonable attorney fees and the fee of the arbitrator and costs and are to be paid prior to the commencement of any lawsuit. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $140 for preparation and attendance at any legal proceeding.

Your Agreement:

I have read the above information and disclosure statement and have had an opportunity to clarify my concerns and questions with Suzanne Oelke. I understand and agree to all the policies and procedures.

Client Signature _____ Date:__/__/__

Provider Signature _____Date: __/__/__

HIPPA ACKNOWLEDGEMENT:

I hereby acknowledge receiving a copy of Notice of Privacy, a separate document.

Client Signature _____Date:__/__/__