Elizabeth Elliott, MA LMFT, CMHS
elizabeth.elliott@elliottcounseling.com
elliottcounseling.com
(425)322- 9515

THERAPIST DISCLOSURE STATEMENT & CLIENT INFORMED CONSENT

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully and initial each section on the back page.

I. THERAPIST DISCLOSURE TO CLIENT

- **Credentials**: I am a Licensed Marriage and Family Therapist in Washington State
- **Education, Training, and Experience:** I received a Bachelor of Arts in English. I completed my Master of Arts in Psychology in the Marriage and Family therapy program from Antioch University Seattle. I completed 23 months of practicum and internship doing therapy with various populations including individual adults, couples, adolescents, and children. I have obtained specialized training in trauma.
- **Services Provided:** I provide psychotherapy for individuals. I specialize in working with trauma, anxiety, issues related to gender and sexual identity and issues related to family of origin work.
- **II. WORKING RELATIONSHIP**
- **Confidentiality**: The privacy of your personal information is of utmost importance. I am compliant with current Federal and Washington State laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.
- **Risks and Benefits**: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be explore challenging territory in your life, you might experience greater difficulty throughout our work. Counseling is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.
- **Appointments**: Scheduling appointments may be done via phone, text or in person at the end of a session. Please notify me as soon as possible via phone or text if you have any schedule conflicts or emergencies requiring you to cancel an appointment. If you do not receive a confirmation that I have received your call or text, please assume that the message was not received and try again. Likewise, I will notify you if I should need to cancel our appointment. I will charge a $150 cancellation fee if you do not give me 24 hours notice of any cancellations. You will not be charged if I cancel our appointment.

  Please be aware that I cannot guarantee the privacy of any information sent via email.

  When you arrive for an appointment, please remain in the waiting area and I will promptly meet you. Our sessions will be approximately 50 minutes long, and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error. Please be

prepared to pay the full session fee from a missed or late-cancelled appointment at your next appointment.

- **Fee for Services**: My standard cash fee is $150 per 50-minute session. In certain circumstances, I might arrange a reduced fee for you, which we will finalize in writing on a separate Sliding Scale Fee Agreement form.
- F**ee for Out-of-Session Services:** A fee of $10 per hour will be charged for any service that is not a part of our regular session. Examples of this include: preparation of requested documents, letters or paperwork to insurance companies, or copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services.
- **Payment for Services**: I accept cash, credit/debit cards, HSA payments, or personal check payments made payable to Elizabeth Elliott . Payments are due directly to me at the time of service (at the end of each session). I will charge a $30 fee for any returned checks.
- **Insurance**: I use a 3rd party insurance biller to submit insurance claims. It is your responsibility to check with your insurance company regarding your benefits. My agreement to bill your insurance company does not guarantee coverage.
- **Record-keeping**: I will keep a confidential file containing your private health information (PHI) in a secure file and in a PHI-compliant, cloud-based system. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording “what happens in a session.” I make an effort to summarize what we discuss in each session, but I make no effort to capture sessions verbatim. Washington State law requires the retention of records for seven years after last contact.
- **Emergency, Urgent, or Other Contacts**: You may call me anytime and leave a message on my voicemail, or send me a text and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within 24 hours. Do not use email to communicate emergent or crisis information. **Please remember that anything you send over email is not confidential.**
  If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or a 24-hr crisis hotline (Seattle Crisis Clinic at (206) 461-3222 / Care Crisis Line at (425) 258-4357). They offer 24-hour availability to crisis counseling, community resources, and emergency assistance.
  If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.
- **Therapy Relationship and Professional Boundaries**: It is my intention to maintain a warm, safe, and professional environment where I consider your best interests my priority. Because I have the

utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1. I will not have a social relationship with you outside of my office; this includes contact on social networking sites, such as Facebook or Instagram. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.
2. I will not, at any time, have erotic or sexual contact with you. Physical contact will be limited to gestures such as greetings (i.e. a handshake or hug), consolation (i.e. holding your hand or arm around your shoulder) reassurance (i.e. pat on the shoulder) grounding, or instructional touch. All physical contact will happen only with your express consent.
3. I will not accept gifts from you. I may accept a card or note from you.
4. If I see you in public at any time, I will not initiate contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate a greeting, I will reciprocate, but I will not attempt further communication unless you request it.
5. I will not have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any business or financial relationships. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.
6. I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to non-healthcare or wellness-related individuals and agencies. I do not accept payments for giving referrals.
7. I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered “privileged.” Neither your death nor mine terminates your confidentiality rights.

- **Therapeutic Work, Duration, and Termination**: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person. If more than 30 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.
- **Unexpected events:** Upon the event of my unexpected death or sudden inability to maintain my practice, I have appointed powers-of-attorney to contact my clients to arrange for continued support and to manage my records. I have left specific instructions that all client records be dealt with according to Washington state law. It is my goal to make sure you have options for continued therapy and that your PHI is not compromised in these circumstances.
- **Complaints**: If you have a complaint or inquiry about my professional service that cannot be

resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Please initial each statement, and sign below:

Elizabeth Elliott, MA LMFT, CMHS
elizabeth.elliott@elliottcounseling.com
elliottcounseling.com
(425)322- 9515

I have read the Disclosure Statement for Elizabeth Elliott and I understand it.

I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

I agree to follow the terms in the Disclosure Statement.

I give my consent for treatment as outlined in this Disclosure Statement.

I will receive a copy of this Disclosure Statement with my signature.

I understand that my therapeutic relationship with Elizabeth Elliott, LMFTA may be discontinued if the terms in this agreement are not fulfilled by either of us.

Client Name (please print)

Client Signature Date:

This form will be retained in the mental health record.