Gretchen Burkholder, LMHC #LH6032834

New Client Packet

This packet includes information and forms that are important for our working relationship and are required by law. It is a lot of reading, but please take the time to review the information in its entirety, as it will inform our work together. Please review and complete all forms before our first session. If you are unable to do so before you come to your first session, I will have copies in my office and we will use that session time to complete the paperwork.

Fees: Therapy is a profitable investment in your holistic wellness, your relationships, and in your lifelong productivity. The benefits can extend well past the time you spend in therapy, and into the lives of your family and friends. I strive to keep my rates reasonable and fair. The fee for individual counseling is **$140.00** per 50-minute session and for couples counseling is **$150.00** per 50-minute session, unless otherwise agreed upon.

A $25.00 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days.

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Missed Appointments: Therapy is an ongoing, cumulative process, and significantly more effective when engaged regularly, in a committed relationship. The time of your scheduled appointment is reserved for you which means it is unavailable for me to schedule another client at that time. Therefore, **It is my policy to charge my full rate of $140 for no-shows or cancellations less than 24 hours ahead of time (unless do illness or an emergency).** Please keep in mind that I cannot bill your insurance for missed appointments. *Copays do not count as full reimbursement for missed appointments.*

Insurance: It is your responsibility to confirm the extent of your insurance coverage in my care. You are ultimately responsible for counseling sessions you request. If I am out of network with your insurance company, I will provide you with a monthly receipt/invoice, upon request, which you may submit to your insurance company for possible reimbursement.

Co-Pay: If your managed care policy requires a co-pay, it is the individual's responsibility to bring the co-pay to each session or make other arrangements. I do NOT send out statements for co-pays. **Deductible:** Your health insurance may also have a deductible. If it is applied by your insurance company to any claim I submit, you are responsible for these amounts also. You should check with your insurance to see if a deductible applies.

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Auxiliary Services: Occasionally requests are made for mental health evaluations and other reports. A fee will be charged for these reports.

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Choosing a Counselor / Termination of Treatment: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time. When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is in your best interest that we will discuss the prospect of termination and agree upon a last session for closure. If at any time you do not schedule a future appointment, cancel a scheduled appointment, or miss a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment.

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Services: I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult. If, for any reason, you are unable to contact me by telephone (510) 698-9447, and you are having a true emergency, please call 911 or go to the nearest hospital emergency room.

Confidentiality and Client Rights: There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, **I can assure you that I strive to maintain the strictest ethical standards of confidentiality**. For this reason, if you want me to release information about your participation in therapy to anyone, I will require you to sign the "Authorization to Release Health Care Information" form. This confidentiality has the following exceptions provided by law:

a) In the event of a medical emergency, emergency personnel or services may be given necessary information.
b) In the event of a threat to harm oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made.
c) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.
d) If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed.
e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released.
f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena.
g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities.
i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities.

The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity.

The therapist will have broad discretion to release any information she deems relevant in situations where she believes the client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect. Each client has the right to refuse treatment at any time.

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Consultations: I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas about how to best work with you. These consultations are common professional practice for therapists and are conducted in such a manner that names and identifying information are not provided as to keep within the frame of confidentiality.

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State Information: Therapists practicing psychotherapy for a fee must be registered or certified 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 implies the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (A) to provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure called "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health an the following address and phone number:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360-664-9098

My Availability: I am often not immediately available by telephone. My telephone is connected to a 24-hour, confidential voice messaging system that I monitor frequently. I will make every effort to return your call as quickly as possible, typically within 24 hours, excluding weekends and holidays. You may leave me a voice message at ((206) 940-7754.

Please limit your phone conversation needs to appointment scheduling. If I am to be unavailable for an extended period of time, I will provide you with the contact information of a colleague you may contact if necessary.

Emergencies: In the case of emergency please call: 911, you may also call King County Crisis Clinic, which is available 24 hours every day, at 1-800-244-5767, or 206-461-3222.

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Court Appearance Policy: I am a Licensed Mental Health Counselor, who provides clinical services to adults. This clinical work takes the form of individual counseling. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client. As a Licensed Mental Health Counselor, I cannot disclose any therapy information without the consent of my client. This is required by Washington law, HIPAA Standards, and the LMHC Code of Ethics.

Please do not ask me to write any reports for the court as I cannot do so.

I do not make any court appearances, because this will destroy my professional relationship with my clients.

I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to my client.

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In addition to your signature below, please initial all pages of this document.

Client Consent to Engage in Therapy: I have read Gretchen Burkholder's Disclosure statement and understand its contents. I have asked any questions I have about this statement. My signature on this document attests that I have read the above information, that I consent to therapy under the terms described above, and that I agree to the terms in this document.

Client Signature _____ Date _____

Gretchen Burkholder, LMHC (therapist) _____Date _____