Eastside Modern Family Therapy

Mental health counseling and consulting services for modern youth and families
Michele Loewy, MS, LMFT, # MFT.LF.60682827
325 118th Ave SE, Suite 210, Bellevue, WA 98005
(425) 202-5985; therapy@eastsidemodernfamily.com; Website: eastsidemodernfamily.com

DISCLOSURE FORM

The following contains important information about my professional services and business policies. It also will inform you about your rights as a client. Please read it carefully and ask any questions. Once you provide your signature at the end of this document, it will constitute an agreement between us.

EDUCATION, PROFESSIONAL EXPERIENCE, LISCENSURE

I am a Washington State Licensed Marriage and Family Therapist (License #: MFT.LF.6068282). I earned my bachelor's degree in Psychology and Child Development at Whittier College in California and attained my Masters of Science in Marriage and Family Therapy from Seattle Pacific University in Seattle, Washington. I completed my internship at Youth Eastside Services in Bellevue, Washington. I am a current member of the Washington Association of Marriage and Family Therapy, the American Association of Marriage and Family Therapy, The National Honors Society for Psychology, the Washington Association for Play Therapy, and the International Obsessive Compulsive Disorder Foundation (IOCDF). I am certified to use Prepare and Enrich curriculum. I have a Gottman Level 1 Bridging the Couples Chasm Certification and a certificate in Adlerian therapy. I also completed the Behavioral Tech Training Institute through IOCDF for training in OCD Treatment. Counselors practicing for a fee in Washington State must be registered with the Department of Licensing. I am registered and also received state licensure, which requires additional education, training and supervision.

MENTAL HEALTH THERAPY SERVICES

THERAPEUTIC APPROACH

I approach therapy from a systemic perspective, attending to the broader relational context that a person is living in. I believe people know their own lives best and have the right to make their own decisions. It is my job to sit with a client on his/her journey, but never to tell anyone how to live their life. I believe every client has their own resources and resiliency that can be used to make positive changes in overcoming obstacles. I am open to work with clients from diverse cultural and religious backgrounds, along with any sexual orientation. The practice of psychotherapy varies greatly depending on the client(s) and the presenting problems. Some common approaches that I may use in talk therapy include: Psychoeducation, Experiential therapy (e.g., mindfulness, role play, play therapy, art modalities), Cognitive Behavioral Therapy, Exposure Response Prevention therapy, and Brief Solution Focused Therapy, and assessment instruments.

The lengths of treatment varies depending on each presenting case. Some clients need only a few sessions to achieve their goals, while others may benefit from longer term therapy. Thus, we will discuss the length of treatment and recommendations as therapy progresses. Clients have the right to ask any questions you may have about the process, methods, duration, and goals of therapy; the right to discuss any concerns you may have about your progress in therapy; and the right to terminate therapy at any time. Although I share office space with other licensed therapists, this is NOT a group practice. Please be aware that each of us is an independent solo practitioner.

RISKS AND BENEFITS OF THERAPY

Therapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. It often leads to better relationships, it can provide solutions to specific problems, and there is often a significant reduction in feelings of emotional distress. However, due to the complexity of human nature, I cannot guarantee the effectiveness of treatment.

VOLUNTARY TREATMENT

You have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs. Treatment is completely voluntary. If you are motivated to participate in therapy, the benefits are far greater than if you are simply attending because you feel forced to come. If you wish to stop treatment at any time, you have the right to do so without penalty. I encourage you to discuss this decision with me. I am happy to refer you at any time to other therapists or to community resources to further assist you. For minors, I will do a few sessions and if after the child tries it and he or she does not want to continue, I may end the therapy because it is unethical for me to treat someone if it is not

reasonably beneficial to the client. In this case, referrals will be made as appropriate along with a conversation before concluding.

TERMINATION

Unless otherwise arranged, if I do not hear from you in 3 months, I will close your file. Termination is also decided either in person during a final session or via you contacting me at any time via mail, email, phone or text to inform me that you would like to officially discontinue services. You can always return at any time if I have space in my schedule. This just means that initial paperwork and forms will have to be resigned. If I do not have availability, I will be happy to provide you with referrals.

COMPLAINTS

I welcome and encourage you to speak with me regarding any concerns or dissatisfaction you have with therapeutic services. If you are not comfortable with this, are dissatisfied by our discussion, or believe I am practicing unethically, you have the right to direct any complaints about Unprofessional Conduct at any time to the Department of Health (Health Systems Quality Assurance Complaint Intake: PO Box 47857/Olympia, WA 98504-7857; Ph: 360-236-4700; E-mail: HSQAComplaintIntake@doh.wa.gov, Website: http://www.doh.wa.gov/hsqa/Complaint.htm). For a list of specific reportable Unprofessional Conduct, see RCW 18.130.180 online at http://apps.leg.wa.gov/RCW.

CONFIDENTIALITY AND LIMITATIONS OF CONFIDENTIALITY

In general, all communication between a client and a therapist is protected by law and I can only release information or admit that you are a client with written authorization from the client, the client's legal guardian if under 13, or in the case of death or disability, the client's personal representative. I am legally bound by Health Insurance Portability and Accountability Act laws, and my Notice of Privacy Practices form expands upon your rights and my privacy practices (this can be found anytime at www.eastsidemodernfamily.com). Below are some exceptions to confidentiality:

- HARM TO SELF OR OTHERS. I may breach confidentiality if I believe it will avoid or minimize an imminent danger to the health or safety of a client or any other individual. However, I have no obligation to so disclose. If I believe a client is threatening serious harm to themselves or any other individual, I will take steps to keep the client and others safe. I will contact law enforcement, the potential victim, involve supportive others, other professionals, and/or possibly seek hospitalization for the client to ensure safety of the client and others. In all cases, when clinically appropriate, I will make every effort to discuss this with the client before taking action.
- ABUSE. I am legally obligated to report to local authorities and/or protective agencies any physical abuse, neglect, and or sexual maltreatment of a person under the age of 18, an elder, a dependent adult, and/or a disabled person.
- COURT CASES. I do not go to court for clients and if you are looking for this service, I am happy to refer you to another provider. While our communication is generally protected in federal court and courts in the state of Washington, there are some other exceptions: (a) I must respond to a court ordered subpoena from the secretary; (b) If you choose to file a legal complaint against me, you forfeit your rights to confidentiality so that I may defend myself; (c) I may also have to disclose information if a client is detained and I am motioned by the court in a probable cause hearing to testify/provide documentation to help keep you and others safe.
- PROFESSIONAL CONDUCT. If you reveal information about the impairment or sexual misconduct of another mental health therapist licensed in the State of Washington, I am required by law to report that conduct to the Department of Health.
- If you have an outstanding balance on your account after 60 days, I may breach confidentiality to file with small claims court.

ARTWORK (OPTIONAL)

Therapy sometimes includes a great deal of creative process. Client artwork and sand trays or creations in session are considered confidential information. By **initialing** here _____, _____ you (or your guardian if under 13 years old) release the disclosure of artwork and play-based creations for consulting, teaching, publishing, and educational purposes. Any identifying information will be removed.

PROFESSIONAL CONSULTATION.

I do consult with other professionals in order to provide quality services. I make every effort in these cases to avoid revealing any identifying information about you. If you have any concerns or questions about this, please discuss them with me.

MINORS (UNDER 18 YEARS OLD)

In the state of Washington, minors are able to consent to counseling services at the age of 13 years without consent of a guardian. Under this law, adolescents 13 and older are able to decide what information is released to others, and to whom, including parents. Before the age of 13, parents or guardians consent for counseling services and sign releases of information on behalf of the child. In order to maintain the trusting relationship between therapist and child, it is advised that parents allow the therapist discretion with respect to disclosure of the child's therapeutic information to the parents, regardless of age. Of course, a threat to safety to self or others is the absolute exception (see Confidentiality).

TREATMENT OF CHILDREN OF DIVORCED OR SEPARATED PARENTS

For families with residential schedules (shared custody, parenting plans, etc.), both parents are invited to participate in the child's treatment. **For all children under the age of 13, both parents must sign consent for treatment.** In some cases, treating children over the age of 13 will require the consent of both parents, when I deem necessary.

In order to keep the treatment child-focused, and to reinforce the sole purpose is to provide a safe place for the child to work and process, *the therapist will use not disclose detailed information from child sessions with either parents (within the limits and exceptions of confidentiality listed above, or as it relates to the treatment plan/progress), nor will the records be shared with either parent or the court.* Further, parent consultation sessions with both parents (together or separate) are required as clinically indicated. Both parents have a right to know how often the child will be/is being seen for therapy, unless there is a legitimate safety concern or as restricted by the court.

I _____ understand that it is the policy of Eastside Modern Family Therapy/Michele Loewy, MS, LMFT to obtain consent from both parents *before* my child will be seen for counseling. In addition, I understand that all court related documents and parenting plans must be submitted before the first child session, and I agree to submit any updated documents as soon as they become available. By signing below, I agree to this policy for treating children of divorced or separated parents outlined in this section.

Initial(s) here (when applicable):_____ _____

COURT TESTIMONY AND LEGAL INVOLVEMENT

In order to avoid dual relationships and conflicts of interest, I will provide you or your child with clinical services only. I do not intend to become involved in legal disputes such as personal injury lawsuits, divorce proceedings, dependency hearings or custody battles. These proceedings erode the client-therapist relationship and compromise you or your child's ability to be honest with me during treatment. In addition, I do not participate in evaluation for adoption home studies or provide evaluations of parental fitness to adoption agencies or State entities. By signing this document, you agree:

- That my role is limited to providing treatment and that you will not involve me in any legal dispute;
- That you will instruct your attorneys not to subpoena me or refer in any court filings to anything I have said or done;
- That you will not ask for my participation or recommendations in parenting plans, custody arrangements, visitations, or dependency hearings;
- If there is a court-appointed evaluator in your child's custody or dependency dispute, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will NOT include recommendations concerning custody, custody arrangements, or visitation;
- If, for any reason, I am required to provide expert testimony or documentation for a legal dispute, adoption proceeding or dependency case, or to appear as a witness, the party responsible for my participation agrees to reimburse me at a non-negotiable rate of $260 per hour for time spent traveling, parking fees, time preparing reports, testifying, being in attendance, and any other case-related costs.

OTHER STATE OF WASHINGTON DISCLOSURES

The State of Washington requires that I provide you with the following information: You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the Department of Licensing for the protection of public health and safety. Credentialing of an individual with the Department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

COMMUNICATION

You may call and leave a voice or text message at any time at **(425) 202-5985**. This is a VOIP line via Google. You may also email me at any time at **therapy@eastsidemodernfamily.com**. I typically check messages multiple times per business day Monday through Friday and sometimes on weekends and or holidays. That said, I will do my best to return texts, calls, and emails within 48 business hours. If you contact me via email, text, or by phone, you are giving permission

for me to respond in these manners respectively and/or other methods that you have already consented to. In case of emergency or clinical crisis, do not call me first. *If you have an emergency, are in crisis, do not feel like you can keep yourself safe, or do not feel like you can remain safe from harming others, my voicemail will direct you to call the 24-hour Crisis Clinic at (206) 461-3222, call 911, or go to the nearest Emergency Room. Please call the above numbers and then inform me once it is safe to do so.* For your privacy, and with your permission, I will mainly only discuss scheduling appointments, billing/logistical information, etc. via email and text to respect your privacy unless you specify otherwise, such as giving written/oral permission, asking a question or requesting I email you something.

OTHER COMMUNICATION NOTES

If I am away from the office for an extended time, I will provide you with a number and name of a trusted colleague on my voicemail/email. If I become suddenly incapacitated or deceased, a trusted colleague will contact you and maintain your records.

SOCIAL MEDIA POLICY

In order to protect your privacy, I will not connect with current or former clients via social media. I will not respond to social media requests or comments to protect our privacy. I do not solicit reviews and ask you to refrain from doing so. If you do decide to, as I cannot control what you decide to post, please note that I will not respond on any of these platforms and likely will not see your comment.

APPOINTMENT AND FEE AGREEMENT

To meet with me in person, you must have a scheduled appointment, which is scheduled by calling, emailing, or texting me. I will meet you at my office. Payment is due at the time of service. **Note that fees are subject to change, but you will have notice before this goes into effect.*

PROFESSIONAL FEES

Initial diagnostic interview	**60 minutes …….……..….. **	**$160**
Individual therapy	**46-60 minutes……. **	**$130**
	**30-45 minutes ……. **	**$110**
Couple/Family therapy	**45-60 minutes……..……..….. **	**$130**
Therapy longer than 60mins	**per 15 minutes…… **	**$32.50**
Other Fees	**per 15 minutes …… **	**$32.50**

-E.G., Report writing, meetings, phone calls (free up to 15 minutes), special transportation

Court related services **60 minutes ..……..……..……$260**

-This will be charged in 15minute pro rated intervals. Please note, I do not provide court-related services except when someone has broken this agreement with me and/or I am compelled by the court to become involved with court related matters (e.g. testifying in court under subpoena, participating in a deposition, transportation to and from the court, waiting at court, parking fees, etc.)

Non-Sufficient Funds Checks **$25 per check**

CANCELATIONS/LATE APPOINTMENTS

All cancelations must be made at least 48 hours in advance, otherwise, cancellations are subject to a late cancellation fee of 100% the cost of the session. I schedule this time for you. Please note that insurance companies do not reimburse for missed appointments. If you are running late for your appointment, please call me as soon as you can.

BILLING.

You are expected to pay for each session at the time it is held, unless we make other arrangements. If you think you may have trouble paying your entire balance at the time of service, please discuss this with me. In circumstances of unusual financial hardship, I may be able to provide a discounted rate. I currently accept cash and checks made out to Michele Loewy.

Delinquent Accounts: If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon. I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In collection situations, the only information I would release is the patient's name/person responsible for payment, the nature of services provided (e.g., family therapy, individual therapy, other service related charges) and the amount due.

For clients under the age of 18: It is policy that the parent or guardian who initiates services for a child is the party responsible for payment. ***In cases where parents are divorced and separate appointments are required, payment is expected at the time service that services are rendered, regardless of which parent accompanies the child/attends the appointment

(unless other arrangements are made in advance). Shared financial arrangements between parents should be worked out between the parents involved. I will not facilitate this process.

REIMBURSEMENT/OVERPAYMENT/ADVANCED PAYMENT.

If you over pay for sessions, the balance will either be reimbursed in cash, or applied to future sessions. This will be discussed with you and you may decide how you would like to proceed. I typically do not take advanced payment for more than one extra session. It is not required and only occurs in special circumstances when requested by the client. I do not spend money or cash checks until after the services are utilized. If something were to happen to me and I could not do a session you pre-paid for, or in the case of incapacitation, a trusted colleague would contact you to arrange for reimbursement.

INSURANCE

I am an in network provider with most Premera Blue Cross Blue Shield plans, Wellspring EAP, and Lifewise. If you have any of these plans and would like to use your insurance; you are responsible for your deductible, co-insurance, and co-pay at each session. If you would like to use Wellspring EAP benefits, this has to be arranged *prior* to the first session by you calling Wellspring and requesting to see me. For all other insurance plans, I am an out of network provider. Upon your request, I will provide you with a receipt for each appointment with fees listed and appropriate insurance codes that you can submit to your insurance company. Regardless, call your insurance to find out about your out of network and/or in network coverage. I am happy to discuss this with you. Please provide a copy of your insurance card at the first session if you wish to pay with Premera Blue Cross Blue Shield or Lifewise and fill in the card information below:

Subscriber's legal full name on card: _____
Subscriber's birth date _____
Employer _____
ID Number (include letters if applicable): _____
Group Number_____

THIRD-PARTY PAYER ISSUES

If you choose to use your insurance, whether I bill them as an in network provider, or you submit receipts to them as yourself, your treatment here will be subject to utilization review by a managed care or insurance company. This usually requires disclosure of confidential protected health information such as symptoms, diagnosis, treatment plan, and relevant history. For the purpose of audits, third-party payers also have access to clients' records. Moreover, you must meet minimum criteria for "medical necessity" for insurance to cover services. They may not pay for all diagnoses, or may not pay if you do not have a diagnosis in the *Diagnostic Statistical Manual of Mental Disorders*. These diagnoses usually remain permanently on your medical insurance records. If you disagree with an insurance company's authorization decision, you have the right to appeal that decision. Please be mindful when deciding whether or not you would like me to bill your insurance and whether or not you want to submit information to your insurance company independently. You have the right to choose!

Please initial a line below:

_____ I choose NOT to use my insurance and pay for services out of pocket.

_____ I choose to use my insurance benefits. I authorize the release of any medical or other information necessary to process these claims. I hereby authorize Michele Loewy, MS, LMFT to submit all Personal Health Information necessary to my insurance company, and clearinghouses in order to bill my insurance and for Michele Loewy, MS, LMFT to receive reimbursement. I further authorize direct payment to Eastside Modern Family Therapy, LLC and/or Michele Loewy, LMFT.

_____			_____
Print Name	Signature	Date	On behalf of (for clients under 13 yrs old)
_____			_____
Print Name	Signature	Date	On behalf of (for clients under 13 yrs old)
_____			_____
Print Name	Signature	Date	On behalf of (for clients under 13 yrs old)

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Client(s): _____

Patient's Acknowledgement of Receipt of Forms

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Michele Loewy's:

- Notice of Privacy Practices
- Fee Agreement
- Disclosure Form

I consent to accept these policies as a condition of receiving mental health services. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I have read, understand, and agree to abide by these documents. I accept therapeutic treatment services from Michele Loewy, MS, LMFT for myself/as the legal guardian of my child (if under 13). I understand a copy of this form will be kept in my legal record.

Client or Responsible Party Signatures:

_____ _____

Print Name Signature Date On behalf of (for clients under 13 yrs old)

_____ _____

Print Name Signature Date On behalf of (for clients under 13 yrs old)

_____ _____

Print Name Signature Date On behalf of (for clients under 13 yrs old)

_____ _____

Print Name Signature Date On behalf of (for clients under 13 yrs old)

_____

Counselor Signature Date

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OPTIONAL--ELECTRONIC CORRESPONDENCE AGREEMENT

By signing this document with phone numbers or emails entered below, you are waiving your right to electronic protected health information. You are agreeing to receive correspondence for such purposes including, but not limited to, electronic receipts for services rendered, scheduling, and communicating regarding counseling services. By signing this document, you expressly acknowledge and consent to the use of your email account/texting you for the purposes of scheduling, billing, exchanging information that affirms a client-therapist relationship, and any other protected health information.

- You understand that I will not provide therapy via email/text.
- Your email address will not be shared with third-parties outside of Eastside Modern Family Therapy.
- Please be aware that I do not typically use encrypted email/text/telephone software and I cannot guarantee that information transmitted by email/text/voice will not be intercepted or read by other parties. That said, to my knowledge, I am the only person with access to this phone line and email address.
- If you give me permission to communicate with you via an email address, text message number, or voicemail that can be accessed or is shared by anyone else, please be aware that confidentiality may be broken.
- Also, please be aware that all voicemails, text messages, and emails are stored on servers and can be accessed by those affiliated companies. I cannot control what these companies do with this information.

By signing below, I _____, unconditionally agree to accept the Terms of Use as stated above. To opt out of receiving email/texts/voicemails at any time, please notify Michele Loewy at Eastside Modern Family Therapy in writing. My Protected Health Information can be released in these methods to the following addresses/phone numbers. **I have read the above and agree to hold Michele Loewy, MS, LMFT/Eastside Modern Family Therapy harmless for any breach of confidentiality that may result from unauthorized access to confidential information included in any emails/texts/voicemails sent to or from me at the following numbers/emails:**

Email(s): _____

Phone: _____ Calls: Yes/No Voicemail: Yes/No Text: Yes/No

Phone: _____ Calls: Yes/No Voicemail: Yes/No Text: Yes/No

If you only want electronic communication via encrypted messaging and phone lines, please ask me about using the *Signal* application to communicate. You will have to download this free application onto your cellular phone. If you would like me to only use this method of communication with you outside of the office, please inform me ASAP.

_____ _____ _____ _____
Print Name Signature Date On behalf of (for clients under 13 yrs old)

_____ _____ _____ _____
Print Name Signature Date On behalf of (for clients under 13 yrs old)