Mindful Talk Therapy

INFORMED CONSENT FOR TREATMENT

Christopher J. Rosales MA, LICSWA, LMHCA
Mindful Talk Therapy

This document when signed is a formal agreement between us for therapeutic services. You have the right and responsibility to choose your provider and treatment modality that best suits your needs. Please ask if you have questions or concerns pertaining to this document or treatment.

ABOUT ME:
I am an employee of Mindful Talk Therapy INC, and Sacred Heart Medical Center. I am trained in individual, family, and group counseling using the following modalities: Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavior Therapy (DBT). In our sessions we will utilize a strength based, solution focused, systemic, and client centered approach.

Licensed in Washington State:
Licensed Mental Health Counselor Associate (LMHCA) MC61363997
Licensed Independent Clinical Social Worker Associate (LICSWA) SC61396998

Education:
Eastern Washington University, Master's Degree in Social Work
Whitworth University, Bachelor's Degree in Social Work

CONTACT INFORMATION:
Phone number: 509-680-6374
I may not always be able to answer my phone due to being in session with other clients. Please leave a detailed message and I will return your call within 24 hours or sooner.
Email: chrisrosales29.cr@gmail.com

INTERNET/MEDIA POLICY:
I advise and recommend that email correspondence only be utilize to communicate appointment communications.
I understand that email communication may not be secure and/or confidential _____ (initial)

NUMBER TO CALL IN THE EVENT OF EMERGENCY OR NEED IMMEDIATE MEDICAL ATTENTION:

PLEASE CALL 911

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT OF 1996 (HIPPA)
HIPPA is a Federal privacy protection that employs a national standard pertaining to individual's electronic health information for health care providers, health plans and employers. Under this act it is required that clients be informed of their rights pertaining to their records.

CLIENTS RIGHTS /RESPONSIBILTY/CONFIDENTIALITY

You have the right to non-discriminatory treatment and to be treated with dignity. You have the right to have your records protected. Furthermore, you have the right to obtain a copy of your records. I will need a written request and a fee will be charged for copies. If the clients are seen as a couple or a family, no information will be released without the written consent of all parties. Exceptions to the right to obtain your record include the therapist concluding that the release may cause harm to you or someone else, or if it is legally advisable. You also have the right to confidentiality and the right to request restrictions on disclosures of your protected health information- with exceptions as noted in **limits to confidentiality (Appendix A.)** With written authorization, you have the right to authorize the release of your protected health information and the right to rescind your release of protected health information. (To withdraw your consent you need to have it in writing and understand that information already disclosed cannot be undone or recovered.) As a client you have the right to refuse treatment, and obtain referrals to other therapists and/or agencies. You have the right to discuss complaints with me or with anyone of your choosing, including other therapist. You have the right to a copy of this informed consent.

I encourage you, and it is your responsibility, to ask questions when you have concerns, be honest, follow the treatment plan, attend therapy appointments, and inform me of any changes (contact information, or information that would impact you and our therapeutic process such as employment, significant relationships, etc.) It is your responsibility to make payments prior to therapy session.

BENEFITS AND RISKS:

Individual, couple, and family therapy has all been shown to have benefits for many people. However, there can be risks associated with therapy. Growing, making self discoveries and changes is a process and can cause discomfort and experience unexpected feelings such as frustration and guilt. During the therapeutic process clients may experience setbacks which may be inevitable. Individual, couple, and family therapy has all been shown to have benefits for many people. However, there can be risks associated with therapy. Growing, making self discoveries and changes is a process and can cause discomfort and experience unexpected feelings such as frustration and guilt. During the therapeutic process clients may experience setbacks which may be inevitable.

PROPOSED COURSE OF TREATMENT:

The first session can be up to 90 minutes to review intake forms and/or complete intake forms and to allow adequate time to go over concerns and understand informed consent. Sessions are typically once a week for 30, or 45-50 minutes. However, there may be times where twice a week is more appropriate for the treatment. The first few sessions, as we get to know each other, and to explore the issues that have brought you into therapy as an individual or as a couple/family.

Together we will explore what goal(s) best meet your needs and discuss a treatment plan for how your goals can best be achieved. It is your right to request changes or revisions to your goals. We will regularly evaluate progress that is made, and make sure the goals are still appropriate and allow for revisions in a collaborative effort.

There are various techniques I may use during therapy to support the therapeutic process to help you/your family in reaching set goals.

Participate agrees to Telehealth via audio and/or video for therapy sessions_____(initial)

FEES/INSURANCE:

The standard fee for individual therapy is $140.00 per session and $240.00 couple. I do accept some insurances. I also can provide you with an invoice with my license credentials for reimbursement for out of network provider. Please check with your insurance company with questions regarding coverage and filing procedures. Co-payments and Payments for session fees are due on day of service and may be made by cash apps like Venmo, Apple Pay, Zelle, or with QuickBooks invoice.

PLEASE NOTE: If cancellations are necessary please provide 24 hour notice, otherwise YOU WILL BE CHARGED FULL SESSION RATE. ____ (initial)

If there is a matter where you need a brief consultation with me, you may call to discuss the issue. Should the calls exceed 15 minutes or become frequent, a fee will be charged a proportionate amount of your typical session fee.

COMPLAINTS:

Unprofessional conduct can be defined under the revised code of Washington State (RCW 18.130.180) If you feel you have been discriminated against or otherwise treated unethically or unprofessionally you may contact the Washington State Department of Health, PO BOX 47869, Olympia, WA 98504-7869, (360) 236-4700.

COLLABORATIVE SHARING:

Occasionally, I consult my cases with professional colleagues; all names and unique identifying information will remain concealed. The other professionals with whom I work with are bound to the same standards of confidentially and ethics as I am.

Your signature acknowledges that you have agreed to treatment and have read and understood the information in this informed consent. It also acknowledges that you have received the limits of confidentiality form and have been informed of your rights and notice of privacy practices as required by the Health Insurance Portability and Accountability Act (HIPPA).

Client Signature: _____ Date: _____

Client Print Name: _____

Client Signature: _____ Date: _____

Client Print Name: _____

Therapist Signature: _____ Date: _____

Therapist Print Name: _____

LIMITS OF CONFIDENTIALITY APPENDIX A

All content of therapy sessions are confidential. Written consent is required for the client's verbal information and/or written

records to be shared. However, listed below are the following legal and/or ethical exceptions to confidentiality:

ABUSE OF CHILDREN If a client states or suggests they are abusing or neglecting a child or a mental health provider has reasonable cause to believe a child has been abused or neglected or had been previously abused a mental health provider is mandated by law to report this information to the proper legal authorities and/or department.

VULNERABLE ADULTS If a client states or suggest that they have abandoned, abused, financially exploited or neglected a vulnerable adult a mental health provider is mandated by law to report to proper legal authorities and/or department.

HARM TO SELF If there is reasonable cause to believe and/or a client states or suggests they have a plan or intend to commit suicide, the mental health care provider is legally required to notify the proper legal authorities and make reasonable attempts to notify the family of the client.

DUTY TO WARN AND PROTECT If there is reasonable cause to believe and/or a client discloses they plan or have intentions to harm another person, a mental health provider has an ethical duty to warn the intended victim, notify the proper legal authorities, and make reasonable attempts to notify the family of the client.

SUBPOENA/COURT ORDER If a mental health provider is subpoenaed or court ordered, information and/or records will be released that are related to a report or a complaint. Mental health provider will make reasonable attempts to notify client. If client is contesting the subpoena it is the client's responsibility to properly inform me of the contest.

PRIVILEGE WAIVED If any Washington-state agency that oversees my licensure subpoenas me as part of an investigation, I am required to comply and may be asked to disclose your personal information. If legal actions are brought against a mental health provider by a client the privilege of confidentiality is null and void.

MINORS Parent/legal guardians hold the privilege of confidentiality when the child is under age 13. Information obtained in therapy from a minor under age 13 may be shared with patents/legal guardians.

INSURANCE COMPANIES/BILLING Insurance companies may need dates of treatment and diagnoses for reimbursement. Complete confidentiality cannot be assured when using insurance.

I have read the above and fully understand the limits of confidentiality.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____