

Disclosure and Consent for Treatment

When you come to me for therapy often you are looking for some kind of change in your life. You may want me to help you look at options for a particular problem, explore your feelings, or make a decision. My approach is to be direct, listen well and help you gain clarification in a manner that provides you with strength and confidence. This will require that you state what you want from counseling and make a verbal contract around this.

DEGREES & License

MS—Master of Science, 1983, Central Washington University, Ellensburg, WA, specialization in counseling psychology and school counseling

BA—Bachelors of Arts, 1968, University of California, Berkeley, CA

Specialization in social science field major

Licensed Mental Health Counselor LH00005234

I have been a family therapist for 27 years and a former school counselor for 12 years with both the Northshore and Lake Washington School Districts. I have given parenting presentations and trainings for parents in both school districts along with Evergreen Hospital and Children's Response Center. I am a member of the National Association of Counselors and a board member for Salud Juntos, a nonprofit that supports community healthcare in Honduras.

CONFIDENTIALITY

The issues discussed in the course of therapy are kept in the strictest of confidence. By law information about our professional relationship can only be released with your prior consent. There are specific exceptions to this:

1. Any communication that reveals the contemplation or commission of a harmful act.
2. Any information regarding a client subpoenaed from a court of law.
3. If the client is a minor, any information relating to the client having been been the subject or victim of a crime.
4. If there is suspicion of child abuse or neglect, I am required to inform Child Protective Services.
5. For our mutual benefit, I take part in professional consultation and may discuss your case with other professionals omitting your name. You have the right to ask me not to discuss your case.
6. If a client is court order to counseling I am obligated to give the results of treatment.
7. All communications among the parties, the child, and the counselor will be confidential and privileged from disclosure. **All parties agree that Lynn Tienken will not be required to testify at or to produce for any proceedings or in any court, opinions, records, documents, or recordings formed or created as part of the therapy process unless agreed upon by all parties.** Without this stipulation the therapeutic alliance may be affected detrimentally. This stipulation does not preclude following the statutory requirements to report all information regarding: child abuse or neglect; a threat of violence against a reasonably identifiable victim; or mental illness that requires involuntary commitment because of danger to self or others or grave disability
8. Because of a lack of confidentiality, I choose not to communicate confidential information by e-mail. A client may request scheduling via e-mail but my response will usually be by telephone. A cancellation of an appointment may not be given by e-mail. A client cannot assume confidentiality when conversing with me by cell phone. .

FEES & APPOINTMENTS

My professional fee is \$115 for individuals and \$125 for families/couples for 50 minutes. Home visits are \$150 not including travel time. Sessions are prorated if they extend beyond the agreed time. Other than discussing scheduling in an e-mail, I charge for all communication sent to me about the particular clients' therapy. There is a fee for all documents read or produced by me. I provide a free 10-minute phone contact. Beyond the 10 minutes, I charge the same as my in-office visit.

If you are unable to keep your appointment I require that you give me at least a 24-hour advance notice. Otherwise, I charge for the time that you have reserved. An interest charge of 1.5% a month will be added to any outstanding balance that are 30 days or more over due.

Emergencies

In the event of a problem and I am unavailable, contact Crisis Clinic 206 461 3222.

Clarifications

If there are any questions about the therapeutic relationship or my business relationship with you, please do not hesitate ask me. My intention is to discuss these matters with you openly.

Authorization for Service

My signature below indicates agreement with the above policies and authorization for services. I have read and clarified any questions about office policies or treatment. I have been given a copy of this agreement.

| | |
|-------------------------------------------------------------------|------------------------------------------|
| _____ Signature of Client (or person acting for client) | _____ Date |
| _____ Signature of Client | _____ Date |
| _____ Printed Name | _____ (relationship to client) |

I, Lynn Tienken, have discussed the above with the client or his parent or guardian or his representative.

| | |
|----------------------------------------------|----------------------|
| _____ Lynn Marie Tienken, MS, LMHC | _____ Date |
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