BAKER
FAMILY THERAPY
BOBBIE BAKER, MA, LMFT, RPT

4000 AURORA AVE. NORTH, SUITE 224

SEATTLE, WASHINGTON 98103

Professional Disclosure Statement and Consent for Services

Washington State law requires Mental Health Professionals provide clients with information about their rights and responsibilities. You have the right to choose a therapist that best suits your needs and purposes. This document is designed to provide details and information pertinent to engaging in a therapeutic relationship. Please read it carefully. Your signature below indicates that you have read and understand this Disclosure Statement and that you willingly consent to treatment.
Counselors practicing for a fee must be registered or licensed with the Washington State Department of Health for the protection of the public health and the safety of their clients. Licensure of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

Training, Experience, and Theoretical Orientation - Bobbie Baker, MA, LMFT, RPT
My theoretical orientation and approach are based on the power of a warm, accepting, and trusting relationship. Within such a relationship, children and caregivers are free to explore feelings, thoughts, and behaviors in a supportive, non-judgmental, and culturally sensitive environment. I utilize a person-centered, strength-based, systemic approach to working with individuals and families, with a focus on attachment theory.

I have a Bachelor of Arts (BA) in Communication Arts from the University of Wisconsin and Masters of Arts (MA) in Marriage and Family Therapy and Art Therapy from Antioch University. I have additional training and experience in Child Parent Psychotherapy and Child Parent Relationship Therapy.
I work with children both individually and with their primary caregiver(s), depending on the child's age and the issues being addressed. I am a Licensed Marriage and Family Therapist in the state of Washington (license number: LF 60967090) and a Registered Play Therapist (RPT).

Appointments and Availability
Your child/family will have a set day and time for weekly appointments. If you have questions or concerns that cannot wait until your session, please call and leave a message on my confidential voicemail (206.660.9562). I check my messages daily and typically return calls within 1-2 business days Monday through Friday. **Lengthy phone calls and those related to treatment will be billed in 20-minute increments.** Infrequent communication regarding scheduling or other matters will not be billed.

If you are unable to attend your session, please call and cancel at least 24 hours prior to your appointment. Because your spot is reserved for you, missed or canceled sessions with less than 24-hours notice are billed at $60/hour. Regular attendance is essential to the therapeutic process. However, in order to protect the health and safety of clients and prevent the spread of disease, please keep your child home if he/she is sick, has a fever, lice or any other contagious ailment.

Emergencies
If you are experiencing a life-threatening emergency, please dial 911 or go to the nearest hospital emergency room. If you are experiencing a crisis that is not life threatening and I am not available, call the **King County 24-hour Crisis Line at 206.461.3222.**

Treatment of Minors
I want to help your family foster an environment that promotes open communication. With that in mind, please know that if your child is under 13 years of age, the child's permission is not required for me to talk to you about their private sessions. However, your child may benefit from a "zone of privacy" - a place where they can express their feelings and thoughts without having them reported to their parents. 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.

In the state of Washington, minors are able to consent to counseling services at the age of 13 years. Under this law, adolescents 13 and older are able to decide what information is released and to whom, including parents. Of course, a threat to safety to self or others is the general exception (see confidentiality).

It is my policy that parents/guardians of children under the age of 13, stay on the premises during their child's session since parents may be asked to participate. In addition, unforeseen circumstances such as a sick or disruptive child, or other emergency may require that a session end early.

Confidentiality
Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is generally held to be confidential. Some limits to confidentiality exist in which I may choose to, or be required to, disclose this information.

- If you give me written consent to have the information released to another party;
- Without your written consent for the purpose of treatment, payment, or healthcare operations;
- In the case of your death or disability, I may disclose information to your personal representative;
- If you waive confidentiality by bringing a legal action against me or another person;
- In response to a valid subpoena from a court or from the Secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to you/your child's health or safety or the health or safety of any person in particular or of the public in general;
- If, without prior agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children, an elderly person, or a vulnerable or dependent adult.

For best practices, I may utilize supervisors, colleagues, or attorneys about your case. In these instances, your personal and identifying information will be kept confidential to the extent possible. Living in the same city, it's possible that we may see one another outside the office in the public arena. In those cases, to maintain the privacy of the therapeutic relationship, I will not address you. In order to maintain therapeutic boundaries, I will not discuss therapeutic content outside of the office.

Record Keeping
I keep a record of the health care services I provide you. You may ask to see and copy that record. You may also request to correct that record. I may not agree with your request but will keep a record of your request.

Treatment of Children of Divorced or Separated Parents
For families with residential schedules (such as shared custody or parenting plans), both parents are invited to participate in the child's treatment. **For children under the age of 13, the consent of both parents is clinically indicated – even if not legally required -- to initiate treatment, consistent with any court orders or parenting plans.**

In order to keep the treatment child-focused, and to reinforce the sole purpose of the therapy (to provide a safe place for the child to work through feelings), *I will **not** disclose information from child sessions with either parent (with 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, unless legally compelled to do so.* Further, parent consultation sessions with both parents will be encouraged (but not required) every 4-6 weeks, or as clinically indicated. Both parents have the right to know how often the child will be seen for therapy, unless there is a legitimate safety concern or as restricted by the court.

It is my policy not to testify in court proceedings regarding custody or parenting plans and *at no time will I offer an opinion or recommendation in any court matter*, especially as it relates to custody.

By initialing here, I understand that it is your policy that you receive consent from both parents *before* my child will be seen for counseling (unless mandated by court order/parenting plan). In addition, I understand that all court related documents and parenting plans must be submitted in advance of the child's first session and I agree to submit any updated documents as they become available. By initialing here, I agree to this policy for treating children of divorced or separated parents.
_____ _____ (initial here)

Social Media Policy
Current legal and ethical standards do not allow therapists to engage in a personal social media relationship with clients. For this reason, I do not connect with or "friend" clients or their families on social networking sites including but not limited to Facebook, Instagram and Linked-in.

Client Rights and Responsibilities
As a client, it is important that you have a general understanding of your rights under Washington State law and to know the background of your therapist. You have the right and responsibility to choose a treatment provider and a treatment modality that best suits your needs. If you believe that the work we are doing together is not helpful or that I am no longer the right provider for you, it is your right and responsibility to tell me so that I can either consider other therapeutic options or suggest a referral that may be more helpful. There are no guarantees as to the benefits therapy may have. You have the right to refuse consent and the right to withdraw consent to services.

There are benefits and risks involved in therapy. Since therapy often involves uncovering troubling aspects of life, clients may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Some clients see positive changes right away; others may feel that it gets worse before it gets better. It is normal for strong emotions to arise within the therapeutic relationship. It is also possible that your child may get physically hurt, as we are often active in play therapy sessions, though I make every effort to avoid this and have several safety precautions in place. In the event that your child is physically hurt in session, I will inform you verbally at the end of session and document it in writing in my chart.

Please know that I will endeavor to make your child's treatment as beneficial and productive as possible. If at anytime you feel concerned about the course of therapy, please do not hesitate to talk with me about your concerns. It is every client's right to terminate treatment at any time, with or without notice to the therapist. If you believe you need to address your concern with a professional monitoring agency, please contact: Department of Health, Professional Licensing Services, 1300 Quince Street, P.O. Box 477869, Olympia, WA 98504, 360.664.4375.

Fees and Financial Information

My fee is $130 per 45 to 50-minute session and is due at the time of service. Intake sessions are 75 minutes at a rate of $190. I offer a discounted rate depending on individual financial need. This will be your rate unless otherwise specified here: _____.

Stored payment information may be used to process recurring or one-time payments. By providing your credit card information, you accept that this information may be used for payment and will be stored in compliance with payment processing regulations.

I am an out-of-network provider and therefore do not bill insurance. Some insurance companies will reimburse for out-of-network providers, but it is not guaranteed. In many cases, your out-of-network reimbursement covers a significant amount of therapeutic services, though you should contact your insurance company for more information. Please call your insurance company to ask about your Out-of-Network Outpatient Mental Health Benefit. I *may* be able to submit claims *on your behalf* directly to your insurance company, whereby you will be reimbursed directly. In cases where I cannot electronically submit claims on your behalf, you will be provided insurance-ready documentation that you will be able to submit for reimbursement. Please be advised that in order to bill insurance, I will need to provide treatment information to your insurer, including a psychiatric diagnosis.

Termination

There can be as much benefit from proper closure as there is from the therapeutic process itself. This is an opportunity to review our time together, to consolidate the gains made, and to address prevention and intervention strategies for the future. As you are free to terminate therapy at any time, please provide notice so that we can plan accordingly to ensure maximum gain. I am also able to terminate clinical services. Examples of cause for termination may include nonpayment, nonattendance, safety, optimal care, and necessary progression. This Disclosure serves as notice that I will terminate services if you miss three consecutive sessions without contacting me.

Email/Text Messages

Though I maintain confidential and HIPAA compliant email accounts, email and text messages are not considered a secure form of communication. By initialing here ____ ____ I understand the limits to confidentiality in email/text communication and choose to communicate through email/text despite these risks. Emails with therapeutic content with be copied and pasted and entered into your child's clinical file.

Artwork (Optional)

Client artwork and sand trays are considered confidential information. By initialing here _____ _____ I agree to the use of client artwork and play-based creations (including sand tray) for the purpose of consultation and supervision. Any identifying information will be removed. This is your permission for me to use your child's de-identified artwork or play-based creations in published works or presentations.

Video (Optional)

Recording of any kind requires consent on the parts of all parties. You may not record me nor I you without express consent given verbally on the recording. Audio and video recording of sessions can be useful for consultation and supervision. If recordings are made, they are not part of the client record and are stored securely according to HIPAA standards. Recordings will be destroyed upon the retirement of the therapist, or the closure of the business, whichever comes first. You may withdraw your consent to be recorded at any time.

By initialing here _____ _____ I acknowledge that I have read and understand the terms applied to audio/video consent, and acknowledge that my consent is entirely voluntary and will not impact my therapeutic services in any way.

Consent for Services

By signing this document, I hereby agree that I have read and understand the terms stated in the above Disclosure Statement and give my consent for me, or my child, to receive counseling services with Bobbie Baker at Baker Family Therapy. I acknowledge that I have received an electronic copy of the Clients Rights and Responsibilities and HIPAA Privacy Notice (or a paper copy if requested).

_____

Client's Name (Please Print)

_____ _____

Parent/Guardian Signature/Client's Signature (age 13 or older) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Clinician Signature Date