A Better Way Counseling Service, LLC

601 E. McLoughlin Blvd. Vancouver, WA 98663
Phone: 360-281-6824 **Fax: 360-314-2908**

Tina L. Powell, LMHC, NCC **Disclosure Statement**

This disclosure is provided for your information and protection. It contains information about the types of services that I provide my approach to treatment, my education, and my fees. **If you have any questions about the information on this page, please do not hesitate to ask me.**

Qualifications: I graduated from the University of Laverne in 2005 with a Bachelor of Science Criminology/Psychology (BS), and Argosy University, AZ in 2009 with a Master of Art (MA) in Forensic Psychology. More recently in 2017, I achieved a Clinical Mental Health Counseling-Forensic Counseling Master of Science degree from Walden University. My academic coursework included: individual, group, family, couples, victims, and offenders assessment, diagnosis, treatment planning, clinical and motivational interviewing, and various theory based counseling and psychotherapy interventions as well as specializations in Forensic and Addictions counseling. Other areas of my academic coursework included: individual and group psychopathology, pharmacology, multicultural assessment, mental health law, evidenced-based research, and ethics. I am a Washington State registered Agency Affiliated Counselor (AAC), Licensed Mental Health Counselor (LMHC) and a Nationally Certified Counselor (NCC).

Experience: In residential ,community, mental health agency, Forensic, and school settings, I have professional experience working with children and adolescents experiencing abuse, neglect, and abandonment, as well as legal blindness and various visual impairments, and adolescents and adults diagnosed with a variety of severe and persistent co-occurring, substance use and mental health disorders such as Schizophrenia, Bipolar, Depression, ADHD, Conduct Disorder, Anxiety, and Post traumatic Stress using Cognitive-behavioral, Person-centered, Psychodynamic, Gestalt, and Play therapy as well as other evidence-based counseling interventions. In collaboration with other community agencies, I specialize in working with adolescents and adults diagnosed with mental health disorders, in need of various types of counseling services, and involved in both the civil and criminal justice systems.

Nature of Counseling: Counseling is collaboration between the client and the counselor to resolve specific concerns in the context of a safe, supportive, and therapeutic relationship. Successful counseling involves communication, respect, and a willingness to explore different ways of feeling, thinking, and behaving that build upon the client's strengths and empower the client to make choices that promote their health and well-being.

Informed Consent

Counseling Relationship: The nature of our counseling relationship is professional, and I will abide by all legal and ethical requirements as stated in the Code of Ethics for Marriage and Family Therapists, Mental Health Counselors and the laws of the state of Washington. We will establish together the frequency and focus of sessions based on your specific needs and situation. Typically, most clients meet with me for 45-50 minute sessions. I return all client phone calls within 2 business days, unless we have arranged otherwise in advance. I do not discriminate on the basis of race, gender, religion, national origin, sexual orientation, or physical ability. Please inform me how you would like for me to address you. You may call me Tina **In the event of an emergency please contact the Clark County Crisis Clinic line at (360) 696-9560, call 911, or head to your nearest Emergency Hospital**.

Legal Statements: Washington State law requires Licensed Therapists to provide clients with certain information about their rights and responsibilities (see WAC 246-809-710). This subsection does not grant (clients) new rights and is not intended to supersede state or federal laws and regulations, or professional standards. You have the right to refuse treatment and the right to choose a practitioner and treatment modality that best suits your needs. If you wish to obtain a list of the acts of unprofessional conduct listed in the laws (RCWs), you may contact the Department of Health at:
Washington State Department of Health
PO BOX 47890, Olympia, WA 98504-7890
(360) 236-4030

Termination of Therapy: As a client you are always encouraged to share any thoughts or concerns you might have regarding me as your counselor. If you are feeling that your concerns are not being heard and resolved then you have the right to contact the Washington State Department of Health. You also have the right to terminate therapy or request a referral to see a different mental health counselor.

Confidentiality: Discussions between you and I are confidential. Even the fact that you are in counseling with me is confidential. For this reason if I see you in public, I will protect your confidentiality by greeting you only if you greet me first. If I need to contact you outside of the session, I will contact you using the telephone number for which you have provided written authorization in this Disclosure document. This contact may be for the purpose of providing appointment reminders, information about treatment alternatives, or other services and issues related to your care. **Your confidentiality is of the utmost importance to me. Your feelings of safety and comfort are what make our time together effective and helpful.**

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I use and disclose Protected Health Information (PHI) to provide treatment to and for clients. Your legal rights and limits to confidentiality and disclosure of your Protected Health Information (PHI) are outline below:

Your Rights Regarding Your Protected Health Information

A. *Right to Request Additional Restrictions:* You may request restrictions on my use and disclosure of your PHI (1) for treatment, payment, and health care operations, (2) to individuals such as a family member, other relative, close personal friend or any other person identified by you involved with your care or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While I will consider all requests for additional restrictions carefully, I am not required to agree to a requested restriction.

B. *Right to Receive Confidential Communications:* You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

C. *Right to Revoke Your Authorization:* You may revoke your authorization, except to the extent that I have taken action in reliance upon it, by delivering a written revocation statement to me.

D. *Right to Inspect and Copy Your Health Information:* You may request access to your record file and billing records maintained by me in order to inspect and request copies of the records. Under limited circumstances, I may deny you access to a portion of your records. If you request copies, they will be subject to the records fees listed below.

E. *Right to Amend Your Record:* You have the right to request that we amend PHI maintained in your record file or billing records. I will comply with your request unless I believe that the information that would be amended is accurate and complete or other special circumstances apply. In such cases, I will allow you to place any statements into your chart to accompany the document/statement you wish to amend.

F. *Right to Receive An Accounting of Disclosures:* Upon request, you may obtain an accounting of certain disclosures of your PHI made by me during any period of time prior to the date of your request, provided such period does not exceed seven years after discharge/termination from service.

G. *Right to Receive Paper Copy of this Notice:* Upon request, you may obtain a paper copy of this notice.

Permissible Use and Disclosure Without Prior Written Consent

A. *Public Health Activities:* I am legally required to disclose your PHI for the following public health activities: (a) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability; and (b) to report child, elderly and disabled persons' abuse and neglect to the Washington Child Protective Services or other government authorities authorized by law to receive such reports.

B. *Victims of Abuse, Neglect, or Domestic Violence*: If I reasonably believe a you are a victim of abuse, neglect or domestic violence, I may disclose your PHI to the Washington Child Protective Services, the Washington Department of Human Services or other governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

C. *Judicial and Administrative Proceedings:* I may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

D. *Law Enforcement Officials:* I may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

E. *Decedents:* I may disclose your PHI to a coroner or medical examiner as authorized by law.

F. *Health or Safety:* I am legally required by law to use or disclose your PHI to prevent or lesson a serious and imminent threat to a person's or the public's health and safety. [164.512(j)].

G. *Specialized Government Functions:* I may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances. [164.512(k)]

H. *Workers' Compensation:* I may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs. [164.512(l)]

I. *As required by law:* I may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your capacity or an emergency circumstance, I may exercise my professional judgment to determine whether a disclosure is in your best

interest. If I disclose information to a family member, other relative, or a close personal friend, I will disclose only information that I believe is directly relevant to the person's involvement with your health care.

It is a professional best practice for counselors to engage in either peer-to-peer or professional oversight supervision activities throughout the course of their career. During my supervision meetings I may discuss cases and treatment for the purposes of improving care and/or professional development. If I make reference to my counseling with you, I will do so in a way that disguises your identity and limits disclosure of your PHI. If such a disguise is impossible or undesirable, I will ask you to sign a waiver. If you do not agree to sign, I will not make identifiable reference to you.

Financial Terms and Conditions

Individual Counseling Fees: The hourly fee for counseling sessions is $150 with a sliding scale as low as $45. Counseling sessions are 45-50 minutes long. A no show or late cancellation (within less than 24 hours of appointment) will require full fee (insurance rate plus your co-pay/coinsurance or full out of pocket fee) payment unless there is a documented medical emergency. The fee can be waived for other emergencies if the counselor deems it okay.

Requesting Records: If you require information from your records, it will be subject to a documentation fee. The clerical fee is $15. The first 30 pages will be $0.65 per page; anything above 30 pages will be $0.50 per page. However, where editing of records by a health care provider is required by statute and is done by the provider personally, the fee may be the usual and customary charge for a basic office visit.

Default: Default of the Financial Terms and Conditions of this Agreement occurs when payment is not received within thirty days of when service(s) is provided or when a fee is incurred.

Event of Default: In the event of default, we shall have the right to the following remedies, which are intended to be cumulative and in addition to any other remedies provided under applicable law or under this Contract:

1. If we incur attorney fees because of a default by Client, Client shall pay all such fees whether or not litigation is filed and all costs related to legal action including without limitation filing fees, court fees, and other service fees.
2. Venue for any such action by us shall be in Clark County, Washington.
3. If we employ a collection agency to recover delinquent charges, Client agrees to pay all collection agency and other fees, if any, charged to us in addition to other sums payable under this Contract.
4. If the collection agency incurs attorney fees because of default by Client, Client shall pay all such fees whether or not litigation is filed and all costs related to legal action including without limitation filing fees, court fees, and service fees.
5. Venue for any such action by the collection agency shall be in Clark County, Washington.

Collection Costs: In the Event of Default of the Financial Terms and Conditions of this Contract, the undersigned agrees to pay a 35% collection fee and all reasonable attorney fees:

Terms of Consent

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment by this counselor. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives. If for some reason I am not able to continue as your counselor at any time I will try to provide referral options and let you know how to obtain your records.

Consent to Treatment: By your signature below, you are indicating 1) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop treatment or services that you receive through me; 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you; and 4) that I provided you with a copy of this statement. By my signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

This Agreement is governed by the laws of the State of Washington.

Washington State Law requires that the following statements be placed in every disclosure statement:

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"*Counselors practicing counseling 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 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 would commit acts of unprofessional conduct.*"

Severability Clause: The provisions of this Agreement are separate and divisible, and if any provision hereof should be declared to be void and/or unenforceable, the remaining provisions shall be construed and shall be valid as if the void and/or unenforceable provision was not included in this Agreement.

Acknowledgment: I have read and understand the information presented in this disclosure statement, and have been offered a copy of the statement. If the client is a minor, the legal guardian (managing conservator) must sign the statement.

I require documentation of conservatorship/guardianship. If your conservatorship/guardianship is established by a divorce decree or custody document, you are require to furnish me with a photocopy of the cause page (first page calling out the case), the page specifying conservator(s), and the signature page from the decree or document before clinical services can begin.

Email and Text (SMS) Messaging Informed Consent

If you would like to be communicated with by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these terms and agree to them.

I understand that all email messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my email communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information we send via e-mail. I understand that SMS messages are even less secure than email, and the same conditions apply. I understand that for this reason my therapist has advised me not to send sensitive information via email or SMS message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.

By signing below I hereby give permission for my therapist to reply to my messages via email, including any information that my therapist deems appropriate, that would otherwise be considered confidential. I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of email via the Internet.

I understand that my therapist will limit SMS messages to brief inquiries or responses regarding scheduling. I understand that my therapist may at times email me information about resources that I can use as part of my treatment. I hereby consent to receive such information via email. I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use email but will call my therapist. If I do not receive an answer to a routine email or text message within two working days, I understand that I should call my therapist. I understand that all email and SMS communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via email or SMS by notifying my therapist in writing.

TeleHealth Informed Consent

I am aware of my options for doing sessions via telehealth or in-person.

If I choose to do sessions via telehealth:

I understand how the video conferencing technology will be used to affect such a session, and will not be the same as a direct/client/therapist visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that the telehealth system being used is a HIPPA compliant platform and have been offered this platform as the most secure option to perform the telehealth session. I understand that my therapist or I can discontinue the telehealth session if it is felt that the video conferencing connections are not adequate for the situation.

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I understand that billing will occur to my insurance company as a telehealth session using the same confidentiality practices as all other sessions. I understand that it is my responsibility to ensure that my health insurance plan covers telehealth sessions and that I will be financially responsible for payment of the session in the case that my insurance does not provide coverage for this service, or if it only covers a portion of the cost.

I have had a direct conversation with an employee of A Better Way Counseling Service, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.