**Springs of Hope Therapy**

**Robynn Frey, LMFTA**

**WA State License # MG 60505824**

**(360) 801-8038**

Discloser Statement, Informed Consent and Financial Agreement

Welcome! The following is my disclosure statement for Springs of Hope Therapy per Washington State Law. This seeks to inform you the client, about my background, treatment approaches, client rights, my confidentiality statement, as well as my office procedures and policies. If you have any questions of concerns please feel free to let me know. Thank you for your time!

 **Approach to treatment and Educational Background-**

I hold a Masters in Marriage and Family Therapy and have had training in working with children, couples, and families. I have had specialized training in working with children with Autism. I have counseled children, teens, couples and families in depression, anxiety, self-esteem, and family relationships. I believe there is a practical use for many therapeutic interventions however; Solution Focused Therapy is one of my standard approaches. The theory focuses on the future possibilities of a client while seeking to establish obtainable goals. It is my belief that we are always changing and that there is motivation that propels that change which is often times the solution. I do believe it is important to be aware of the past where change has already happened and identify those circumstances in order to seek out solutions for the future. Looking and working towards a future is often establishing a strength with in the person or family that can grow confidence in their ability to develop solutions for future changes in their life.

**Licenses**

I hold my Marriage and Family Therapy Associate License for the state of Washington which means I am currently gaining my state hours working under a state approved supervisor.

**Confidentiality-**

You have the right to confidentiality. If you are 13 years and older you have rights to your own records and they can only be requested by you in writing. Please give up to three weeks after written notice has been requested. If you are 12 years of age and younger parents may request records but it is asked that this is only done in extreme cases as there is a trust built in a therapeutic setting in what we discuss. By law information concerning your treatment may be released only with your written consent with the following exceptions:

 If there is suspected abuse or neglect of a child, dependent adult or developmentally delayed person.

 If your give strong indications that you are likely to harm yourself or someone else.

 If your records are subpoenaed by court of law.

 IF you bring a complaint against me with the state or with a local regulatory agency.

 If you are involved in a life-threatening emergency, in which case information pertinent to that emergency may be released.

 If an involuntary commitment for mental health services assessment seems necessary.

 If the insurance company that is covering your visits, requests client information, I am audited or a diagnosis is needed for payment. (I do not give any details of session content and keep my notes brief and simple for your benefit.)

**Consultation-**

To ensure I am giving you the best treatment possible, I do consult with other professionals in consult group format or one on one with an approved clinical supervisor who is ethically bound to the same confidentiality as I am. Please know that your identity remains protected during this consultation. Teresa Jones MSW is the current acting supervisor.

**Ethical and Professional Standards-**

You have the right to receive appropriate care and to be fully informed about your therapy.

You have the right to participate in the development of your treatment plan and to refuse any proposed treatment.

You have the right to receive care that does not discriminate against you and that is respectful of your gender, race, religion, national origin, language, age, disability status and sexual orientation.

You have the right to contact the state of Washington Department of Licensing to lodge a grievance if any of these rights are violated, or if you feel that you have been treated in an unprofessional or unethical manner.

*If you have and concerns or complaints about your therapy please let me know as I will be happy to discuss them with you*.

**Session, Fee and Payment-**

My standard fee is 65.00 for individuals, 80.00 per couple and 90.00 per family. As per most insurance I am not allowed to Bill insurances for services rendered as a MFTA. You may however check to see if you can receive compensation after our visits from them by sending them receipt of payment as I am not a in network provider. I do not handle this portion of payment. Because of this I am willing to discuss a sliding scale fee based on financial need. This will need to be discussed at the initial visits. If such sliding fee scale arrangements have been made this contract will reflect that amount as such\_\_\_\_\_\_\_\_\_\_\_. **Payment is due at time of service.** I accept cash, personal check, and Major Credit Cards. I reserve the right to stop services if payment has not been made for two consecutive therapy sessions. I will discuss this with you in advance. *Please discuss any financial situations that may impact services as soon as you can so that if needed I can refer you or adjust payment.*

**Texting:** Scheduling Only

**Emailing:** Scheduling Only

**Phone Call:** Free for information about scheduling or information related to resourcing. All other communication I charge session fees.

For example if I am answering questions for 25 mins. I will charge 25.00. No counseling will be done over the phone unless we have previously arranged this. Examples: Out of town or Non-Life Threatening Emergency.

 **Report Writing:** Fee 45.00 per report requested

**Court Appearance:** In the event I am called to court there is a 125.00 fee per hour.

**Appointments and Cancellations-**

For counseling services to be effective it is important to have a level of consistency. Exceptions will be made for major holidays, serious illness and anything we discuss that may affect such constancy. If there is a need to cancel our weekly appointments or previously scheduled appointments please let me know and I will reschedule to the best of my abilities. I have a 24 hour cancelation policy. If you are unable to attend the session please let me know as soon as possible. I require full payment if less than 24 hour notification has been made unless there has been an emergency.

**Crisis-**

If you ever feel that you are in a crisis and cannot reach me due to the time or nature of the crisis you can call the 24 hour crisis hotline at: (206)461-3222. If your crisis is life-threatening, call 911, and admit yourself to the emergency room of the nearest hospital.

**Professional Standards-**

At all times I try to adhere to the highest possible professional standards of competence and ethics. If you have any questions with the treatment you are receiving again I encourage you to please contact me however if you are not satisfied you may contact the WA Department of Health at (306) 664-9098.

Therapy is your choice. You have the right to stop treatment or to be referred to another therapist who may better suit your needs. If this does come up please know that I am open to discussion and to find you the best help possible as that is your right as a client and mine as a therapist.

**Consent for Services, Financial Agreement and Privacy Practices-**

I, the undersigned, have read this 5 page document, and/or have had it explained to me to my satisfaction. By signing this, I agree to receive therapy services from Robynn Frey MA., LMFTA according to the terms described. I understand my rights as a client, and I agree to pay the per session fee of $\_\_\_\_\_\_\_. I understand that I may terminate this relationship at any time and/or request referral to another.

I understand that any reimbursement from insurance is my responsibility and I may be solely responsible for payment if I cancel without 24hour notice.

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Client or Guardian/ Representative Date

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Robynn Frey MA., MFTA Date