

# Seattle Compassionate Counseling

Katherine Ferrell, MA, LMHC

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Washington State License Number: LH60805407

Welcome! This form sets the groundwork for therapy and reviews my approach to counseling and policies. I encourage you to review it carefully and to ask questions at any time. We will also review it together during our first session. I look forward to beginning our work together. *Please wait to sign until after we discuss in session.*

## **Disclosure Statement and Informed Consent**

### **Approach**

I work from a wellness perspective, which is about more than freedom from illness. Wellness is an active process of being aware of, and making choices toward, a fulfilling and healthy life. It is a process of growth and change. Wellness involves working with your physical, mental, emotional, social and professional health, as well as developing the sense of meaning and purpose in your life. The foundation of therapy is a relationship and I care passionately about creating a healing space of mindfulness and compassion where you'll feel accepted and acknowledged. Through the relationship, we'll explore who you are, what you want and what holds you back.

Therapy looks different for each person. My therapeutic orientation is eclectic, meaning I draw from various approaches and techniques to promote health and wellness. Approaches I draw from include humanistic, cognitive behavioral and mindfulness. The humanistic approach emphasizes the uniqueness of each person. Cognitive-behavioral approaches explore how thoughts affect emotions, actions and beliefs. Mindfulness is a way of paying attention to our present experience, including feelings, thoughts and sensations, without judgment and with kindness. As a strengths-based therapist, I encourage you to build on your strengths and resources rather than focus on your problems and limitations.

### **Education, Training and Licensure**

I obtained a Master of Arts in Mental Health Counseling and Behavioral Medicine from Boston University School of Medicine in Massachusetts. Through schooling, internships and work experience, I have partnered with clients through a range of ages and challenges. My background includes training in treating substance use through the VA in Boston. I am a Licensed Mental Health Counselor in Washington State, license number LH 60805407. My background also includes mindfulness and meditation. My Bachelor of Arts in Psychotherapy, Mindfulness and Creative Expression is from the University of Redlands in California. I completed an internship at the University of California, San

Diego Center for Mindfulness focused on leading mindfulness workshops and additional training to lead Mindfulness-Based Relapse Prevention groups. I have had a meditation practice for over ten years. For more information on my training and experience, please refer to my website [www.seattlecompassionate.com](http://www.seattlecompassionate.com)

### **Services and Scope of Practice**

Psychotherapy is a professional relationship with clearly defined roles, rights and responsibilities. Clear roles and boundaries create a safe space.

I offer psychotherapy for adults. In the first few sessions we will begin to build a relationship, set goals and review paperwork. We are partners in treatment and you have the right to agree or disagree with my recommendations. I offer weekly 53-minute sessions. The length of treatment is usually determined by you and by conversations between us.

I meet with clients by appointment. To respect my time, and the time of other clients, I do not offer case management (services outside session times). As it is outside my scope of practice, I do not provide forensic legal services, perform custody evaluations, give opinions as to custody, provide assessments of disability or provide letters or evaluations regarding emotional support animals or service animals.

For your privacy, I will not acknowledge a client, or the existence of a relationship with a client, outside of session. I do not accept social media requests or engage in any social media platforms and will not respond to messages from current or former clients. I will not engage in physical contact, except handshakes, and do not accept gifts, including food.

In order to provide the best treatment, I consult with other professionals, including my supervisor, regarding clients. I may also seek legal consultation if I believe doing so could be helpful. If I believe I am not the right fit to help you move forward, I will consult and/or offer a referral.

You are welcome to contact me at 206-686-9390 and, with the exception of weekends, I will do my best to respond within 24 hours.

### **Benefits and Risks of Therapy**

I am here to support you and help you to move towards health and wellness. Working toward change requires effort, openness and honesty. Therapy often requires remembering or talking about uncomfortable events, feelings and aspects of your life. Assumptions and perceptions may be challenged, and you may be introduced to different ways of thinking about and handling situations. You may feel more frustrated or lonely before you feel better. Change may be easy and fast, but it is often slow and challenging at times. There are no guarantees to results of therapy.

### **Emergencies**

I provide non-emergency therapy by appointment. Unfortunately, I am not available to respond to immediate or severe psychiatric crisis. ***If you are experiencing a crisis, an emergency or a threat to yourself or others, please call 911 or go to the nearest emergency room. The Crisis Clinic 1-866-427-4747 (King County) or 1-800-584-3578 (Snohomish County) is also available for urgent mental health support. National crisis hotlines are available at 1-800-SUICIDE and 1-800-273-TALK.***

As part of clinical practice, I will ask for an emergency contact and ask you to sign a Release of Information. I will contact this person if there is a physical or mental health emergency that occurs on property or if I am concerned for your physical and/or emotional safety. If I am unable to reach you via phone or email, and am concerned for your safety, I may call your emergency contact, identify myself as your counselor, express my concern and ask that they check on your wellbeing. I will only disclose the minimum amount of information needed.

If you engage in violence towards, threaten, or harass me or anyone on property, or ask me to engage in any illegal conduct, I will immediately end our relationship and treatment. No referrals will be provided. Your signature below serves as notice of termination for such a circumstance.

### **Confidentiality**

What you share with me is confidential and protected by privilege. I am required by law to maintain the privacy and security of your “Protected Health Information” or “PHI.” You may authorize disclosure via written “Release of Information” (ROI). I comply with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to PHI. You received a Notice of Privacy Practices explaining HIPAA in addition to this disclosure. In all cases, only the minimum necessary PHI will be communicated.

I may use your PHI:

- To provide treatment. I may disclose PHI to your current providers, to your prior providers or to other persons for the purpose of your care.
- For Healthcare operations such as administrative, legal or financial services to help me treat you. I may authorize individuals or companies to perform professional services on my behalf which may involve their collection, use or disclosure of your PHI.
- To coordinate with medical insurance for purposes of payment.

There are exceptions and limits to confidentiality where PHI may be released without your consent. These exceptions are determined by law and are consistent with ethical conduct. These include:

- I may disclose PHI when needed to prevent or lessen a serious and immediate threat to the health or safety of you, any other individual or the public. Examples include medical emergencies, suicidal thoughts and domestic violence. If you pose a threat to yourself or someone else, and the threat is perceived to be serious, the law requires me to contact the proper individuals to help. This may include the individual against whom a threat is made and/or the police. I am required by law to protect public health and safety.
- I must contact the proper authorities if I have reasonable cause to believe a child, dependent adult or elder have suffered abuse or neglect.
- I will release PHI as requested or required by the State to resolve the issue if you register a complaint against me or an individual or company performing services on my behalf.
- I may disclose PHI if your records are subpoenaed or a court order is issued in accordance with RCW 70.02.060, and you have not obtained a protection order.

### **Client Rights**

You have the right and/or responsibility:

- To choose the mental health provider and treatment modality which best suits your needs. I may or may not be the right fit.
- To ask me questions about my qualifications and about anything that happens in therapy.
- To refuse treatment and/or a particular treatment method if you so choose.
- To request a referral to another therapist if treatment does not meet your needs. You have the right to terminate therapy without my permission or agreement. If you do decide to stop treatment, I hope you will discuss with it with me.
- To request communications by specific means and mailing addresses.
- To file a complaint about unprofessional conduct

Counseling is strengthened by honest communication and I hope you will speak to me if you have concerns or questions about the law or my conduct. Washington State has rules and regulations regarding professional conduct and there is a formal complaint process should you feel it necessary. I can provide you, upon request, the copy of the law explaining the behaviors that are considered unprofessional. You may also obtain a list of acts of unprofessional conduct by contacting DOH, Health Professions Quality Assurance, Counselor Section, PO Box 47869, Olympia, WA 98504 and by phone 360-236-4700. Complaints regarding unprofessional conduct may be addressed to the Washington State Department of Health, Health Professions Quality Complaint Intake, P.O. Box 47857, Olympia, WA, 98504, or by phone at 360-236-4700. I will not retaliate against you for filing a complaint. You may also register a complaint via email at <https://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility>

### **Treatment and Medical Record**

As part of responsible clinical practice, I keep written records of each session and communication between us in a HIPAA-secure electronic medical record (EMR). Your records will be maintained for at least six years after finishing therapy. I do not audio or video record clients and ask that you do not audio or video record sessions.

You have the right to read and receive a copy of your PHI, to request I make correction/s if you believe that it is incorrect or incomplete and to receive a copy of the required list of non-routine disclosures made of your PHI. You may see your record by submitting a written request to me. In certain circumstances, I can deny the request. Further, I may say “no” to your request to make changes to your record, but I will tell you why in writing within 60 days of your request. You have the right to write a statement of disagreement if a requested amendment is denied. When more than one client is involved (such as couples or family therapy), I require signed releases from all who are capable of providing consent (age 13+) before releasing any records. You have the right to request restrictions on uses of your PHI. You may request in writing that no treatment records be kept. I shall not agree to the request, as keeping treatment records are part of clinical practice.

### **Fees and Financial Responsibility**

You are responsible for coming to your sessions on time, paying in full at time of session and for knowing your insurance benefits. There are no refunds for sessions. You are not liable for any fees or charges for services rendered prior to the receipt of this disclosure at intake.

My private pay rate for each individual 53-minute psychotherapy session is \$140.00. I reserve the right to increase my fee over time and you will be given a month's notice prior to the increase. If you are unable to pay at the time of service, I will not see you for the session. If you are unable to pay for two or more at time of service, I may choose to end treatment and provide a referral. This is for your financial protection and mine. I am out-of-network with insurance companies. If you have out-of-network benefits, you can request a billing statement to submit to your insurance for potential reimbursement.

My time is best served providing services to you in session. I reserve the right to bill my private pay hourly fee for services completed at your request outside sessions. I will discuss any fees with you at the time of a request. Services include, but are not limited to, telephone conversations exceeding 5 minutes and preparation of records. Insurance does not re-reimburse for this time. Involvement in legal matters is outside my scope of practice. If you become involved in legal proceedings that require my participation, you will be billed \$300 per hour for each hour (pro-rated if less than a full hour) that I am engaged in activities related to the legal proceeding, even if I am called to testify by another party, and even if my services are ultimately not required, such as if a case is settled at the last minute. This includes time spent traveling, waiting, preparing for the proceeding or activities related to the proceeding. Your signature below acknowledges that you will pay these fees, whether or not you are the party requesting or requiring my services.

### **Cancellations, No-Shows and Late Policy**

Life happens. I understand that things come up and you may need to cancel or reschedule a session. Please give me as much notice as you can so I can offer the time to another client. As your session time is reserved specifically for you, a minimum of 48 hours' notice is required to reschedule or cancel without a fee. A \$100 fee is billed for cancellations with less than 48 hours' notice and for no-shows, at my discretion. Insurance cannot be billed for missed sessions.

If you cancel or reschedule more than two sessions in a month, you will be removed from your recurring session time and will have access to my on-call list. If there is a pattern of canceled appointments, I will attempt to problem solve with you. If cancellations continue, I may choose to refer you to another counselor. It will be considered withdrawing from treatment if 30 days pass without a session. Your signature below serves as notice of termination of treatment for such circumstances.

Time is important. If you are more than 10 minutes late, you may be asked to cancel and are welcome to reschedule your session for any opening I may have in the same week. I cannot guarantee an opening but if you are able, I will waive the \$100 fee. If you are unable to reschedule, the \$100 fee will be applied. If you no-show, and I do not hear from you, all future appointments in your reserved time will be canceled.

If I need to cancel a session, I will attempt to reach you as early as possible. I will do my best to provide you with ample notice for any planned vacations or absences and will provide the contact information if another counselor is covering my practice, should you need support.

### **Electronic Communication and Media**

Technology, including but not limited to email and cell phones, can compromise privacy and confidentiality. Servers have unlimited access to all emails that go through them. If you choose to communicate with me through email, phone or other electronic means, you agree to not hold me

responsible for any breach of confidentiality that may occur by someone else accessing the information sent to or from me.

**Changes to Disclosure and Treatment Agreement**

I am permitted to change the terms of this treatment agreement at any time, will discuss changes with you and will provide you a copy upon your request.

**ACKNOWLEDGMENT & CONSENT FOR COUNSELING TREATMENT**

**Provided by Katherine Ferrell, MA, LMHC License Number: LH 60805407**

I have read, understood and been given a copy of the Disclosure Statement of Katherine Ferrell, LMHC. I have read, understood and been given a copy of the Notice of Privacy Practices. I have had an opportunity to ask questions. I agree to abide by the terms of the agreements listed above in this disclosure statement during my professional relationship with Katherine Ferrell, LMHC.

I consent to take part in psychotherapy with Katherine Ferrell, LMHC and agree to play an active role in the process of therapy. I understand that no promises have been made as to the results of treatment or of any procedures provided. I participate voluntarily and understand that I am responsible for my experience. I understand that I have the right and responsibility to choose the treatment provider and modality of treatment that best suit my needs; and that if Katherine Ferrell does not provide the services that best suit my needs, I will inform her directly. By signing below I acknowledge that I received this form prior to beginning treatment and I acknowledge receipt of this disclosure form.

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client Printed Name:** \_\_\_\_\_

**Signature of Katherine Ferrell, LMHC:** \_\_\_\_\_ **Date:** \_\_\_\_\_