Sally McIntosh Stoehr, MA, LMFT
Licensed Marriage & Family Therapist
"Helping Children, Families & Individuals to more positive fulfilling lives."

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Agreement Regarding Fees and Services

This agreement outlines what you can expect from me as your therapist, and what I will expect of you as we work together.

Professional Qualifications

I am a Licensed Marriage and Family Therapist, as well as a Child Mental Health Specialist in the State of Washington. I have a Master's degree in Psychology from Antioch University, Seattle. My undergraduate degree is in Liberal Arts with an emphasis in Psychology from The Evergreen State College. I have specialized training in trauma work, child development, parenting and positive behavior management. I have worked with infants, toddlers, preschool children, school-aged children, adolescents, their parents and adults in community mental health settings, schools, and currently in private practice.

My Theoretical Framework

My theoretical orientation is based on developmental psychology, how family systems work and helping individuals build positive, healthy relationships. I incorporate cognitive, behavioral, psychoanalytical, developmental, gestalt and relationship-based principles. I also employ Eye Movement Desensitization and Reprocessing (EMDR) therapy. I believe it is essential for me to have a working knowledge and full understanding of your family, social, cultural, educational, and emotional experiences in order to effectively treat you in therapy.

Course of Treatment

The first few sessions are evaluative and may include contact with referral sources, physicians, other therapists or family members (your permission is required). Once my initial evaluation is complete, I will meet with you to discuss treatment goals, methods, and anticipated length of treatment.

If after meeting with you it is determined that we will proceed with any specialized therapy, such as EMDR, I will give you additional information to read on these specialty areas.

Ending counseling can be a difficult process. Often we have had many poor endings in our lives and our society does not have many good rituals for saying goodbye. Because of this, I require at least two sessions to say goodbye. At the first session, you announce that you are ready to end counseling at this time. We discuss the reasons for this and any recommendations I may have about it. We also plan some kind of a goodbye ritual/celebration. At the second session we have the ritual/celebration, review gains made and skills learned in counseling and say goodbye.

Appointments. Appointments are scheduled for 45-50 minutes. Please enter the waiting room and wait for me to join you. If you arrive late for an appointment, the lost time will be part of your scheduled time. In the event you cannot keep an appointment for any reason, **please give at least 24 hour notice of cancellations, otherwise you will be charged the full fee for the time I have reserved for you**. For your convenience, you can leave me a voice mail message any time of the day or night if you are unable to keep a scheduled appointment. If you are ill or contagious or have a temperature, please do not come to the office.

Fees. The fee for therapy sessions is $100 per session. Telephone consultation with you or with professionals such as physicians or other therapists is billed at the usual office rate of $35 per 15 minutes. Out of office work will be billed at $130 per hour, including travel time. These services will be billed to you at the next session and payment will be required at that time. Routine calls fewer than 10 minutes and time spent scheduling appointments and billing will not be billed to you.

Payment may be made in cash, money order, or check. Checks should be written to Sally McIntosh Stoehr. ***Payment in full is due at the time of the session***. Bills not paid in full within 90 days from the date of service may be sent to a collection agency unless you have made other arrangements with me.

Insurance. Many insurance plans cover outpatient mental health services**. It is your responsibility to check with your insurance carrier for specific information regarding your coverage.** Please be aware that authorization for treatment by your insurance carrier does not insure payment to a provider. If your insurance carrier refuses payment for any reason, **you are responsible for your bill.**

If you plan to seek reimbursement from your insurance company, please be advised that most insurance companies require a statement of the type of services rendered and a diagnosis. In addition, some carriers require more detailed information such as progress reports or treatment summaries. Please sign an informed consent for release of information if you plan to seek reimbursement from your insurance carrier.

Communication. I have a confidential 24-hour, time-stamped voice mail service so that you may leave necessary messages for me. I make every attempt to check my messages regularly during the week but often will not return routine calls until my office hours. However, I typically do not check voice mail messages on weekends unless I have made specific arrangements to do so. In the event of an emergency and I cannot be reached, please call the Crisis Clinic (360-479-3033 or 1-800-843-4793), your primary care physician, or dial 911. If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Ethics and Professional Standards. If you have any questions about any aspect of our professional relationship or about the specifics of those ethics and standards, please review them with me. Please see your rights below. If you find no adequate resolution with me, you may contact the Washington State Department of Health. My Washington State License number is LF00001895. *"Counselors practicing counseling for a fee must be registered or licensed with the department of health for the protections 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 is to provide protection for public health and safety, and to empower citizens of Washington by providing a complaint process against those counselors who would commit acts

of unprofessional conduct. A copy of acts of unprofessional conduct listed in RCW 18.130.180 is on file in the office for your review.

Client Complaint/Grievance Rights.

1. You have the right to file a complaint at any time.
2. You have the right to assistance from the ombudsperson for filing, pursing and resolving your grievance. The Washington State Obudsperson for mental health complaints can be reached a 1-888-377-8174.
3. You have the right to be free of any form of retaliation as a result of filing a complaint.
4. You have the right to continue receiving services (at the customary fee) during the complaint process.
5. You have the right to have records of your complaint retained in confidential files separate from your case record.
6. A complaint form is attached, or you can go to the Department of Licensing website at: https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm

Confidentiality. All information discussed in the course of therapy is strictly confidential. By law, information regarding treatment or evaluation may only be released with the written consent of the person treated or the person's parent or guardian (forms are available for this purpose). Please see Notice of Privacy Practices below for more information on exceptions to confidentiality.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

As of April 14, 2003, the Health Information Portability and Accountability Act of 1996 (HIPPA) requires that I provide you with information about how I use and protect the information you provide to me in the course of treatment. This Notice is a statement of my privacy policies and your rights under HIPPA.

Information that is included in your file:
Your file of "protected health information" includes all of the data I collect from you (address, telephone number, insurance information, history, medications, payment records, and so forth) and the progress notes I create after each session. The file also contains notes of any contacts with other "collateral" contacts (schools, doctors, other professionals etc.).

How your information is stored:
All of your protected health information is stored in a locked file cabinet in my office, in a folder identified by your name. Only I have access to the keys to that file cabinet. Typewritten notes may temporarily also be stored in my personal computer. They are password protected and only I have the password. They are erased when the permanent copy is printed and placed in your file. If you choose to correspond with me by email, that information is temporarily stored with the internet service provider.

How your information will be used:
It is my policy to hold your information in strict confidentiality, and to use it only for purposes of your treatment. This means that I will not disclose any personal information, including the fact you are receiving treatment to anyone without your written permission (and the written

permission of legal guardians of children under the age of 13). There are certain legally required exceptions to this policy:

1. I am required by Washington law to report incidents of abuse or neglect of a child, elder or vulnerable adult of which I become aware to the appropriate authorities. It is my policy to discuss the necessity of such a disclosure with my client if at all possible before reporting.

2. If you are suicidal or in danger of hurting yourself, I am ethically obligated to notify the appropriate authorities in order to protect your safety.

3. If you threaten to harm another person, I have a duty to break confidentiality, warn that person, and warn the appropriate authorities.

4. In certain legal proceedings I may be required to reveal information in response to a court or administrative agency order, and in certain cases in response to a subpoena, discovery request or other lawful process.

5. Please be aware that both custodial and non custodial parents may have access to the treatment records of their minor children (children under 18).

6. I have the right to disclose necessary protected information in any legal proceedings involving my license.

7. I have the right to disclose necessary protected information in the course of an investigation by the Secretary of the Department of Health and Human Services regarding compliance with HIPPA.

8. I may be required to disclose certain protected client information for public health purposes, or in regard to communicable diseases.

In addition, I participate in consultation with other professionals. Any individual case information revealed in consultation is disguised to prevent identification of the client involved, and of course your name will never be used.

Electronic Billings by Insurance Providers

I submit billings to your insurer(s) either by USPS (mail), FAX or electronic billing through Office Ally, a HIPPA compliant service. Your authorization for me to bill your insurer(s) constitutes consent to this arrangement.

Clinician's Duties:

I have the duty to protect the privacy of your client information as discussed above, and to provide you with this written description of my privacy practices and policies.

I must abide by my written privacy policies then in effect.

I may change my privacy practices or policies, but I must also revise the Notice and inform you of any change. Revised policies are effective for all protected client information, whether or not you are still in treatment with me. You may request a copy of my revised policies at any time, by providing your name and address.

Your rights under HIPPA:
You have the right to request that I restrict the use and disclosure of your protected health information for treatment, payment and health care operations. I am not required to agree to your restrictions, but I am bound by any agreements Id o make with you in this regard. (Under Washington law, you have a right to request that I not keep notes of our session, other than a record that the session occurred. Please discuss this with me if you are interested in exercising this option).

You have the right to request that I contact you by alternative methods and locations, instead of the standard practice of telephoning you at your home or office.

You have the right to inspect and obtain a copy of your official record. Copying and administrative costs will be charged for this service as per Washington State law.

You have the right to amend information in your client record which you believe is erroneous.

You have a right to an accounting of disclosures of your private health information.

You have a right to receive a copy of this notice upon request.

You have a right to file a complaint with me, the Secretary of Health and Human Services, or both in regard to my HIPPA practices. I will not retaliate against you should you file such a complaint.

Location:

My practice is located within the offices of Collaborative Family Therapy, an association of independent practitioners and not a partnership. There is no implied or expressed professional or business relationship between practitioners within the clinic.

CONSENT FOR TREATMENT

I hereby acknowledge I have read and understood this contract for services and notice of privacy practices and have received a copy for myself if I so desire. If you choose to contact me by email, your signature below also authorizes me to correspond with you by this medium.

I hereby authorize Sally McIntosh Stoehr, LMFT, to render mental health services to:

____(Patient's name).

This authorization constitutes informed consent without exception.

Signed:
____

Print
name:____

Date: ___________________________