



Linda Hanby, MA  
Mental Health Counselor  
Washington State License No. LF60256554  
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Kent, Washington 98032  
253-398-2023

## **DISCLOSURE OF INFORMATION, POLICIES AND CLIENT AGREEMENT**

**PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGMENT OF ITS RECEIPT ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.**

### **Your Rights As A Client In Counseling**

As a client in counseling, you have certain rights that are important for you to know about. There are also certain limitations to those rights I want you to know about.

As a client of a counselor registered or licensed by the State of Washington, you have the right to expect our communication to be kept confidential under state law. With the exception of the situations listed below, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The confidence is yours, not mine, and cannot be waived without your consent. I will always act to maximize your privacy even when you waive your right to confidentiality.

**CONFIDENTIALITY:** All issues discussed in the course of therapy will remain in the strictest of confidence except those for which you may choose to sign a release of confidentiality information (i.e. your medical doctor, other treatment providers or family members). Also, your insurance company or its agent may have the right to audit your records for the purpose that may include, but not limited to accuracy of claims, coverage of services, medical necessity, proper utilization and appropriateness of services and billing. In the course of clinical consultation, your case information may be discussed with other professionals. However, this is done without revealing any information that would identify you. Exceptions to confidentiality are provided by law. When Federal and State laws differ, the more stringent law supersedes the other.

### **HOW I MAY USE OR DISCLOSE YOUR PROTECTED INFORMATION**

- **Public Health/Law Enforcement: the following situations are exceptions to your rights of confidentiality.**

- If I believe that you are likely to do harm to yourself or another person, I am required by law to take steps to protect you and/or the other person.
- If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective Services or Adult Protective Services.
- If you submit claims to your insurance company, they will likely require some information regarding your treatment with me. Most insurance companies require information including your psychiatric diagnosis.
- If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner) I will not release any information to a third party (courts, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement.

In some cases, it is useful for me to discuss your situation with others such as your physician or your former therapist. I will always discuss this with you and obtain your written permission before seeking any exchange of information.

I regularly consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed at informal consultation sessions. During these consultations, neither your name nor other unique identifying information will be revealed. All discussions of this type with other professionals is still subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contacted me and thank them for the referral. I will not discuss your situation with them unless I have your written permission.

You have the right to request a change in treatment or to refuse treatment. It is important that what we do together in treatment meets your needs. Your participation in therapy is fully voluntary. If you believe that you are not being helped, please tell me so that we can work through the difficulty together. If we can not do so, I will help you in finding a new therapist.

My office number is **253-398-2023**. Please leave a message if there isn't an answer and I will get back to you as soon as possible. In you are unable to reach me and are in crisis call **Seattle Crisis Clinic at 206-461-3222** or **911** for immediate help.

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to you that the counseling relationship be closed in a straightforward manner, ensuring that all counseling issues have been dealt with to the best of your and my ability. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an

appointment or miss an appointment without leaving notice of reschedule with my secretary, notice of termination will be assumed and your time slot will be given away to the next available client.

### **APPOINTMENTS AND FEES**

Appointments are usually scheduled once per week or once every other week. **The session lasts 45-50 minutes**, unless we arrange, in advance, for a longer time. Longer sessions will incur an extra charge based upon the amount of time we take. **The scheduled time is set aside for you. If you miss a session without cancelling or if you cancel with less than 24 hours notice, I will bill you in full for that time.** Insurance or third party pay will not compensate you under these circumstances. If you are late for a session, you will be seen for the remainder of your time and billed for the full hour.

My standard fee is \$125.per session. I also offer sliding scale for families or individuals that do not have insurance coverage. Sliding scale is based on family income. This fee is standard regardless of the number of people attending the session. Payment must be made at the beginning of the session unless we specifically agreed on another method of payment. I accept **cash, checks, Debit cards** and some insurance at this time. **There will be a \$30.00 fee will be charged for any returned checks.** A financial charge of 1 percent per month or \$2.00 minimum, whichever is greater, will be assessed on any balance that is outstanding for 30 days or more, unless you have made other arrangements in advance about your incurring a debt to me. If you are unable to pay for a session, you will be required to pay for the unpaid visit and the current visit **BEFORE** a sessions resume. You will be required to pay for services rendered **BEFORE** we resume sessions. If you miss 2 sessions, you will be removed from the schedule and the payment will be pursued by legal means. If you discontinue services without payment I will send a letter stating that you are about to go to collections. You are required to make payment for the sessions attended that insurance doesn't cover. \_\_\_\_\_ **(Initial here)**

If I am doing work related to your treatment that is outside of the bounds of our scheduled counseling, I will bill you at my hourly basis for all the time I spend on your case. This will include travel time to another location (such as the hospital, your home, an attorney's office or another setting), meeting with professionals regarding your case, writing reports, preparation time, etc. My fee for this type of work is \$75.00 per hour.

### **TRAINING AND APPROACH TO THERAPY**

Washington State Law requires all licensed mental health counselors to disclose their training, education, experience, and approach to therapy to prospective clients. Please feel free to discuss this information with me if you have any questions. Being a life long learner, I continue to educate myself in newer methods of therapy through workshops and educational offerings.

My counseling background includes working with client of all ages; children, adolescents and adults. My therapeutic orientation stems from Systems Therapy. Systemic theory is based in part on the assumption that how people think, feel and behave is largely dependent on their role or position in their family system. This role is usually rooted in the client's family of origin. Part of therapy is an exploration of your role(s) and discovering how patterns reappear in the current situations such as family or social environment of your life. I attempt to bring to light some habitual patterns of interaction that are sources of difficulty for you and/or your family. I also will assist your learning and developing new ways of behaving that might be more useful for you. My role of

therapist can be likened to one of a “coach”; I challenge old ineffective behaviors and beliefs. Together we create a safe environment where risks can be taken and new possibilities can emerge.

We take this journey together. You are responsible for setting your goals and working toward change outside of the therapy hour as well as during it. My role is to educate and support you during this period of change. In supporting your perception of reality, present and past, I will not attempt to determine in a legal sense whether the events you describe happened exactly as you remember them. I see you as the one who sets the course for your own life and as the one responsible for the decisions and life changes that you make. I may, at various times, make suggestions and give advice, but of course, you are in control of what choices you make and how you implement them.

Since people are complex, I cannot guarantee that specific changes will take place as a result of our work together. Usually my clients gain a greater understanding of themselves and frequently improve their interpersonal skills. If you find yourself dissatisfied with any aspect of therapy, it is important that you share your concerns with me as soon as you are aware of them.

My theoretical approach to counseling is person centered. There are as many different approaches as there are people. My approach is based on the individual’s need.

**EDUCATION:**

Central Washington University, Bachelor of Science in Community Health, area of emphasis in Chemical Dependence.

Antioch University Seattle, Master’s in Child, Couple and Family Therapy.

Dispute Resolution of King County Mediation Certification, Parenting Plans.

**LICENSES:**

State of WA Marriage & Family Therapist License LF60256554

State of Washington Business License #601-698-528

**EXPERIENCE:**

Child, Couple and Family Therapy in School based Services. 2007-2008.

Prevention Intervention Counselor School based Services 2000-2007.

Chemical Dependence Professional with agency work 1998-2000.

Facilitator for *Strengthening Family* parenting groups 2003-2007.

Facilitator for Alcohol and Drug Information School 2000-2007.

I am an Associate member of the American Association of Marriage and Family Therapist, (AAMFT). I must also answer to the ethical and professional standards of the Washington State Omnibus Credentialing Act for Counselors and the Uniform Disciplinary Act for the Regulation of Health Professionals.

**Quality of Service**

If you think I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you think that this does not resolve the issue, you may contact one or both of the following:

State of Washington  
Dept. of Health  
Attn: Quality Assurance  
P.O. Box 47857  
Olympia, WA 98504  
(360) 236-4700  
www.doh.wa.gov

American Association of Marriage and Family Therapists  
Attn: Committee on Ethical & Professional Practice  
112 South Alfred Street  
Alexandria, VA 22314-3061  
(703) 838-9808  
[www.aamft.org](http://www.aamft.org)

**YOUR AGREEMENT**

I have read and understand all this information explained to me in Linda Hanby's Disclosure of Information, Policies and Client Agreement and understand it, including my rights as a patient. I agree to all the above policies and procedures. I hereby authorize Linda Hanby, MA, to render mental health services to me under the terms described by Linda Hanby in the above statements. I understand that I have the right to terminate counseling at any time I desire. I also understand that Linda Hanby request notice of terminations at the beginning of a regularly scheduled session so that the reasons for termination may be discussed in terms of my therapeutic issues. My signature below indicates that I have received a copy of this agreement.

Client \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

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Linda Hanby, MA, LMFT