

PSYCHOTHERAPY INFORMED CONSENT & DISCLOSURE DOCUMENT

Therapy is a partnership toward a common goal that relies heavily on honesty and trust. This document is designed to establish those qualities by disclosing your rights and responsibilities to the therapeutic relationship, and by informing you as to what you can expect from me, as well.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Any email I receive from you, and any responses that I send to you, will be archived.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If, in my professional opinion, I believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If, in my professional opinion, I believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If, in my professional opinion, I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step.

I have a consulting relationship with A Canelli, LMHC, and it is common practice for me to consult with him on my caseload. Similarly, in keeping with generally accepted standards of practice, I frequently consult with other mental health professionals in the management of cases. The only purpose of consultation is to ensure quality of care. Every effort is made to protect your identity at all times in these settings.

II. Record keeping

I prefer to take some notes during and after our sessions, and retain them in your records, for both your protection and mine. In the state of Washington, you have the right to request

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that I not keep any detailed records. If you would like to exercise this option, please let me know, and I will present you with a written request to sign. You have the right to see your records, but you will need to give me 24-hour advance notice to supply them. Your records will be kept for 5-years after your last visit, at which point they will be shredded. All reasonable precautions are taken to secure your records, and they are strictly confidential, with the following exceptions:

1. Records are released with your written authorization, or that of your personal representative, should you become disabled or die.
2. Records are released if you waive privilege by bringing charges against me.
3. Records are released in response to a subpoena from the state secretary, in response to a regulatory investigation, and as required in cases of abuse, neglect, or harm to self or others.

Your Rights as a Therapy Client

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful, so we might discuss my level of experience with the technique you have in mind. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. Limits of my practice include I cannot diagnose organic or medical conditions of any nature, or prescribe medications for same.

You are free to leave therapy at any time, for any reason. Usually, it will be up to you to decide when to discontinue therapy. If, in my professional opinion, I am no longer serving your best interests, for any reason including an exceeding of my competence, I will refer you to another qualified professional. If you do violence to, verbally or physically threaten, or harass my family, or me I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

You have the right to refuse treatment, and the right to choose a practitioner and treatment modality that best suits your needs.

Your Responsibilities as a Therapy Client

I. ATTENDANCE: You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp, which will keep track of time of cancellation. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires). **A NOTE TO COUPLES/GROUPS:** As a therapist for the relationship, it is inappropriate for me to meet with any less than the whole relationship, unless arrangements have been made to do so in advance and with the full consent of all parties. This means that if one of you cannot keep our appointment as planned, I will not meet with the remaining party(ies). Sessions cancelled with less than 24 hours notice will be required to pay for the missed session.

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II. ALTERED STATES: Therapy with me involves working together to help you access, observe, and process deeply emotional content as a resource for insight. You are responsible for coming to sessions “unaltered.” I have no judgment about your recreational activities outside of our time together, but the presence or residue of any drugs, alcohol, or the like in your system challenges our ability to reach those deep emotions in a way useful to our purpose. You will also not be permitted to use any substances by any means of delivery while in session. “Substances” include, but are not limited to alcohol, nicotine, marijuana, caffeine, benzos, narcotics, and psychedelics/hallucinogens. **UNLESS substances are PRESCRIBED BY A MEDICAL PROFESSIONAL**, and taken as prescribed, you will be asked to reschedule your session should your altered state become apparent. You will be charged full fee for the session.

III. RATES: My fee for a session is \$120 for individuals, \$140 for couples, and \$170 for multi-partner groups/families. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time.

IV. PAYMENT: You are responsible for paying for your session at the time of service unless we have made other firm arrangements in advance. I do not accept insurance, but will accept cash, personal checks, and credit/debit cards for a small processing fee. You will be surcharged \$25.00 each for the first two checks returned for insufficient funds; thereafter, I will not accept your check. I am not willing to have clients run a bill with me. I cannot accept barter for therapy, nor can I take DSHS medical coupons. Any overdue bills will be charged 1.5% per month interest.

V. COMPLAINTS & CONCERNS: There are no guaranteed results in therapy. If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to:

Health Professions Quality Assurance, Customer Service Center
PO Box 47865
Olympia WA 98504
Email: hpqa.csc@doh.wa.gov
Phone: (360) 236-4700

You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, as you are the person who has the right to decide what you want kept confidential.

My Training and Approach to Therapy

I have an MA in Psychology, earned in 2010 at Antioch University Seattle. I am a licensed mental health counselor associate (#LH60414109) in Washington State. My areas of special training and expertise include women's, gender, and sexual identity issues in general; people in recovery from alcohol and drugs; and people living any number of “alternative” or

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“fringe” styles of life, including those who work in the sex industry. I completed my internship with Seattle Counseling Service in 2010, and am a member of the American Counseling Association.

My approach to therapy is based in object relations theory . That is to say that I conceptualize your problems systemically, relationally, and practically. I am interested in how your issues are affecting and affected by all aspects of your life, particularly as they relate to your early childhood relationships. Therapy with me usually begins by collecting information on your view of the issues that brought you to therapy, then moves into a look at your childhood relationships. Together, we will make connections between the two, and use here-and-now techniques that enable you to rewrite your current thinking patterns and subsequent choices, such as cognitive reframing, awareness exercises, self-monitoring experiments, inner child work, journal-keeping, and reading books. I am also open to the possibility that biological factors may play a role in your symptoms. If this seems likely to me, I will offer you a referral to a provider qualified to discuss medication options with you.

Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

I am available for brief between-session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours, please call the Crisis Clinic at 206-461-3222. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

Client Consent to Psychotherapy

I have read this statement, considered it carefully, asked any questions that I needed to, and understand it. I agree to pay the fee of \$_____ per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Kristen Knapick, MA, LMHC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made. I am over the age of eighteen.

Client name (printed)	(signed)	(date)
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Client name (printed)	(signed)	(date)
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Client name (printed)	(signed)	(date)
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Kristen A Knapick, MA, LMHC	(date)
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Notice of Privacy Practices

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or “PHI”). I must follow the privacy practices described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal and State of Washington law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in supervision and consultation so that I may provide high quality services for your benefit.

2. Health care operations: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing or credentialing activities. I will notify you in advance of any such disclosure.

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if

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you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.

e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.

f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy notes: Notes recorded by me documenting the contents of a counseling session with you ("Psychotherapy notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. Marketing communications: I will not use your health information for marketing communications without your written authorization.

3. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.

4. Other Uses and Disclosures: Uses and disclosures other than those described in Section I. A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, to your attorney, or to your health care providers. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of paying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you (such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older).)

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

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer", as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement", based upon your proposed amendment, must be added to your record.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy right, you may contact me, Kristen Knapick, MA, LMHC, by telephone at (206) 779-9178 or, in writing, at 105 14th Ave, Suite 120, Seattle, WA 98122. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360) 236-4900, P.O. Box 47869, Olympia, WA 98504. I will not retaliate against you if you file a complaint with me or with the Department of Health.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on January 3, 2011.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will inform you, and you may obtain any revised notice by contacting me.

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Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I _____,
acknowledge that I received a copy of the Notice of Privacy Practices for Kristen Knapick, MA, LMHC. This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations. The Notice of Privacy Practices also describes my individual rights and responsibilities and the duties of Kristen Knapick, MA, LMHC with respect to my protected health information.

Signature of Client

Date

FOR OFFICE USE ONLY

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented me from obtaining Acknowledgment
- ☐ Other (specified below)

This form will be retained in the mental health record.

Date:

Client Initials:

INTAKE INTERVIEW

1. Name _____
2. Date of Birth ____/____/____ Current Age _____
3. Address _____
4. Preferred Phone Contact _(____)_____ Message OK? _____
5. Secondary Phone Contact _(____)_____
6. Email address _____
7. Emergency Contact _____
(only minimally necessary info will be disclosed in event of emergency)
8. How did you find me? _____
9. Currently employed? _____ If yes, how so? _____
10. Please describe your gender _____ Pronoun preference? _____
11. Please describe your sexual orientation _____
12. Relationship Status _____
13. Names and ages of children _____

Treatment History

14. Have you had previous counseling? When? With whom? Results? _____

15. Do you take any medications for psychiatric reasons? What? How much?

16. Have you ever been hospitalized for psychiatric reasons? For what reasons?

17. Any previous mental health diagnoses? _____
18. Any suicidal or homicidal ideation/attempts in your history? _____
_____ Currently? _____

19. Any history of self-harm? Type? _____

20. Describe *previous* and *current* substance *use or abuse*. _____

_____ Any history of substance treatment? _____

21. Do you have any current health concerns? _____

Prominent Family History

22. Were you raised with any religious practice? If yes, what sort?

23. What is your current belief system?

24. What is your ethnic background? (“where did my people come from?”)

25. Tell me about your Family Of Origin roles and relationships:

26. Anything else about your family history it would be helpful for me to know? (abuse, abandonment, divorce, illness, death, estrangement, etc.?) _____

Miscellaneous

27. What are your goals for therapy? _____

28. Is there anything else you'd like me to know about you?

Techno Communications & Social Media Policy

1. PHONE CALLS are the most secure means for us to communicate. The exceptions to this include if either of us is using a Bluetooth device, or if you are using a phone connected directly through the Internet (i.e., Vonage). Phones that use Internet lines but are not routed through the Internet itself (i.e., Comcast) are secure.

Initial Here _____

2. TEXT MESSAGES sent phone-to-phone are NOT secure. I will not engage in text messaging with you. I will not acknowledge any texts you send me.

Initial Here _____

3. EMAIL is not considered a secure form of communication unless done through an encryption service. For this reason I prefer to use email only to arrange appointments when necessary. I encourage you not to email me with any information you want kept confidential, as the potential for interception by a third party is present. I will read your emails, but will reply with the minimum content necessary. If you choose to exchange emails with me, you do so knowing your privacy is at risk.

Initial Here _____

4. SOCIAL MEDIA such as Facebook, LinkedIn, and Twitter are not an appropriate means by which to maintain professional boundaries with my clients. I will not engage with you through social media; I will ignore all “friendship requests,” “requests to follow,” and “invitations to connect.” This is out of respect for our professional relationship, and not intended as a personal slight to anyone.

Initial Here _____

5. RESPONSE TIME: I check all messages periodically as I am able Monday – Thursday, noon-7pm, and I respond during those same hours, as I am available. I do not receive or reply to messages Friday – Sunday, and cancellations for a Monday must be made according to the 24hr policy, but by the Friday before, in order to avoid being charged for the appointment. If you are in Crisis, please call the Crisis Clinic at (206) 421-3210, or call 911.

Initial Here _____

Signed	Printed name	Date
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Signed	Printed name	Date
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Signed	Printed name	Date
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