Barbara Overson, MS, LMHC, CMHS, BCB

Licensed Mental Health Counselor

LH60074799

2215 Elm Street

Bellingham, WA 98225

TERMS OF SERVICE & CONSENT TO TREATMENT

Welcome to my practice. Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods and service policies. It is your right and responsibility to choose the provider and treatment that best meets your needs. To help make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read the information carefully and ask me to explain anything you do not understand. This statement, in its entirety, serves as our agreement to our respected rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

THERAPY/TREATMENT

In my practice, I work with individuals from a client-centered perspective and believe interventions are most effective when they are tailored to each client. I utilize a variety of hands-on techniques in my work and believe every individual possesses personal strengths and knowledge of their needs. I believe it is important to create a supportive, trusting, and safe environment in sessions in order to increase self-awareness and promote personal growth. I use a variety of integrated therapeutic approaches to treatment that include, but are not limited to, the following: cognitive behavioral therapy, interpersonal therapy, Eye Movement Desensitization and Reprocessing (EMDR) and phenomenological therapy. In addition, I am board certified in biofeedback and may integrate biofeedback interventions in treatment when appropriate. I aspire to help clients and families build on their strengths and learn additional skills to empower them to better manage life's challenges

Therapy may be offered in a variety of modalities including individual, family or group. With a client's permission, parents and family members may participate in the treatment process to facilitate positive changes for the client as well as help improve interpersonal functioning. When necessary, I will also consult with school staff, medical providers and other professionals involved in the client's treatment with the client's consent.

While we will work together to achieve maximum benefits of therapy, there is no guarantee to such benefits or outcomes. In addition to our collaborative efforts, it is important to maintain regular attendance to appointments for therapeutic progress.

You have the right to choose a counselor who best suits your needs and purposes and if ever you or I feel that our therapeutic relationship does not suit your needs, I can provide information about contacting other professionals in the area. You also have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6).

EDUCATION

2007 M.S. Psychology, Mental Health Counseling, Western Washington University
2003 B.A. Psychology, Gonzaga University
2003 B.A. Art, Gonzaga University

CONFIDENTIALITY AND PRIVACY

Within the limitations discussed below, the information that you reveal to me during our professional relationship will be kept confidential and will not be released to anyone without your written consent. By law I am required to report actual or suspected child or elder abuse to the appropriate authorities. I am also legally bound to protect anyone you might threaten with violence, physical harm or other dangerous actions, including yourself. If a legitimate court order is issued, or your treatment is ordered by or under the supervision of the court, I am obligated to share information about your treatment with court appointed authorities.

Good clinical practice requires occasional peer review and consultation. Please be aware that your case may be clinically reviewed in consultation groups with other mental health professionals and every effort will be made to preserve your confidentiality during these consultations. Additionally, other providers may provide clinical coverage when I am out of town, and thus some information may be shared with them so they will be better prepared to assist during any of my absences if necessary.

If I will be working primarily with your child or adolescent, I will use my clinical judgment to determine what information will be kept private in addition to the limitations to confidentiality outlined above. While general information about the sessions and your son or daughter's progress will be shared with you, I will make every effort to respect his or her autonomy. We will discuss the confidentiality of therapy for minors, and the law in Washington State, in greater depth when we meet.

FEES AND PAYMENT

Unless otherwise arranged with me, my fees are as follows:

Initial Interview	$150 per 60 minute session
Individual Therapy	$100 per 50 minute session
	$125 per 60 minute session
Biofeedback	$100 per 50 minute session
Family Therapy	$100 per 50 minute session
Court Testimony and Preparation	$200 per 60minutes

Telephone consultations that exceed 10 minutes will be charged at the hourly rate. Out-of-office appointments including treatment coordination with other professionals will be charged $100.00 per hour.

Fees for service are due at the time the service is provided. Please make your checks and money orders payable to Barbara Overson. Checks returned by your bank for non-sufficient funds [NSF] will result in a $35.00 fee. I will send monthly bills for balances more than 30 days overdue. If your account is more than 90 days overdue, it may be sent out of the office for further collection.

While payments and co-payments are generally due at the time of service, I have agreements with some insurance companies to submit billings for the insurance company portion directly to them. They will pay me directly for covered services. With other insurance carriers, we will decide

together whether you will pay me the co-pay or co-insurance only or the full fee at the time of service. You are responsible for determining the specifics of your insurance coverage, as well as procuring relevant paperwork (such as primary care physician referrals) as your insurer may require. I will assist you by providing any necessary information. **Please note that as the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time the insurance company notifies me of any unpaid portion.**

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit it to your insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or a behavioral health care manager. By signing below, you are acknowledging that your insurance carrier has full access to your client records. If you have any questions about the details of your plan, please refer to your benefits booklet or contact your insurer.

CANCELLATIONS

Twenty-four hours notice is required for cancelled sessions, barring emergencies that preclude you from attending. The voicemail system is available 24 hours a day and you can leave a message for me at any time. **Unless 24 hours notice is given, you will be expected to pay in full for missed appointments. I cannot bill your insurance for missed sessions, and insurance will not pay for missed sessions.**

EMERGENCIES/CONTACTING ME

Messages can be left on my confidential voicemail at any time: (**360) 312-3830**. I am in the office part-time, however, I generally check and return messages throughout the week. Also, please remember to leave your contact phone numbers with every message as I am not always in the office when retrieving messages and may not be able to get back to you otherwise. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If a contact of more than 10 minutes is necessary, a fee will be charged at the proportion of the hourly rate.

If you are unable to reach me and feel you need immediate support, please call my answering service at (360) 715-2470. For life-threatening emergencies, please call 9-1-1 or go to the Emergency Room.

COMPLAINTS

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Washington State Department of Health Customer Service Center at (360) 236-4700.

By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure statement. I also give my permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

______________________________ __________________________

Client's Signature (age 13 or over) Date

______________________________________ ____________________________

Parent/Guardian’s Signature & relationship to minor Date

______________________________________ ____________________________

Barbara Overson, MS, LMHC, CMHS, BCB Date

Please read the attached Notice of Privacy Practices for more information about your privacy rights, and initial here to acknowledge that you received a copy of the Notice: ________