PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

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Jill Newman, MSW, LICSW

This document contains important information about my professional services and my business policies. Please note that this Disclosure Statement and Informed Consent does not give clients new rights under the law and is not intended to supersede state or federal laws and regulations, or professional standards.

Please review this document carefully before signing it and let me know if you have any questions so that we can discuss them. When you sign this document, it will represent an agreement between us.

Education, Training and Experience

I am a Licensed Clinical Social Worker in the State of Washington, License #LW 60220997. I am also accredited through the National Association of Social Workers, in the Academy of Certified Social Workers (ACSW). I am a Washington State Approved Clinical Supervisor.

I received my training at the University of British Columbia, School of Social Work in Vancouver, BC, Canada. I graduated with a Master's degree in Social Work in 2007. I have 14 years of experience working as a therapist in agency and outpatient mental health settings and in private practice. I have a specialized focus in working with adolescents and young adults. I held a clinical faculty appointment as an instructor in the Department of Psychiatry at the University of British Columbia from 2013-2019. My education, training and experience have prepared me to counsel individuals of all ages, ethnicities, race, religion, sexual orientation and gender identities.

The Therapeutic Process

My approach to counseling is person centered, in which I focus on creating a safe, supportive and non-judgmental environment for my clients to explore issues that are causing them to feel stuck or distressed. I believe that positive change is always possible. I focus on collaborating with my clients to support them to gain insight, find solutions to the challenges in their lives and work towards achieving their goals. I use a variety of therapeutic approaches in my practice including Cognitive Behavioral Therapy, Mindfulness Practices, Dialectical Behavioral Therapy, Solution Focused Therapy, Narrative Therapy
and Expressive arts (music).

During the therapeutic process, our relationship is very important and contributes greatly to the effectiveness of our work together. If at any time you have concerns about our work together, please talk to me about this so that we can come to an understanding about what you need. You are under no obligation to continue treatment with me. You have the right to choose a therapist and treatment modality which best suits your needs. Any concern that cannot be satisfactorily resolved with me can be brought to the attention of the Washington State Department of Health.

Course of Treatment

The duration of treatment varies, based on presenting problems, goals for therapy and the client's own dedication to change. We will discuss the recommended course of therapy and number of recommended sessions at the conclusion of your first appointment.

Confidentiality

With certain exceptions, I am required to keep your content of your therapy sessions confidential. I cannot and will not tell anyone what you have told me, or even that you are in therapy with me without your prior written permission. The exceptions to my confidentiality obligations include, but are not limited to:

- Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a developmentally disabled person.
- When disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- In response to a subpoena issued by the secretary of Health that is associated with a Regulatory complaint
- If you sign a written authorization to release your information

As an ongoing part of my clinical development and in pursuit of providing you with the best care, I consult regularly with my colleagues who are licensed mental health providers. Should I discuss your therapy in consultation with any other clinician, I will only relate the content of our work together. You will not be named, nor will I share any details of your life that might identify you. In the event that I am out of town, other providers at Associates in Mental Health may provide clinical coverage for my clients and some information may be shared with them so they are best able to assist you if needed.

Anticipated Benefits of the Proposed Treatment

Goals for the proposed treatment include a reduction or remission of the presenting symptoms, such as a reduction in anxiety or depressive symptoms, and an increase in positive behaviors such as increased participation in social activities.

Possible Risks of Treatment

Possible risks of treatment include a temporary increase in symptoms, as you work on issues. This may include an increase in difficult memories. We will discuss these risks further in session and work on ways to minimize and cope with any increase in symptoms. Clients are partners in their treatment and have the choice whether to proceed.

Fees and Payment

I provide a free 15 minute consultation to ensure a good fit before beginning our therapeutic work together. My fees for therapy are $130 for a 50-55 minute individual or family therapy session. The initial 60 minute intake session is $150. These fees apply to in-person or telehealth therapy. All co-payments and fees not covered by insurance are due at the time of each session.

Court and legal services will be billed at $200 per hour. Telephone calls that exceed 10 minutes will be charged at my hourly rate.

Cancellations

I require 24 hours notice for cancellation of your scheduled appointment in order to avoid a cancellation fee. If an appointment is missed or cancelled without 24 hours notice, I will charge $65 for a first missed appointment and my full hourly rate of $130 for any additional missed appointments or late cancellations.

Insurance and Billing Information

I accept a variety of insurances. Please check with me during our consultation appointment to make sure that I am able to accept your insurance. You are responsible for checking with your insurance company to determine your insurance eligibility, benefits, co-pays and deductible amounts. Please note that many insurance companies require their clients to obtain an authorization for mental health services prior to attending therapy. Clients are responsible for all co-pays, deductibles and any fees not covered by their insurance provider.

Emergencies and Contacting me

Messages can be left for me on my confidential voicemail at any time. Telehealth clients may also leave a message for me on your secure messaging portal on simple practice. Please note that email is not a secure means of communication and I do not use email for therapeutic exchanges as your privacy cannot be ensured. I work on a part time basis and generally check and return messages Monday – Friday. I try to return messages within 24 hours on weekdays between 9am-5pm.

If you are not able to reach me and you are in need of immediate support, you may call my answering service at (360) 715-2470. The 24-hour care crisis line is (800) 584-3578 or you can text TALK to 741741. If you are experiencing a life-threatening emergency, please call 911 immediately or go to your closest hospital emergency department.

Records

I keep electronic records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section.

Contact Information for Department of Health

In order to obtain a list of acts that constitute unprofessional conduct or to file a complaint, you may contact the Washington State Department of Health at:

Washington State Department of Health
Health Systems Quality Assurance Division
P.O. Box 47877
Olympia, WA 98504-7877
Phone: (360) 236-4700

By signing below, each of us confirms this document to represent the agreement between us, and that each has read, understood and received copies of this Disclosure Statement and Informed Consent.

Client _____ Date _____

Therapist _____ Date _____

If client is under 13 years of age
Each signatory below represents and warrants that he or she is the parent or legal guardian of the client named above and is authorized under Washington State law to provide consent to mental health treatment on behalf of the client.

_____ Date _____
Parent/Guardian Signature

_____ Date _____
2nd Parent/Guardian Signature (if applicable)