Connie Chapman, MSW Registered Counselor # RC00045850
Symmetry Counseling, A Limited Liability Company
815 West Seventh Avenue, Spokane, Washington 99204 - 509.838.9922

Client Disclosure and Information

This document gives you information about me and my practice, as well as explains our rights and responsibilities as part of our therapeutic working relationship. Washington state law requires all counselors to disclose certain information to you, which is provided here. If you have questions, please discuss them with me.

Your Right to Know: Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include a recognition of any practice standards more necessarily imply the effectiveness of any treatment.

Confidentiality: By law, what you say or do during a psychotherapy session cannot be shared with anyone else without your written permission. There are however some exceptions to this rule that you should know:

a. If you report to me that you are the victim or perpetrator of child abuse or molestation, I am obligated to report it to the proper authorities. This includes if I strongly suspect child abuse. This also includes reported or suspected dependent adult abuse.
b. If you indicate that you intent to injure or kill yourself or someone else, or there is serious concern about suicide, imminent harm to yourself, or serious threat or risk to harm someone else, I must act to notify potential helper or victims.
c. I keep brief, written notes of your treatment progress. In certain unusual situations, a court may subpoena treatment records and I may be obligated to surrender them. This is very uncommon, and would not be done without your knowledge.
d. If you are a minor, I have to keep your parents or guardians informed of your progress if they ask. However, I do not have to tell them details of our conversations.
e. For the purpose of providing the most appropriate and effective treatment possible, and for my own professional growth, I may participate in clinical supervision, or professional consultation. However, if I consult regarding my work with you, I will not reveal your identity in order to maintain your confidentiality.
f. I am currently seeking licensure as a Social Worker, As a result of this I meet individually with a supervisory therapist and as a member of a small group with a second supervisory therapist. While I may discuss your treatment in these sessions, you are provided the same level of confidentially we share in our therapeutic relationship.

Right to Choose: You have the right to choose a counselor/therapist who best suits your needs and purposes. At any time feel free to discuss with me any questions you have regarding my qualifications, practice, course of treatment and/or intervention techniques, or any other issues or questions you may have regarding our work together.

Education, Training and Experience:

Master of Social Work
University of Washington

Bachelor of Arts, Cum Laude, Psychology
Saint Martin's University

I have over thirteen years professional experience in social services, providing direct services to adults, and adolescents. My professional experiences have included working in the following settings; courts and legal systems, state institutions, residential adolescent group homes, foster care systems, parent education, alcohol and drug prevention, and disability services. I have enjoyed the opportunity to work with clients and client populations spanning the entire diversity of age range, background, ethnicity, race and life experiences, needs and concerns.

My professional roles have included those of educator, advocate, case manager, supervisor, assessment specialist, researcher, consultant and group co-facilitator. I have received specialized training in the areas of EMDR (Eye Movement

Desensitization Reprocessing), the Gottman Method of couples therapy, disability service, parent education, personality disorders, child physical and sexual abuse, and assessment techniques.

Areas of Focus: Anxiety*, Coping Skills*, Depression, Couples*, Parenting, Personal Growth, Relationships, Self-Esteem, and Trauma*. (*Indicates specialties)

Theoretical Orientation: My therapeutic interventions and methodologies are based on an eclectic model which includes, but are not limited EMDR, the Gottman Method, Empowerment and Systems Theories.

Course of Treatment: To be agreed upon with the client.

Client Responsibility for Choice of Treatment: You have the right to decided whether to engage in any course of treatment and to decide whether that treatment is suitable for your needs. I encourage you to discuss with me your goals for therapy, and the treatment. Clients have the right to request a change of therapy, referral to another therapist, or other referral sources, or to discontinue therapy. If you do wish to terminate therapy, I encourage you to discuss your decision and reason for termination at the beginning of a regularly scheduled session. I hope you will discuss any dissatisfaction or questions with the therapeutic process and consider it of therapeutic value that the counseling relationship and issues be dealt with in a straightforward manner and in the best of your and my ability.

Fees: My standard fee is $70.00 per 50-minute session for individuals, and couples. EMDR sessions and Gottman Method based sessions are typically 80-minute sessions. These sessions are $105 each. Requested report writing and other requested work related to your treatment outside of our scheduled sessions will be charged at the same rate as office sessions.

My fee for court-related services, including such services as testimony, deposition, time away from my practice, travel expenses, preparation, and other expenses involved, is $100 per hour.

Payment for Service: All charges are due and payable at the time of your appointment, unless other arrangements have been made in advanced of the session.

Appointment: Making and keeping appointments is important to the therapeutic process. The time we have scheduled together for your appointment is **your** reserved time. It is important that sessions occur when scheduled. **You will be charged the full fee for any appointment which is not kept and not canceled at least 24-hours in advance.**

Emergencies and Non-Scheduled Contact. In case of emergency, I cannot guarantee my availability. However, I do check my messages regularly, and you may leave a message for me at 509.838.9922 at any time. If it is an emergency and I am not available, the 24-hours crisis line is available at 1-800-584-3578.

Concerns About Provisions of Service: I am a member of the National Association of Social Workers and I am registered to practice in the State of Washington. I am committed to the highest quality of professional and regulatory ethics and standards of practice. The purpose of the law regulating counselors and the Counselor Credentialing Act, is to: a) provide protection for public health and safety; and b) to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. If you have any questions about any aspect of our professional relationship or about the specifics of those ethics and standards, please discuss them with me. If you find no adequate resolution with me, or you have further questions, you may contact the Department of Health, at (360) 753-1761, in Olympia.

If you would like to review my professional resume, the National Association of Social Workers Code of Ethics or the Law Relating Counselors, I would be glad to make copies available to you.

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. PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of my professional practice, I maintained personal information about you and your health. State and federal law protects such information by limiting its uses and disclosure. "Protecting health information" (PHI) is information about you, including demographic information, that may identify or used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payments of the provision of health care.

Your Rights Regarding Your PHI The following are your rights regarding PHI I maintain about you.

- *Right of Access to Inspect and Copy*. You have the right, which may be restricted only in certain limited circumstances to inspect and copy your PHI that I maintain. I may charge a reasonable cost-based fee for copies.
- *Right to Amend.* If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree with the amendment.
- *Right to an Accounting of Disclosures.* You have the right to request a copy of the required accounting of disclosures that I make of your PHI.
- *Right to Request Restrictions*. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. I am not required to agree with your request.
- *Right to Request Confidential Communication*. You have the right to request that I communicate with you in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making those requests.
- *Right to a Copy of this Notice.* You have the right to a copy of this notice.
- *Right of Complaint.* You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

My Uses and Disclosure of PHI for Treatment, Payment and Health Care Operations

Treatment. I may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, I may disclose your PHI to others of your current providers, and to the extent you have not raised an objection in writing to your providers, including family members, involved in your care.

Payment. I may use your PHI in connection with billing statements I send you and my system of tracking charges and credits to your account. In addition, but with your authorization, I may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage and remaining availability, as well as to submit claims for payment and to disclose PHI for medical necessity and quality assurance reviews.

Health Care Operations. I may use and disclose your PHI for health care operations of my professional practice in support of the functions of treatment and payment. Such disclosure would be with business associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist me in my delivery of your health care.

Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with

investigation of deaths. I also must make disclosure to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose your PHI to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me (such as a third-party payer).

Threat to Health or Safety. I may disclose your PHI when necessary to minimize an imminent danger to the health and safety of you or any other individual.

Appointment Reminders. I may use your PHI to contact you to remind you of your appointments with me.

Business Associates. I may disclose your PHI to my licensure supervisors and business associates that are contracted by me to perform health care operations, or payment activities on my behalf which may involve their collection, or disclosure or use of your PHI. My contact with them must require them to safeguard the privacy of you PHI.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will also disclose your PHI if (1) you and I have each been notified in writing at least fourteen days in advance of subpoena or other legal demand, identify the PHI sought, and the date by which a protective order must be obtained to avoid my compliance. (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurance that you received notice of an opportunity to have limited or quashed the discovery demand and (4) such time has elapsed.

Uses and Disclosures of PHI With Your Witness Authorization

I will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This Notice

This Notice of Privacy Practices informs you how I may use and disclose your protected health information (PHI) and your rights regarding your PHI; I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect your PHI. I am required to abide by the terms of this notice of Privacy Practices. I reserve the right to change the terms of my Notice to Privacy Practice at any time. Any new Notice of Privacy Practice will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by providing you a copy upon your request or providing a copy to you at your next appointment.

Contact Information

I am my own Privacy Officer, so if you have any questions about his Notice of Privacy Practices, please contact me.

My contact information is: Connie L. Chapman, MSW, Symmetry Counseling, LLC, 815 West Seventh Avenue, Spokane, WA 99204, Tel: 509.838.9922

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified in this notice. I will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Department of Health and Human Services.

By signing this document, I confirm that I have read the above information, disclosure statement and Privacy Practice Notice and received a copy the documents. I further confirm that I have had the opportunity to discuss this information with Connie Chapman, MSW and that I understand its content. By signing this document, I also agree to participate in and receive counseling from Connie Chapman, MSW of Symmetry Counseling, LLC.

______________________________	______________________________	________________
Print Parent Name	Parent Signature	Date

Fee Agreement

The standard fee is $70.00 per 50-minute session or $105 per 80-minute session.
I, (parent's name) ____________________________ agree to pay the standard rate per session for therapy sessions for (name of child) _______________________________. **No shows and cancellations made with less than 24-hours notice are billed at the full hourly rate and payment is required at the next scheduled appointment or within 15 days, whichever comes first.** I agree to pay for court-related services at the rate of $100 per hour, as described in to me in full in this information sheet.

I understand that payment is expected in full at the end of each session unless another arrangement has been made.

_____________________________________	________________________
Parent Signature	Date