**Trish Ferreira**

**Licensed Independent Clinical Social Worker #LW00008193**

22525 Marine View Dr. S., Suite 205

206-499-7623

**PROFESSIONAL DISCLOSURE STATEMENT**

Please read the following information carefully and feel free to ask me any questions you may have about this material or anything else related to your therapy. As a consumer of psychological services, it is important that you have an understanding of your rights under Washington state law to enable you to make informed consent to your treatment.

You are entitled to know about my professional training and experience. I earned a Bachelor of Science (1998) in Psychology and Sociology from Tulane University and a Masters in Social Work (2000) from Tulane University School of Social Work. The school is accredited by the Council on Social Work Education (CSWE). I am also professionally trained as a Chemical Dependency Counselor, and I am a specialist in Children’s Mental Health. My clinical experience has included work with outpatient children, adolescents, adults, couples, families, and groups. My theoretical orientation is an integrated approach involving such therapies as Motivational Interviewing, Cognitive-Behavioral Therapy, Solution-Focused Therapy and EMDR. My approach involves a developmental understanding of a client’s feelings, beliefs, thoughts, and experiences.

I view therapy as a collaborative effort, with the therapeutic goals and course of treatment mutually defined by client and therapist, and open to discussion and modification as necessary. It is important to me that you feel your needs in therapy are being addressed, and that you are comfortable to raise questions about your therapist, the treatment approach and therapeutic progress. You will be expected to take an active role in your treatment, and you may discontinue care or request a change in treatment plan or therapist at any time. You can expect to be treated with respect and to receive my best professional efforts. I may on occasion, refer to a specialist or recommend adjunctive care or medication for some clients if necessary.

Practicing counselors who charge a fee must be registered or licensed with the Department of Licensing for the protection of the public’s health and safety. Any complaints related to professional or ethical issues can be addressed to the Department of Health, P.O. Box 47857, Olympia, WA 98504-7857; (360) 236-4700.

**Confidentiality**

A record will be kept at this office of the health care services provided to you. You may ask to see and copy that record, and ask that corrections be made to it. All mental health records and information discussed in your sessions are legally protected and kept confidential in accordance with established ethical standards for the practice of psychology. Your insurance company will be provided with your basic information necessary for accounting and claims information. Mental health records and information regarding treatment will only be released at the expressed written consent of the client or guardian, or as permitted by law. Washington state law requires the release of confidential information without your consent in the following situations: (1) there is a reason for suspicion of abuse or neglect of a child, vulnerable dependent, or developmentally disabled adult; (2) there is reason for concern that a client may inflict harm on self or another person; or (3) the information is subpoenaed by a court. In order to best serve my clients, I do occasionally consult with other practitioners. In that event, your identity would not be disclosed, and they would also be bound by the same rules of confidentiality. Legal evaluations or opinions of any kind will not be provided. To provide both therapy and opinion at the same time presents a conflict of interest and interferes with the therapeutic process.

**Appointment and Fees**

Individual appointments are 55 minutes in length. It is essential that you provide a minimum of 24 hours’ notice in the event that you must cancel an appointment. You will be charged the full fee for a missed appointment or an appointment canceled without 24 hours’ notice. Please note that these charges cannot be billed to your insurance company.

You are ultimately responsible for the payment of your fees. While some insurance plans provide coverage for outpatient psychological services, it is important for you to determine the extent of your coverage. Fees are to be paid at the start of each session by credit/debit card, Unless I will be billing your insurance for you. In this case, you will be required to pay only your cost share and deductible in advance. Accounts that become delinquent over 90 days may be subject to a service charge and/or sent for collection.

My fees are $160 for an initial intake evaluation, and $130 per following session. All payments are due at the time of service. As a participating provider for some insurance companies, I have agreed in advance to accept their maximum allowable fee. Fees will be charged for emergency calls and consultations with you, reports and consultations with attorneys, doctors and other professionals. These fees will be incurred in proportion to the hourly charge. Please be aware these charges cannot be billed to your insurance. Any questions regarding fees and insurance can be discussed at any time. If you have overpaid at any time, a refund will be given to you by check, once an Explanation of Benefits has been received documenting the overpayment. You are not liable for any fees or charges for services rendered prior to the receipt of the disclosure form.

If you have additional questions or concerns regarding your treatment or the above information, please feel free to discuss them with me at any time. Your signature below indicates that you have read, understood, and been provided with a copy of this information and agree to the conditions herein.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have provided to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The disclosure information required by RCW 18.19.060.

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Trish Ferreira, MSW, LICSW