# *Disclosure and Policy Statement*

This is a statement of your rights and responsibilities for our therapeutic relationship. The RCW 18.19 .060 and Washington 246–810–031 require counselors to provide written disclosure of the following information to their clients.

Educational experience

I received my BA of Liberal Arts with a concentration in Social Ethics and Human Behavior from the University of Washington in 2000. I then went on to receive a Masters in Counseling Psychology from City University in 2003. I maintain my knowledge and expertise through continuing education and specialized trainings, to enhance my skills and provide quality services to my clients.

Field experience

I am an advocate for the emotional health of those who seek my services for positive growth and healing. My field experience is not limited too, extensive work with families in major transitions both at Seattle mental health and the YWCA , parent education counseling, and those dealing with various types of trauma. I take pride in recognizing the diverse needs of my clients, and guide them to explore their thoughts, emotions, and goals, in a safe, objective, and confidential environment.

My services include, couples, family, and individual counseling, in addition to several educational and support groups. I dedicate myself to those interested in achieving emotional balance and happiness, with an eagerness of self determination, and willingness to invite positive change.

Counseling orientation

My usual therapeutic approach is derived from a cognitive behavioral model with a positive psychology component, where the client is able to acquire information for positive growth through exploration of thoughts and feelings with the support of the therapist. I want to ensure that all of my clients have the best chance possible in gaining self-fulfillment and awareness for positive growth. I also integrate components of emotional focused work, attachment theory, and other modalities depending on the client's needs.

Clients rights and responsibilities

You have the right to choose a counselor who best suits your needs and purposes you may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

Clients can rely on me to maintain confidentiality regarding our work together, with a few following exceptions as required by 19.19 .1801. Washington State Law requires that suspected abuse or neglect of a child, dependent
adult, or developmentally disabled person be reported.

2. Washington State Law also requires that others be informed if you threaten to harm

yourself, or others. If that threat is perceived to be serious, the proper individuals must be contacted: this may include the individual against whom the threat is made.
3. In the event of a court order, counselors may be required to disclose information in the presence of a judge.
4. In the event of a medical emergency, emergency personnel may be given necessary information.
5. If you bring a complaint against me with the State of Washington, Department of Health, information will be released.
6. In the event of your death or disability, the information may be released if your personal representative or the beneficiary of an insurance policy on your life signs a release authorizing disclosure.

Tele-therapy
Please note that there are some risks involved with sessions that take place outside of the office. Although the risk is low, confidentiality could be compromised. Due to technical difficulties, sessions could be interrupted. Virtual sessions are a convenient and effective alternative approach.

Email, phone, and messaging
Again, there is some risk while using these portals of communication. Please inform KSM Counseling if there are lines of communication that you would not want to be used.

Payment is expected at the beginning of each visit. You are responsible for the full fee. For those utilizing Insurance or EAP, please note if for any reason issues arise and reimbursement is not provided, full payment is the responsibility of the client.

Sliding Fee
If you are on a sliding fee scale, we will honor the rate for 8-12 sessions, then we will re-evaluate and increase your treatment fee
Sliding Fee _____ initial _____

Counseling Fees
Initial Intake: $185 45-50min
individual: $165 for a 45-50min session or $220 for a 75min session
Couples and Family: $185 for a 45-50min session or $245 for a 85-90min session
mini sessions: 20-25 minutes $85
Any additional time over the scheduled session will be charged appropriately
Please keep in mind rates are subject to change and a treatment plan will be developed with your agreement.
Counselors practicing for a fee must be registered or certified with the department of health for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standard, nor necessarily imply the effectiveness of treatment.
Any additional time spent for emails, phone consultations, collaborative care etc, will be billed at the regular rate of $165.
Please note that rates may increase due to inflation.

Regarding court requirements

It is my policy not to provide clinical evaluations of assessments of the quality of client and or participation when clients are accessing counseling to fulfill courts or other requirements. Arrangements for disclosure of attendance may be provided when proper release of information is provided. Any time in regards to court ordered information or tasks are subject to $250 per hour.

Treatment Records

*To ensure greater confidentiality, you have the option to request that no treatment records be kept. If you make this request, the only records that I will maintain are your name and address, our fee arrangement, a record of payments received, the dates that we met for counseling and a copy of this form, including this written request. To avoid any misunderstanding, and as required by law, it is my practice to ask that you indicate your preference below and that you specifically initial and date your preference. I will also sign and date my name indicating my consent to the arrangement that you have requested. If you are a couple being seen for couples counseling then both individuals must agree and then initial and date below.*

□ *I want you to keep treatment records. (Initial(s)_____ & date)_____*

□ *I do not want you to keep treatment records. (Initial(s)_____ & date)_____*

*Provider Acceptance*

□ *I agree with your request and I will not keep treatment records,*

□ *I agree with your request and I will keep treatment records*

□ *Counselor_____ Date_____*

**Failure to Cancel**

Appointments that are not cancelled **48** hours prior to a scheduled session, will be charged the **full** session rate as agreed above.

Return check fee

All return checks will be charged a $40 and SFE

Adolescents

Please note that children ages 13 years of age and above may give consent for their own treatment.

Consent for treatment

With my signature, I acknowledge that I have read and understand this disclosure and the accompanying counseling information sheets. I consent to therapy with Kaji Martinez, according to the terms described here.

_____ _____

Signature Date

_____ _____

Signature Date

_____ _____

Legal Guardian Signature(if under 18) Date

_____ _____

Counselor Signature Date