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. Through my private practice I have helped clients work through relationship challenges and life transitions. 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, adolescent, and individual counseling. 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 also integrate Emotional focused models and attachment theories when working with individuals and couples. I want to ensure that all of my clients have the best chance possible in gaining self-fulfillment and awareness for positive growth.

Benefits and risks of Psychotherapy

Although not guaranteed, therapy can add relief to your life and create productive insight and healing. Benefits are best achieved when clients offer a clear description of feelings and challenges and allow openness with your therapist, so they can better understand your needs for the change you are seeking. It is important to be consistent with attendance and do your best to apply the tools outside of your sessions.

For many there is a strong sense of relief , but for others therapy can bring many uncomfortable and painful emotions to the surface. You may find yourself feeling worse before feeling better. It is important to work through the challenging emotions to gain relief and create an open dialogue with your therapist. If you find it to be incredibly difficult, it is best to bring this up with your therapist to ensure you are on the right course of treatment.

What to expect during therapy

We will go over your expectations and the goals you would like to reach. We will put in place skills and tools to best achieve this. I provide skills for practical application "homework" at the end of most sessions. It is in your best interest to do your best to apply these skills to achieve the best outcome from therapy. I will listen attentively and will always do my best to reflect back to ensure I am actively listening to what you are saying.

It is possible there may be times referrals are given if I feel my client may benefit from additional resources to enhance our therapeutic process. I may also refer my client out if I feel unable to provide them with the treatment necessary. It is always my promise to you that I will do my best to provide you with the best therapy possible, this also means understanding whether or not I am the best fit for you.

Tele-mental health information/Online Psychotherapy

-You will receive a link/invite to access the online video platform. Please make sure to close other windows on your computer that could cause distractions or take up bandwidth.
-Log in early to make sure your connection, mic, and video are working etc.
-Make sure you have privacy and chances for interruptions are low. It is important to have a safe space to ensure confidentiality.
-If technical difficulties should arise we may: restart the computer/device, default to a different video platform, or utilize voice.
-Online therapy offers you to be comfortable in your own home. Feel free to grab some tea, and create a cozy environment. Remember the tissues just in case!
-Connecting with your therapist is a very critical component to therapy, and we will check in to ensure this is achieved.
-Be ready to do your best work!
-Just like in an office, there might be outside noises (i.e., dogs barking, kids playing, traffic).

Clients rights and responsibilities/Confidentiality

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.
1.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.

-In regards to mediation and arbitration regarding disputes about this agreement shall first be referred to mediation. The client and the therapist (I) will choose a neutral third party mediator and equally share the costs. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case or arbitration the arbitrator will determine the sum.(copy write Dr. Amber Lyda)

-Please note that communication portals, such as email, text, video chat, especially if not HIPPA compliant, has security limitations.
-Should I become unavailable due to an emergency, I may share your contact information with another therapist or an associate professional to help provide you with any information that is needed for your continuation of care.
-If we should see each other out and about, I will never disclose our therapeutic relationship since protecting your confidentiality is my top priority. I also am unable to accept social media requests to help protect your confidentiality.
-Dual relationships may occur and can be ethical and even unavoidable. To maintain ethics and confidentiality, the therapeutic relationship will uphold necessary boundaries.

-Emergencies: Should an emergency occur during our online session where you will need medical attention, please provide the address below where you will be doing your online session.

_____

_____

-If you are at a different address listed above, please make sure to let me know at the beginning of our session.

If an emergency should take place, please offer 2 emergency contacts that you give me permission to contact if I feel that it is necessary.

Name,relationship_____
Number_____
Name,relationship_____
Number_____

<u>Confidentiality and communication portals.</u>
-Please note that I will do my best to utilize secure portals of communication. Most portals of communication have risks and your confidentiality could be compromised. Please opt in for the best modes of communication for you with this understanding.

Email Y or N: Email address preferred_____ Initials_____
Text Y or N: text Number preferred_____ Initials_____

Voicemail Y or N: Number preferred_____ Initials_____

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.
-Please choose your billing option below:
____I will pay by credit card and understand my card will be kept on file for future sessions and or late cancellation charges.
____I prefer to place a check in the mail prior to my session(s).

I understand if my account is not kept current, my balance may be referred to an outside collection agency. Initials____

Reduced Fee
If you are on a reduced fee, I will honor the rate for 8 sessions, then we will re-evaluate and increase your treatment fee accordingly.
Reduced Fee _____ Initials _____

Counseling Fees
Initial Intake: $265 75min session
individual: $165 for a 45-50min session
Couples and Family: $185 for a 45-50min 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 and will be prorated if the time is less than 45minutes.
Please note that rates may increase due to inflation.

Other considerations to note:
-If you miss appointments and I am unable to contact you, I will assume treatment has ended.
-If you are inactive for more than 1month, I will assume treatment as ended.
-I do not offer emergency services or after hours care. I am a solo clinician. If you should need more care than I can offer, I will do my best to help find you the therapeutic recourses that may be more suitable for your needs.
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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 due to its difficult nature.
-I want to ensure the confidentiality of our services, therefore neither you or an attorney will ask me to testify in court or other similar situations. We also must agree that disclosure of treatment records will be requested.

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. Intitials_____

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 13) Date

_____ _____

Counselor Signature Date