Tanya Larson Therapy
Heartfelt Transformations

Office of Tanya Larson M.A., LMHC
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Disclosure of Information, Policies & Client Agreement of Tanya Larson M.A. LMHC

In accordance with the Washington Administrative Code and the revised Code of Washington, the following client disclosure Information is provided for the client and must be signed by both the client(s) and counselor. The client's signature indicates that she/he has read and understands the information.

I am a Licensed Mental Health Counselor (Credential # LH60736169).

EXPERIENCE AND METHODS: I earned my Masters of Arts in Psychology from LIOS Graduate College of Saybrook University. I also have a Bachelor's degree in Health Psychology and Human Biology from Bastyr University. I am a member of the American Counseling Association and Washington Mental Health Counselor's Association. My practice includes work with individuals of all ages, couples, and families; Emotionally Focused Couples Therapy (EFT), Gottman Method, Eye Movement Desentization and Reprocessing (EMDR), attachment issues, parenting issues, life transitions, trauma, depression, anxiety, relationship concerns, grief and loss. Systems focused, solution-focused, emotional freedom technique, emotionally focused therapy, Gottman Method, person centered, cognitive structural/behavioral therapy.

CLIENT RIGHTS: Per State law, to 1) be treated with respect and dignity, 2) develop a plan of care and service which meets your unique needs, 3) refuse any proposed treatment, consistent with the Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW, 4) receive care which does not discriminate against you and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation, 5) be free of any sexual exploitation or harassment, 6) review your case record, 7) confidentiality, as described in relevant statutes (chapters 70.02, 71.05, 71.34 RCW) and regulations (chapters 275-54 and 275-55 WAC and this chapter), and the Notice of Privacy Practices (see those pages separate from this document), and see paragraph below on confidentiality, and 8) file a grievance or lodge a complaint with the Department of Health (360-753-1761) or an ombudsman (800-531-0508)

CONFIDENTIALITY: CONFIDENTIALITY: See Notice of Privacy Practices. None of your health care information from counseling here is released to anyone without your written consent, exceptions being when child abuse or neglect or dependent adult abuse is suspected, when you threaten harm to yourself or another, or when records are subpoenaed by a court of law. Your use of insurance does require correspondence about dates seen, diagnosis, and sometimes treatment plan and progress. Other parties

you wish me to consult with about your case or to share your record with require a Release of Information to be signed by you.

APPOINTMENTS: Are 45 or 60 minutes long and together we will determine frequency. I require a 24-hour minimum notice for cancellation. Call 253-686-9421 to cancel. **You will be charged the full, 60-minute session fee for showing up too late, a too-late cancel, or a no-show**.
Text reminders will be sent as a courtesy. If a text reminder is not provided clients are still expected to attend the scheduled session.

EMERGENCIES:
I do not provide after-hours availability. If you are in crisis, you should go the emergency room or call the crisis line a 1-800-576-7764 (24 hours) or the Warm Line at 1-877-942-5655 (3PM to 11PM).

CLIENT RECORDS
I keep record of the health care services I provide. You may ask to see and copy that record. You may ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it by request. There will be a fee for the copying of the clinical file.
I ascribe and adhere to the Code of Ethics of the American Psychological Association and The American Counseling Association.

CONTACT
You may send an email to Tanya@TanyaLarsontherapy.com, leave me a voicemail or send a text message at (253) 686-9421 at any time. I will check those messages on a regular basis. You will not be charged for brief phone calls; however, after 10 minutes, you will be charged in 20-minute increments my normal rate if you want to continue. Please note that these forms of communication are not fully protected and if you do communicate by phone, text or email that you do so at the risk of your confidentiality. I will do my best to respond to your communication in a prompt manner. Please do not use these avenues to deliver important therapeutic information, as your session is the best place to deal with personal issues. Telephone and fax are confidential.

I do not accept or confirm clients as friends on social networking sites at this time in an effort to maintain confidentiality as far as possible.

RATES AND INSURANCE: Intake $140, Sessions $130 individuals, $130 Couples. Telephonic Sessions $130. Court testimony, driving time, waiting time, and preparation, including letters or evaluations for court are at a higher rate. Other (non-legal) letters are at the rate of $100/hour. Payment is due at the time of service, prior to the start of the session. Part of that may be covered by insurance. You are responsible for the deductible, co-pay and co-insurance (the difference after insurance pays) or the entire amount if insurance fails to pay). If you furnish the required information, insurance will be billed by my office as a courtesy to you (see Intake form, page one), but it will not cover late, cancellation, or no-show fees. If out of network, Tanya Larson will provide a super bill you can submit to your insurance for reimbursement. Please contact your insurance to determine out of network coverage.
Under your insurance, **the co-pay or cost share is estimated at** $_____ or _____%, and will be paid prior to each session. (If # is unknown, leave blank). I accept cash, credit, or check payable to Tanya Larson. Check with your insurance company to determine if you have a deductible to meet, and if you have a co-insurance or cost share amount. **If someone else brings your child to counseling, please have them bring the required cost share (co-pay/co-insurance/deductible**). You are responsible for the total

charges and any unpaid balance that insurance will not pay (provided no contract is breached). There is a $25 fee for all NSF checks. **Unpaid accounts will be turned over to bill collection after two attempts to collect**.

I UNDERSTAND THAT INSURANCE PAYMENTS WILL BE MADE DIRECTLY TO TANYA LARSON FOR SERVICES PROVIDED. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL OR PERSONAL INFORMATION NECESSARY TO PROCESS ALL INSURANCE CLAIMS, AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM ALL INSURANCE COMPANIES INVOLVED TO TANYA LARSON FOR MYSELF OR MY CHILD (under 13).
I UNDERSTAND THAT BECAUSE INSURANCE PLAN BENEFITS VARY AND INSURANCE COMPANIES SOMETIMES DO NOT QUOTE ACCURATELY, THE CO-PAY AND/OR COST SHARE IS INITIALLY CONSIDERED AN ESTIMATE UNTIL THE EXPLANATION OF BENEFITS ARRIVES, AND THERE MAY BE ADJUSTMENT NEEDED.
I UNDERSAND THAT TANYA LARSON CANNOT WAIVE A CO-PAY OR COST SHARE AND THAT CO-PAYS MUST BE RECEIVED AT THE TIME OF SERVICE.
I UNDERSTAND THAT NON-PAYMENT WILL RESULT IN BILL COLLECTION AND MAY ADVERSELY AFFECT MY CREDIT RATING.
I REALIZE THAT LATE CANCELLATIONS OR NO-SHOWS WILL INCUR A FEE EQUAL TO THE FULL AMOUNT CHARGED FOR THAT SERVICE AS EXPLAINED HEREIN.
I HAVE RECEIVED NOTICE OF AND UNDERSTAND MY RIGHTS AS A CLIENT AND THIS DISCLOSURE STATEMENT.
I CONSENT TO COUNSELING.

My signature below indicates that I have received a copy of this agreement.

_____ _____

Client Signature Date Tanya Larson, MA, LMHC Date

____Check here to indicate that you have received a copy of my Notice of Privacy Practices.