**Cassandra Kotlarchik PLLC**

Cassandra Kotlarchik, LMFT, IMFT, CEDS-S

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**THERAPEUTI DISCLOSURE AND POLICY STATEMENT**

*PLEASE READ AND SIGN*

These office policies are provided for your information. Please ask me if you have any questions. This document contains important information about my professional therapeutic services and business policies. Please read it carefully. Bring any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**Licenses and Certifications**

I am a Licensed Marriage and Family Therapist (License # LF60326174) and Approved Supervisor in Washington, a licensed Independent Marriage and Family Therapist in Ohio (License #F.2200282) and a Licensed Marriage and Family Therapist in Pennsylvania (License #MF001456). I am also a Certified Eating Disorder Specialist (Certification # 3948) and Approved Supervisor (#18-307) through The International Association of Eating Disorder Professionals. I have been working in the mental health field since 2009.

License verification can be found here:

Washington- https://fortress.wa.gov/doh/providercredentialsearch/

Ohio- <https://elicense.ohio.gov/oh_verifylicense>

Pennsylvania- https://www.dos.pa.gov/ProfessionalLicensing/VerifyaProfessional/Pages/default.aspx

**Education**

My education includes a Bachelor of Arts degree in Psychology from the University of Washington in 2008 and a Master of Science degree in Marriage and Family Therapy from Seattle Pacific University in 2010.

**Therapeutic Orientation and Services**

I work from a combination of different theoretical perspectives and will adjust according to your needs. I base my therapeutic work on a systems perspective and will encourage you to explore how family and other systems (social, cultural, religious, etc.) impact your life. I often incorporate Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Interpersonal Therapy, Acceptance and Commitment Therapy, Exposure and Response Prevention and family therapy into my work with clients.

When working with clients who are struggling with food, body and exercise issues, I take a Health at Every Size® approach. I strongly believe that focusing on finding health and balance in life, without focus on weight, is the only way to find freedom from food, body and exercise issues. Ultimately, I hope to support my clients toward eventually being intuitive eaters, with the support of a dietitian. For clients struggling with eating disorders, I recommend and sometimes require that they also meet with a dietitian and physician. I may recommend meeting with a psychiatrist as well. I am committed to collaborating with these providers to provide the best care for my clients. I will ask clients to sign releases of information for their other providers so I can communicate with them about treatment. I may recommend clients enter a higher level of care if their eating disorder is not managed well in outpatient treatment.

Occasionally, I may ask you to take tests or complete questionnaires in order to provide me with important information about your circumstances. You have the right to decline treatment at any point in time. There are potential emotional risks to engaging in therapy services. Personal issues may be painful and difficult to discuss. Change in your life may also cause discomfort. Sometimes symptoms become worse when you begin to explore underlying emotional struggles. Many clients find the potential benefits of therapy outweigh the potential risks; however, this is a personal decision you will have to make.

Therapy is an experience in which each person contributes. The effectiveness of therapy relies on your contribution. Your contribution and participation within therapy is voluntary and you may stop therapy at any point in time, refuse to participate in an activity, and/or request a referral to another therapist.

My job as your therapist is to provide support and guidance. You as the client are responsible for your own choices and decisions in life and have the responsibility of contributing to the therapeutic process through attendance at sessions and completing any assignments or homework given. For the most successful outcome, issues will need to be worked on at home as well as in therapy sessions. In the case of children, parents often need to make changes in their own behavior in order to help their child change. To achieve the best possible outcome for a child or adolescent, it is usually necessary for parents to take an active role so that positive changes may occur. This means that at different times therapy sessions may involve the parents alone, the child or adolescent alone, or the entire family together.

**Confidentiality and Records**

This office is compliant with the privacy rules of the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Please see my separate “Notice of Privacy Practices” for detailed information regarding how I will handle health care information collected about you in my practice.

For Washington clients who are under 13 years of age who are not emancipated, the law may allow parents to examine their child's mental health records. However, if therapy is to be effective, clients must feel secure that specific confidences will not be revealed to anyone, including parents. By Washington state law, any person who is 13 years or older has the right to consent to outpatient mental health treatment without parental consent. In addition, persons age 13 or older have the right to decide to whom mental health information will be released, including to parents, unless the health care information falls under one of the exceptions to confidentiality (see “Notice of Privacy Practices”). At the outset of treatment, I will clarify limits to confidentiality between a minor and his or her legal guardian.

For Ohio clients who are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if I feel that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that I will have to turn them over to, unless otherwise required by federal law. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Except in unusual circumstances, I like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child’s records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents’ knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor’s parent, or guardian. Only the minor is responsible for paying for services under this option.

Pennsylvania clients 14 years of age or older may consent to their own outpatient mental health evaluation or treatment. A parent or legal guardian of a minor less than 18 may consent to voluntary outpatient mental health evaluation or treatment on behalf of the minor. Neither the minor nor the parent/legal guardian has the right to remove consent given by the other party. For Pennsylvania clients under age 14, the law allows parents to examine their child's mental health records. However, if therapy is to be effective, clients must feel secure that specific confidences will not be revealed to anyone, including parents. When a parent or legal guardian has consented to the outpatient mental health evaluation or treatment of a minor 14-17, the law may allow records to be released to the parent/legal guardian and the minor. If the minor age 14-17 consented to evaluation or treatment without the parent/legal guardian’s consent, records cannot be released to the parent/legal guardian.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. By signing this form, you consent to allow me to do this. I will not tell you about these consultations unless I feel that it is important to our work together.

Client records will remain confidential unless I have your written permission or receive a court order from a judge or administrative agency. In the case of an emergency when I am unable to contact you or access your records (for example hospitalization of the therapist), the professional that has access to my confidential records is Krystal Davis, LMFT. Her contact number is (425)200-4005. If you have any questions, you may request a copy of your file at any time during the course of therapy. I will charge a fee allowed by law and will let you know what that fee is when you make the request. If I maintain your records in electronic format, you have the right to request them in that form. If you receive a copy of your file, it is your responsibility to keep that information confidential if you so wish. Per Federal Law, records will be retained for a period of seven years.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Please note that the confidentiality of email communication is not guaranteed to be secure, and I try to avoid this mode as much as possible. I use email communication for business activities including but not limited to: scheduling of appointments, communication with collateral contacts, and billing procedures. If you wish to not use email or wish to stop using email as a means of communication please request immediately and in writing to Cassandra Kotlarchik, LMFT, IMFT, CEDS during a session or at PO Box 1662 Bothell, WA 98041. If you do decide to utilize any form of electronic communication with me, because I cannot guarantee that those will be totally secure, you agree to accept the risk involved in the use of such communication formats.

If we see each other in public, I will not acknowledge you unless you initiate it. This is not to be rude or because I do not care about you. Your privacy is important and it is your choice whether you wish to interact with me in public. Keep in mind that if we do speak in public, anyone with us will likely ask how we know each other. Please be prepared for this if you choose to approach me in public.

**Exceptions to Confidentiality**

There are some situations when I am permitted or legally required to disclose information without either your consent or authorization which may include:

* If a government agency is requesting the information for health oversight activities.
* If you file a complaint or lawsuit against me, I am permitted to disclose information as relevant for my defense.
* If you file a worker’s compensation claim, and your psychotherapy is relevant to the injury involved in your claim, if properly requested, I must provide a copy of your record to your employer and the Department of Labor and Industries.
* If I have reasonable suspicion that a child, or in Ohio an animal, has suffered abuse or neglect, the law requires that I file a report with the appropriate government agency.
* If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency.
* If I have reason to believe you or someone else is in imminent danger, I may be required to take protective action, including notifying potential victims, contacting the police, seeking hospitalization for you, or contacting family members or others who can help provide for your protection.
* If you are using your insurance to pay for therapy services, I may need to share some information with them in order for them to cover your therapy and you agree to allow me to do that.

**Parents of Minor Clients**

Divorced or separated parents often seek therapy for their children to help them deal with the stress and adjustment to the changes they are experiencing. It is my policy, with rare exceptions, that both parentsof the child consent in writing to treatment and payment before the child is seen. I do not perform custody evaluations, and will serve solely as the child’s therapist. I will also ask for a copy of parenting plans for divorced or separated parents so that I am aware of any legal requirements that may relate to therapy.

**Couples**

If you are seeing me specifically for couples therapy, I will meet with you and your partner together. For couples therapy, I ask that each partner be open with their partner about communication with me. Secrets are not helpful for relationships and I do not want to keep secrets for one partner from the other. If you are concerned about your safety in your relationship, I will gladly speak to you confidentially and will recommend that you and your partner seek individual counseling before doing couples therapy.

If you are seeing me individually, we may decide to include your partner at certain times. In this case, you remain my client and your partner is participating in your therapy session. You will be asked to sign a statement in Ohio allowing a third party to enter a session and the third party will be informed they have no right to any part of the client session notes. In this case, I expect that we will have private conversations about your relationship. However, during couples sessions I will do my best to support you and your partner. I will not automatically side with you against your partner, since this would not help improve your relationship.

**Email Communication Agreement**

I understand that Cassandra Kotlarchik, LMFT, IMFT, CEDS will use reasonable means to protect the security and confidentiality of email sent and received. However, there are known and unknown risks that may affect the privacy of personal health care information when using email to communicate. These risks include, but are not limited to:

* Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by unintended recipients without my knowledge or agreement.
* Email may be sent to the wrong address by any sender or receiver.
* Email is easier to forge than handwritten or signed papers.
* Copies of email may exist even after the sender or the receiver has deleted his or her copy.
* Email service providers have a right to archive and inspect emails sent through their systems.
* Email can be intercepted, altered, forwarded, or used without detection or authorization.
* Email can spread computer viruses.
* Email delivery is not guaranteed.

By Signing below, you agree not to use email for emergencies or to send time sensitive information. It is also agreed that it is your responsibility to follow up with Cassandra Kotlarchik, LMFT, IMFT, CEDS if you have not received a response to an email within a reasonable time period. By signing below, you give permission for Cassandra Kotlarchik, LMFT, IMFT, CEDS to send email messages that include patient health care information and you acknowledge that you have read and understand the risks of using email as stated above. If you wish to not use email or wish to stop using email as a means of communication please request immediately and in writing to Cassandra Kotlarchik, LMFT, IMFT, CEDS in person or at PO box 1662 Bothell, WA 98041.

**Social Media Policy**

It is my policy that I do not interact with current or past clients via social media. If I receive requests from you on social media, I will not accept them. I will not reply to messages received via social media. It is important that we maintain a client/therapist relationship and connecting via social media can blur these boundaries. I will not look at your social media accounts, unless it is something you show me in the context of our therapy sessions.

**Contacting Me/Emergencies**

You may leave a voicemail message for me at 425.405.2837, 24 hours a day. I try to check my messages regularly and will make every effort to return your call within 48 hours (with the exception of weekends and holidays and other times when I am not available), but cannot guarantee that I can get back to you every time. If you are difficult to reach, please inform me of some times when you will be available. I only use text messaging related to scheduling. Please do not text any personal information or seek therapy support via text message.

If you cannot wait for me to return an urgent call, call a crisis line, go to the nearest emergency room, or dial 911 or call or text 988, the new suicide prevention hotline.If I am gone for an extended period of time, I will inform you ahead of time and discuss whether you would like referrals for other providers.

Crisis line phone numbers:

National- 988 Suicide and Crisis Lifeline- dial or text 988 or call 1-800-273-8255

Postpartum Depression - 1-800-773-6667 (1-800-PPD-MOMS)

Youth America Hotline - 1-877-968-8454 (1-877-YOUTHLINE)

WA- Crisis Connections 866-427-4747

OH- Ohio Careline 1-800-720-9616

PA- PA crisis text line- Text “PA” to 741741

**Availability**

I may take time off for holidays, vacations or illness. I will do my best to give you the most notice possible and discuss how you can receive support between our sessions. I will take off holidays and will remind you of this beforehand.

**Appointments and Cancellations**

Therapy appointments are typically 50 minutes long (53 if using insurance), but we may agree to have shorter or longer sessions, depending on the clinical issue. Your appointment time is set-aside exclusively for you, and I cannot fill that time slot without sufficient notice. To cancel an appointment, please provide at least 24 hours notice, or you will be billed the full hourly fee. If I typically bill your insurance and have a contractual relationship with them, I will charge you the full contracted amount for a session. Please note that insurance companies will not provide reimbursement for cancelled or missed sessions. If I do not typically bill your insurance, I will charge you the full out of pocket session amount. If you will be arriving late to an appointment, please call me as soon as possible so that I know you are coming and have not forgotten about the appointment. If you arrive late for an appointment, you will be billed the full fee for your session. If you are more than 10 minutes late for a session, you will need to reschedule. If we are able to reschedule during the same week, I will not charge you for the missed session, at least for the first time this happens.

I typically see clients once a week unless we have agreed to another arrangement. Your session time is reserved for you each week. If you regularly cancel or miss sessions, I may need to give your session time to another client. If cancellations are common, I will have a conversation with you before giving up your session time and if this continues, I may have to discontinue providing services to you.

**Professional Fees**

My current session fees range $150-250, depending on the length and type of the session. I have a limited number of sliding scale openings based on financial hardship.

In addition to weekly appointments, I charge $150.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation, document review or letter preparation, phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, I charge $200.00 per hour for these services. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist I cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

If you request records or ask for written reports, a fee of $0.25 per page will be charged for printing costs.

**Billing and Payments**

If you carry accepted insurance, I will bill your insurance company for your sessions. Co-pays will be due at the time of service. You will also be responsible for anything your insurance does not cover (this may include phone calls, charges for late cancellations or certain types of therapy, such as couples counseling). Please contact your insurance company to check your overall policy coverage. It is also your responsibility to contact your insurance company to obtain any pre-authorizations/ authorizations that are required in order for services to be covered by your insurance policy. After submitting claims to your insurance company, I will provide you with invoices for any additional costs that your insurance did not cover (including deductibles and uncovered services). Please make payments for all invoices within 30 days of receiving the invoice. If your insurance company pays for sessions you agree to assign any payments that they make to me.

If I am not a contracted provider with your insurance company, you will be expected to pay all fees at the time of service. You may contact your insurance company to inquire about out-of-network coverage. I am happy to provide you with superbills that you can submit to your insurance company for out-of-network claims.

Payment schedules for other professional services will be agreed to when they are requested. I accept cash, checks, credit cards and HSA/FSA cards.

**Delinquent Accounts**

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a client’s treatment is his/her name, the nature of services provided, and the amount due. I will make every effort to fully discuss it with you before taking any action. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, this is grounds for termination of services.

**Complaints**

I hope that we have an open and collaborative relationship. I encourage you to share with me if you are unhappy with any part of our work together. If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your Protected Health Information, you may send a written complaint to the appropriate state agency below. I will not in any way limit your care or take any actions against you if you file a complaint.

Washington State Department of Health:

https://doh.wa.gov/licenses-permits-and-certificates/file-complaint-about-provider-or-facility

Ohio Counselor, Social Worker and Marriage and Family Therapy Board:

https://cswmft.ohio.gov/for-the-public/file-a-complaint-elicense-portal

Pennsylvania Department of State Professional Compliance Office:

<https://www.dos.pa.gov/ProfessionalLicensing/FileaComplaint/Pages/default.aspx>

Secretary of the U.S. Department of Health and Human Services

www.hhs.gov/ocr/privacy/hipaa/compliants/.

**Therapeutic Disclosure and Policy Statement Signatures**

*Your signature below indicates that you have received a copy of this form, read the information in this document, understand and agree to abide by its terms during our professional relationship.*

I have read the above and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself (for individuals age 13 and older).

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): Cassandra Kotlarchik, LMFT, IMFT, CEDS-S

I have read the above and have had the opportunity to ask questions. I (parent or legal guardian of minor child under 18 years of age) give permission for evaluation and treatment for my minor child and state that I am the parent or legal guardian for the child.

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

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I am giving consent for communications via:**

Circle all that apply: email phone call/message text message

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_