Disclosure Statement

Michael Casey, LMHC

This statement provides you with my professional background to aid you in your decision of choosing a therapist. Please read each section carefully.

Confidentiality: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality.

Risks and Benefits: Therapy is intended to address complex challenges such as anxiety, depression, and trauma. It carries the risk of exposure to painful emotions that may be felt before the benefits of treatment. Each person's experience in therapy is unique and there is no certain timeframe of how long it takes to recover from any given symptom. Therapy is collaborative and it is important that you engage willingly and openly in the experience. In some cases, a referral by me to another provider may be necessary to address issues that I have been unable to help with. I promise that I will do my best to support you and help you reach your goals when you enter my care.

Appointments: Please notify me at least 48 hours in advance if you have any schedule conflicts or emergencies which would require you to cancel our appointment. You can reach me at michael@sleeptherapyseattle.com and leave me a voicemail at (425) 285-8191. Likewise, I will notify you via email or phone if I should need to cancel our appointment.

When you arrive for an appointment, please make yourself comfortable in the suite's waiting room. Our sessions will be about 50 minutes long (standard for therapy appointments), and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

Please note that you are responsible for the full session fee of $150.00 (this fee also applies if you are using insurance) if you miss an appointment without 48 hours notice of any cancellations. You will not be charged if I cancel our appointment or if you cancel the same day in the following circumstances: being ill or impaired by a health issue, a family emergency, or broader circumstances such as citywide road closures. Please be prepared to pay the full session fee from your appointment that was either missed or canceled late (without 48 hours notice) when you attend your next scheduled appointment. Also, please note that most insurance companies will not reimburse in any case for a late canceled or missed session.

Telehealth: I provide telehealth therapy, or therapy conducted remotely by video conferencing or phone call, in circumstances in which in-person therapy would not be feasible. These circumstances include being sick (you or myself), a public safety situation, and broad transportation closures (for instance due to snow). I believe that therapy is most effective when conducted in-person, and thus I reserve telehealth sessions to situations in which an in-person session would not be feasible. Please note that I will be charging no-show and late-cancellation fees as usual.

Insurance: Please provide full insurance information and your insurance card prior to your initial visit to determine eligibility for benefits and obtain authorization from your insurance provider when necessary prior to your first visit. If you have a change in insurance, please let me know as soon as possible. Any claims returned due to lapse in insurance coverage will become your responsibility.

Out-of-Pocket Fee for Services: My out-of-pocket standard fee is $150.00 per 50 minute session. This is the same fee charged for any missed or late canceled appointments, including those normally paid through insurance (as insurance does not cover such). Additional fees might include: preparation of requested documents, or copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services.

Payment for Services: I accept cash, credit and debit card, and personal check payments made payable to Michael Casey. Payments are due directly to me at the time of service (at the beginning or end of each session) unless we make arrangements otherwise. If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I reserve the right to charge a $30 fee for any returned checks.

Record-keeping: I keep records of sessions through encrypted electronic health record (EHR) software maintained by a third party (AdvancedMD and SimplePractice). Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording "what happens in a session." I make an effort to summarize what we discuss in each session (capture the essence), but I make no effort to record sessions verbatim. Washington State law requires the retention of records for seven years after last contact.

Emergency, Urgent, or Other Contacts: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within one business day. If you need to cancel or reschedule an appointment, please do so via phone or email at least 48 hours in advance. This is to ensure my ability to accommodate other clients and to maintain my workflow. Please also remember that anything you send over email is not confidential. If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or the Snohomish County crisis line at 800-584-3578 (the King County crisis line is 206-461-3222). The crisis line has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information. I am not able to provide on-call crisis or emergency services. If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.

Consultation: I sometimes consult with other licensed professionals who are bound to keep information about you confidential. I do not share your name and keep identifying information to the minimum required to address specific concerns I seek a separate professional opinion on.

Therapy Relationship and Professional Boundaries: It is my intention to maintain a relatively comfortable, safe, and professional environment where I consider your best interests my priority (safe enough to take risks). Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship.
2) You may place unsolicited reviews online about me if you wish (Yelp, Facebook, etc), though I do ask that if there is any critical feedback you have for me we instead discuss this in person. (It's actually a part of treatment in some cases.)
3) I will not, at any time, have sexual contact with you. This excludes handshakes, hugs, and the like, but only when or if you initiate. None of these are expected from you, though.
4) I will not, at any time, accept any gifts from you.
5) If I were to see you in public at any time, I will not initiate any contact with you. However, if you initiate I will respond in kind, but no further than you offer.
6) I will not have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. I will not provide services beyond my expertise, including legal or medical advisement.
7) I will only provide appropriate referrals to other health professionals with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other

non-healthcare related individuals and agencies. I do not accept payments for giving referrals. 8) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered “privileged.” Neither your death nor mine terminates your confidentiality rights.

Therapeutic Work, Duration, and Termination: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. I believe doing so is part of the healing process in therapy. When or if you would like to end therapy, I do ask that we first discuss this in person. If you do not contact me for 30 days I will assume you no longer wish to continue work together and I will close your file. In the best interest of your care, if I feel that your interests are outside of my expertise, I will provide a referral to an appropriate provider and potentially discontinue care.

Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Michael Casey, LMHC
17012 Aurora Ave N, Ste. 206
Shoreline, WA 98133
michael@sleeptherapyseattle.com
(425) 285-8191

I have received, read, and understand the Disclosure Statement. Any questions have been answered to my satisfaction and I accept the terms of the agreement.

_____
Client Name (please print)

_____ _____
Client Signature Date

This form will be retained in the mental health record.