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DISCLOSURE STATEMENT: THERAPY GUIDELINES AND POLICIES

Patient Name: _____

Address: _____

Phone #: _____

INTRODUCTION

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support necessary to overcome old patterns of thought, feelings, and behaviors. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you. This Disclosure Statement describes the details of our working relationship. After you have read this and have asked any questions pertaining to its contents please sign in the appropriate space on the last page. I will give you an initialed copy for your records.

REFERRAL SOURCE

The name of the person referring you to this office or the referral source:

May I thank this person for referring you? Yes () No ()

BACKGROUND AND EXPERIENCE

I am a Licensed Mental Health Counselor (LMHC), Credential #LH-60117655. I received my Law degree (J.D.) from Cornell Law School, a Master of Law degree (LL.M.) from the Judge Advocate General's School – Army, and I received my Master of Arts in Psychology (M.A.) from Seattle University. I have done extensive postgraduate

training in psychology through a series of courses, institutes, workshops and seminars. I am a member of the Center for Object Relations-Northwest Family Development Center, the Northwest Alliance for Psychoanalytic Study, and the Seattle Psychoanalytic Society & Institute. The most important aspect of any therapist's training is he own personal therapy. The reason for this is that a therapist can only take a patient as deep as he has been willing to go himself – I have spent several years in personal psychotherapy and/or psychoanalysis.

CLINICAL ORIENTATION

Psychoanalytic therapy is an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, developmental deficits, distortions of intrapsychic structures, and internal object relations. A psychoanalytic sensibility prefers to think of the mind and the body as an inseparable unity. It focuses on the subjective uniqueness of each patient and each patient's internal world while respecting the biological, environmental, evolutionary, and developmental precursors to each patient's subjectivity. Although grounded in the patient's personal history, it is future-oriented with the ongoing goals of creating meaning, development of both healthy relationships and autonomy, enhancing emotional and sexual intimacy, strengthening the will, developing a more powerful sense of agency, and maintaining an openness to creative possibilities – most especially including love.

During our work together, we may explore patterns of thoughts and feelings derived from your family of origin that impact your current life and relationships. Within the structure and support of the therapy relationship, these patterns become more apparent and conscious, and are thus more easily understood and changed. I like to view my role as collaborating with you to achieve a greater awareness of yourself, to develop more effective patterns of behavior, and to reduce undesirable or troubling emotions and interpersonal conflicts. Feel free at any time to ask me questions about my therapeutic approach and your progress.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time will be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether the pain of change is worth enduring. Not everyone can tolerate the very real difficulties involved in this work.

APPOINTMENTS

How frequently we meet will depend on a variety of factors and will be open to discussion. It is most common to meet once or twice a week. In many cases, three times a week is considered ideal. Only very rarely can meaningful work can be done with less than weekly sessions. Many patients benefit greatly from increasing the standard 50-minute hour to 100 minutes once or twice a week.

Once we decide to work together and find appointment times that are workable, these times will be consistently held for you. I have a 48 hour cancellation policy. If I receive telephonic notification of your intent to miss a session within 48 hours of your appointment you will not be charged. No notice or less than 48 hour notice will be charged. I will give you advance notice for my vacation times. You will not be charged for missed sessions caused by my absence. There is no charge for sessions which are canceled due to federal holidays.

Normally, you will be the one who decides when or how therapy will end, with three exceptions. First, if, in my judgment, I am not able to help you, because of the kind of problem you have or because my training and skills are not appropriate, I will inform you of this fact as soon as I discover it and refer you to another therapist who may be able to meet your needs. Second, if you do violence to me, threaten, verbally or physically to do violence to me, or if you verbally or physically harass me, I reserve the right to terminate you unilaterally and immediately from treatment. Third, after 30 days of non-payment of fees I will cancel further sessions and remove you from the active client list.

EMERGENCIES AND CONTACT INFORMATION

In case of an emergency during non-office hours, you may reach me through my office number: (206) 940-6732. I check for incoming calls several times a day. I return all calls daily. Additionally, the 24-hour Crisis Line is available at (206) 461- 3222. Recent changes in federal law have severely limited the use of email and other electronic, web-based communications between therapists and patients due to concern over security and confidentiality issues. If you need to reach me call my cell/office number. *I do not send or receive emails, text messages, twitters, or use other digital technologies to communicate with patients.*

CONFIDENTIALITY

Information revealed by you in the process of therapy is confidential. Neither the fact that you are in therapy nor the details of your therapy will be revealed without your written permission. Information concerning our professional relationship can only be released after you have signed a "Release of Confidential Information" form. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

This confidentiality has the following exceptions as provided by law:

1. In the event of a medical emergency, emergency personnel or services may be given necessary information.
2. In the event of a threat of harm to oneself or someone else, 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 suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.
4. If ordered by a judge or other judicial officers, information regarding your treatment must be disclosed.
5. If you bring a complaint against your therapist with the State of Washington Department of Health, information will be released to investigating authorities.
6. If records are subpoenaed by an attorney in the State of Washington, they will be released unless you file a Protection Order within 14 days of the subpoena.
7. In the event of a patient's death or disability, the information may be released if the patient's personal representative or the beneficiary of an insurance policy on the patient's life signs a release authorizing disclosure.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Any email I receive from you will be printed out and kept in your treatment record. I interpret the rules protecting your confidentiality quite strictly and, therefore, *I do not send emails, text messages, twitters, or use other digital technologies to communicate with patients. My cell phone cannot receive text messages, etc. It is set up to only receive calls and record voice mails.*

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me:

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

Finally, as part of providing quality services, I may consult with other professionals or receive supervision from a senior clinician. In such instances, identifying information is omitted.

THIRD PARTY COVERAGE

If you plan to use insurance or a managed care plan to cover all or part of your psychotherapy treatment, we should discuss some of the features of your plan or insurance which could compromise your experience of therapy. These factors could include caps or limits on reimbursement by your health plan, limitations on your treatment options that may be imposed by a third party management reviewer, lack of confidentiality of your therapy records, and indirect influences via incentives or guidelines placed on the therapist under contract with the plan to provide services. It is important that you are aware of these potential factors before the decision is made to seek authorization or reimbursement for services through a third party plan.

In order to accept insurance company claim forms, I would – by law – be working for (and responsible to) your insurance company first, with your interests secondary. I am dedicated to providing you with the best available integrated mental health services, instead of working for insurance companies. If I allowed myself to be limited to diagnoses and treatments “approved and covered” by insurance companies, I could not be nearly as effective for you. Therefore, I cannot accept payment directly from third parties. However, most insurance companies will reimburse clients for the expenses incurred by using out-of-network providers. If you wish to do this I will provide you with an invoice that will reflect your payments to me which you may use to seek such reimbursements. This does not change the basic nature of your financial responsibility for payment to me.

FEES AND PAYMENTS

The fee for an initial consultation and subsequent clinical work is \$125.00 per 50-minute session. 100 minute sessions, charged at \$250.00 each, may be clinically indicated and will be discussed with you if appropriate. It is very important for you that I be consistent about starting and stopping sessions on time. Approximately every two years my fees are adjusted and I will inform you in advance of any fee increase. The full fee is collected at the time of service unless we have made prior arrangements. I cannot accept barter for therapy. I do not take credit cards or Paypal, nor can I take DSHS medical coupons. Accounts 30 days past due will ***not*** be sent to collection. However, I would not be able to continue treatment with an account 30 days or more past due. The fee for work with couples is the same as for individuals with a preference for 100 minute sessions to accommodate both individuals' needs.

100 minute sessions, whether couples or individuals, will likely not be reimbursable by 3rd party providers in the full amount.

RECORD KEEPING

I keep very brief records, noting only your name, dates of service, the fee and a record of payments, a signed copy of this Disclosure Statement, presenting problems and diagnosis, the results of formal consultations, and progress notes. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy along with the fee arrangement in the record. A form for such a request is attached to this form. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time.. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else for five (5) years after the last session. After that time, all records will be securely destroyed.

RESPONSIBILITIES AND ETHICS

Effective psychological treatment requires a collaborative working arrangement between patient and therapist and a clear understanding of rights and responsibilities. For you, it means a commitment to invest time, money, and effort in working toward personal change. In order to meet your treatment goals, it is essential that you communicate honestly and participate actively in therapy. My responsibility is to do my best to provide psychological services tailored to your needs. I agree to utilize all of my experience and training to work with you to achieve your stated goals.

COMPLAINTS

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to:

Department of Health
Business and Professional Administration
PO Box 9012
Olympia, WA 98405-8001
(360) 753-1761.

You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential. You may, at any time, refuse treatment, request a change in therapy, or ask for a referral elsewhere.

PATIENT CARE DURING BREAKS IN TREATMENT

I am away from the office a few times in the year to attend professional meetings or to take a vacation. If I am not taking and responding to phone messages during those times I will have someone cover my practice. I will tell you well in advance of any anticipated lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between-session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 pm weekdays or over the weekend), please try to call me first. If I am unavailable, call the Crisis Clinic at (206) 461-3222. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

I have read and understand this disclosure statement. I have discussed my questions and have had my concerns addressed. I give my consent for treatment and therapy.

Client Name Printed

Client Signature

Client Name Printed

Client Signature

Therapist Signature

DATE _____

Request That No Treatment Records of My Therapy Be Kept

In accordance with the Washington Administrative Code (WAC) 246-809-035,

I, _____, request that no treatment records be kept of any session with my therapist, Donovan R. Bigelow, LMHC.

I understand that, in accordance with the above regulation, he must keep my name, the fee arrangement, record of payments, and the dates counseling was received. He must keep a copy of the Disclosure Statement and this written request in my file.

Signed: _____ Date: _____

Signed: _____ Date: _____
Donovan R. Bigelow, LMHC