

Stringer Counseling LLC
Office Policies & Client Treatment Agreement

Jay Stringer, M.Div, MA, LMHC

As part of our therapeutic relationship, I wish to make clear the rights and responsibilities we share. Please read the following information carefully, sign this copy as well as the signature blank on the information form, and keep this copy for yourself. Counselors are required by law to provide this information to their clients.

ADDRESS: 506 2nd Avenue, Suite 1400
Seattle, WA 98104
PHONE: (206) 465-8077

PROFESSIONAL QUALIFICATIONS: I have been doing psychological work with clients since 2008, when I began my clinical internship. I earned my Master of Arts in Counseling Psychology as well as a Master of Divinity from The Seattle School of Theology and Psychology) in 2009. I am a Licensed Mental Health Counselor in the State of Washington (LH60247880) and am regularly involved in continuing education to enhance and maintain my professional skill and understanding.

THERAPEUTIC ORIENTATION: I view the counseling process as forming a reparative relationship with you to explore the nature of your struggles. Although we will spend much time dealing with the specific issues that brought you into counseling, we will often look at the nature of your relationships with the significant people in your life as well. According to my counseling orientation, many of your struggles have their origin in relationships. I believe that you are made for meaning and relationships and that these are likely both the source of your greatest joys and your deepest problems. Thus, we will explore how your posture and habits in relationships interfere with the enjoyment for which you were created. This is meant to give you hope, that by dealing with the source of the problem we will find the power to see you through your present struggles. I believe that some symptoms have a physical component; in such cases, I'll refer you for medical consultation.

I am also an approved provider of EMDR (Eye Movement Desensitization and Reprocessing) Therapy and utilize it when it will help with trauma.

RESPONSIBILITY FOR CHOICE OF TREATMENT: It is your right and responsibility to decide whether to engage in any course of treatment with me and to decide whether the treatment is suitable for you. I encourage you to discuss with me what you wish to accomplish in our work together. Your goals and the means of treatment may be discussed at any time. You may terminate therapy at any time at your own discretion. I strongly encourage you to discuss your decision to end treatment as an important part of the therapy process.

DEPARTMENT OF HEALTH INFORMATION: For more information about health professions including psychologists, you can contact the Washington State Department of Health, PO BOX 47890, Olympia, Washington 98504-7890, (360) 236-4700.

FINANCIAL ARRANGEMENTS: It is important for our therapeutic relationship that we have clear financial agreements. My fee is \$150 for a 50-minute therapy or consultation session or \$240 for a 90-minute EMDR Therapy session. I accept cash or check for the amount due at the beginning of each session. Please write checks out to **Stringer Counseling LLC**. I will bill your health insurance if you desire, but it is your responsibility to work with your insurance company, and full payment for my services is your responsibility. Please become familiar with your plan coverage and be aware of any limitations. If you wish to have your insurance billed for sessions, please inform me and I'll give you an additional form for insurance information. Please feel free to discuss fees or payment options with me at any time. It is very important to protect our working relationship by keeping clear agreements and discussing any changes that may arise. In rare instances when a client fails to pay their bill I have found it necessary to send the account to a collection agency. In the case that a check is returned by your bank, you will be charged a \$25 insufficient funds fee. Periodically I raise my fees to adjust for increases in the cost of living and doing business, and I will give you one month's notice of any fee increase. Interest charges of 1% per month will be added to any account balance that is 60 days or more past due.

APPOINTMENTS: A session is usually 50 minutes in length. When a time period other than 50 minutes is agreed upon, the fee will be prorated accordingly. The frequency of our meetings will be arranged by mutual agreement. Since the time of your appointment is reserved exclusively for you, it is important for you to be on time. If you come late, you lose the time that you have missed. Please cooperate with me in maintaining the 50-minute time frame by writing your check before the session, and by being aware of the approaching end of the session. If you raise new topics and questions at the very end of a session we will be unable to address these in a satisfactory way. If you find it necessary to cancel your appointment for any reason, please give me at least 48 hours notice by calling my office anytime at (206) 465-8077. If you miss your appointment or cancel less than 48 hours in advance you will be charged the full fee for the time reserved. When you arrive for your appointment, please be seated in the waiting room and I will come get you when I am ready.

EMAIL POLICY: I prefer to use email only to arrange or modify appointments, and recommend that you do not use email to send content related to your therapy sessions. I cannot guarantee the confidentiality of email messages. I will include any email communications in your confidential treatment record. I may take a day or more to respond to emails, and any urgent matter should always be communicated by telephone rather than email. Email is not an appropriate method for you to reach me if you are in crisis. If you do choose to communicate with me by email, you are consenting to the limitations and risks involved in electronic communication. If you find at any point that you have a need to correspond with me by email, please discuss this with me in person so we can make appropriate arrangements.

CONFIDENTIALITY: All issues discussed in the course of therapy are strictly confidential. By law, information concerning treatment or evaluation may be released only with the consent of the person treated or such person's guardian. However, the law requires the release of confidential information in three situations: suspected abuse of a child, elder, or disabled person; imminent

suicidal behavior or threatened harm to another; and court ordered disclosure in legal proceedings. When providing for the welfare of minor children, the court may subpoena treatment records. The law also allows exchange of information between health care professionals who are currently treating you. I will discuss any release of confidential information with you. You are entitled to copies of your records under some circumstances. You may also request that no official case notes be kept. For your benefit, and for my own professional growth, I regularly seek consultation with other professionals regarding my work. I will carefully avoid disclosing your identity if I consult regarding my work with you. If you choose to have me bill your health insurance, information pertaining to your psychotherapy treatment may be released to your insurance company.

EMERGENCIES: You can reach my voice mail at (206) 465-8077 at any time. I make every effort to return daytime telephone calls on the same day I receive them, and evening, weekend, and holiday calls on the next business day. If you cannot reach me by telephone, and you are experiencing a crisis and feel that you cannot wait for me to return your call, you should contact the Crisis Clinic at (866) 427-4747, call 911, or immediately proceed to the nearest hospital emergency room. If I am out of town for an extended period of time and cannot receive calls, I will leave this information on my voice mail message. If you feel that you may need arrangements for additional sessions or help during a time of crisis, please let me know. For my vacations and other times I may be out of town for extended periods, I will make arrangements for you to have another therapist available during my absence if you let me know you want this. It is customary for me to take two 2-week vacations, usually one in winter and one in summer, and other shorter times away throughout the year.

CONSENT: I have read the above information and have received a copy of this information. I have clarified any questions I have and understand the information. I agree to the stated terms.

Signed: _____
Client

Date: _____

Signed: _____
Jay Stringer, LMHC

Date: _____