

Eliza S. Dietrichson, MSW, LICSW

Licensed Independent Clinical Social Worker - State of Washington LW00007750

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OUTPATIENT SERVICES AGREEMENT

Disclosure Statement and Informed Consent for Treatment

Washington State Law requires that I provide a written disclosure statement to each client prior to starting a program of treatment. This document provides important information about my professional services, business policies, education, psychotherapy approach as well as policies with regard to confidentiality, privacy, scheduling, fees and cancellations. Please read it carefully and write down any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

EDUCATION AND EXPERIENCE

I received a Masters of Social Work Degree at the University of Washington, School of Social Work in 2000. I completed a one-year clinical practicum training at the Veteran Affairs (VA) Hospital in Seattle, Washington in addictions treatment. I worked as a full-time psychiatric social worker at the VA for 14 years in both outpatient mental health and inpatient psychiatry. Prior to completing my master's degree, I worked in community mental health for 4 years. My undergraduate degree is in Philosophy. I have Certificate in Geriatric Mental Health from the University of Washington, School of Social work. I have a Certificate in Adult Psychoanalytic Psychotherapy from the Seattle Psychoanalytic Society and Institute (SPSI). I am a Licensed Independent Clinical Social Worker (LW00007750) in the State of Washington.

MY APPROACH TO PSYCHOTHERAPY

People choose to begin therapy for many different reasons. These may include life changes and transitions, relationships, identity issues, losses, living with chronic health conditions - all of which bring up a range of difficult feelings, moods and thoughts, such as depression, anxiety, anger and confusion. I draw from a number of theoretical approaches and have trained in a variety of therapies. My approach is best described as psychodynamic and relational, which means working in a conversational style and exploring not only what may be inside your awareness, but also those areas which may be unconscious or outside of your awareness. We all have issues and relationships from the past which influence how we live and relate to others. We often develop patterns that are no longer working for us and these can be challenging to change. I view the therapeutic relationship at the center of change and growth. I provide a professional and confidential setting where you can feel safe to explore painful feelings and conflicts. Together we can help you to find ways of making more conscious and balanced life choices.

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PSYCHOTHERAPY SERVICES

Psychotherapy is not easy to describe and the process varies for each person. I believe that the alliance between the therapist and the patient is the foundation of therapeutic change. Psychotherapy can have benefits and risks and frequently involves the exploration of difficult experiences which can bring up uncomfortable or unpleasant feelings.

Engaging in psychotherapy can lead to: improved relationships and work life, decreased suffering, greater self-awareness and richer life experiences. Exploration and change can take time and how long you remain in therapy will depend on your individual circumstances. You have the right to terminate therapy at any time and since termination is an important phase of psychotherapy, I will encourage a collaborative discussion about termination.

FEE INFORMATION AND PAYMENT POLICIES

Please have your payment ready at the beginning of each session; the therapy session time includes time for scheduling and payment. My Fees are:

Initial Intake appointment	\$170.00
Ongoing Sessions	\$160.00
Couple/Family	\$170.00

Sessions will be 50-55 minutes in length. I accept payment by cash or check, credit card.

APPOINTMENTS

We will agree on specific appointment times, reserved exclusively for our sessions together. Our mutual protection of this time is important in order to preserve the integrity of our ongoing work. I will give you notice well in advance of my vacation time whenever possible, usually at least 6 weeks. Please provide me a minimum of 2 weeks-notice about your vacations so that you will not be charged for missed appointments.

INSURANCE

I am currently a preferred provider for all plans managed by Regence BlueShield, Premera Blue Cross, Lifewise, Kaiser PPO, and First Choice Health. If I am not a preferred provider for your insurance plan, I may be able to see you as an out-of-network provider. I recommend checking with your insurance provider prior to services to ensure you have coverage for out-of-network psychotherapy. Please be advised that reimbursement eligibility is determined by your respective insurance company and I make no representations about whether provided services will be reimbursed by your insurance provider. If I am not a preferred provider for your plan, you will be responsible for payment of my full fee at the time of service. I am happy to provide a monthly invoice which you can present to your insurance company or flex plan for reimbursement.

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CANCELLATIONS AND MISSED APPOINTMENTS

I do not charge for occasional missed appointments when I am given *at least* 24-hour notice of the need to cancel an appointment. This policy is firm and applies even when you are sick or unable to attend your appointment due to work, traffic, snow, or circumstances outside of your control.

I charge my full fee in all other instances (without exception) when you miss your appointment or fail to provide at least 24-hours-notice. Please be aware that insurance does not cover missed appointments, so these same charges apply if you are using insurance.

Insurance plans only reimburse for the time you are in my office or on Telehealth, so if for any reason you need to cut the session short/arrive late, you may be charged for the time not covered by insurance should an audit occur.

TELEPHONE APPOINTMENTS

I am working fully remote and use a HIPAA compliant Telehealth Platform Doxy.me, or by phone. The Centers for Medicare have relaxed HIPAA laws to allow telehealth via FaceTime.

Please initial and date below confirming that you understand and agree to my policies regarding the cancellation of scheduled appointments:

Cancellation with less than 24-hours-notice:	\$160.00	_____pls initial	Date_____
Missed appointment with no notice:	\$160.00	_____pls initial	Date_____
Couple Therapy	\$170.00	_____pls initial	Date_____

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CONFIDENTIALITY

I am bound by my professional ethics to protect client rights to confidential communications in regard to their involvement in psychotherapy. For this reason, if you wish me to release information about your participation in therapy to anyone, I will require a signed "Release of Information" from you. This confidentiality has the following exceptions as provided by law:

1. In the event of a medical emergency, emergency personnel or service providers 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, elder or vulnerable adult 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 me with the State of Washington Department of Health, information will be released.
6. If records are subpoenaed by an attorney in the State of Washington, they will be released unless you file a protection order.
7. In the event of a client's death or disability, the information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
8. In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist **may** release that information to the appropriate authorities.
9. In the case of a minor client, information indicating the client was a victim of a crime **may** be released to the proper authorities.

Other exceptions to confidentiality include:

1. Disclosures and/or exchanges about your participation in therapy and/or coordination about your mental health treatment made at your request, by this psychotherapist, or by a third party, which will require a Release of Information signed by you. We will discuss the necessity for the requested disclosure before I request you to sign a "Release of Information" in which you acknowledge your agreement and authorization for me to make such disclosures and/or exchanges of information.
2. Information necessary for supervision and/or consultation.
3. Release of information outlined in the HIPAA Notice of Privacy Practice, a copy of which will be provided to you.

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**ACKNOWLEDGEMENT OF RECEIPT OF
OUTPATIENT SERVICES AGREEMENT, DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT**

By my signature below I, _____, acknowledge that I received a copy of Outpatient Services Agreement, Disclosure statement and Consent for treatment.

Signature of Client

Date

Signature of LICSW

Date

This form will be retained in your medical record.