
Disclosure Statement

Education and Training: I graduated with highest distinction from the University of North Carolina at Chapel Hill with a Bachelor of Arts in Education in 1995. In the five years following, I worked in North Carolina as a middle school educator, specializing in English and history. During that time, I was a founding teacher of a charter school that served at-risk students. I went on to complete my Masters of Arts in Counseling from Western Seminary (now currently Mars Hill Graduate School) in Seattle, WA. Upon graduation in 2002, I had 500 hours of practicum and supervision experience and completed an internship working with sexual abuse victims where I led groups and counseled individuals. Since that time, I have accrued over 3,000 hours of supervised clinical work in order to become a licensed mental health counselor in the state of Washington. In addition, I have taken training in EMDR, Lifespan Integration and the Emotional Regulation Skills portion of DBT. Most recently, I completed a 100 hour class on Clinical Theory and Practice and have been trained as a clinical supervisor. I currently am the clinical supervisor for Seattle Therapy Alliance, a low-fee counseling agency for women, which I co-founded. I continue to increase my learning through continuing education classes and peer consultation. My license number is LH00010813.

Clientele, Services, and Techniques: My training is in a broad range of areas, but I concentrate in the following: sexual trauma, PTSD, eating disorders, self-harm, depression, anxiety, identity development, life transitions and relationship problems. I also have experience with career counseling, addiction, couples counseling, grief work, and personality disorders. I work with women, men and adolescents.

My technique is grounded in psychodynamic theory, including relational psychoanalysis, existential, family systems, interpersonal and object relations. I believe working with the problem requires addressing the complexities that the problem presents in relationships. Relationships can be a source of great joy as well as a place of intense pain. Part of our work will be to examine how your style of relating inhibits you from the utmost satisfaction in your current relationships. We will explore your problem and focus on finding its source and solution. We will take the insight gained about your past and apply it to the present with the mutual goal of restoring hope in you and bringing freedom in your life. We will do so through the mode of conversation and with the use of other tools as deemed helpful or necessary. Some problems result in physical conditions and medical consultation may be advised.

I believe body, mind and soul are connected, and when one part of you suffers, all areas in your life are affected. Your health and happiness are important to me. I am dedicated to working through the entire therapeutic process with you.

Payment and Scheduling Policy: The fee for my counseling services is \$115 per 50 minute session. Payments are to be made at the beginning of each session unless other arrangements are made. Once your counseling time is established, it is expected that you are responsible for payment of that time, including any missed or cancelled appointments. I will do my best to offer an alternative session if you cannot make your scheduled time. You will not be charged for vacations and other planned absences. Frequent schedule changes result in disruptive work and are discouraged. If you do not schedule for four consecutive weeks, I will assume you are

terminating your work with me. I take vacation a few times a year and observe major holidays. I will inform you in advance of my time away from the office.

I do not file insurance claims for you. If your provider is covering any or all of the costs, then you need to make arrangements to be directly reimbursed. You are responsible for filling out any paperwork. My payment should not be affected. I will fill out any necessary parts as indicated by your insurance company and provide you a monthly bill with the required information for reimbursement.

Confidentiality: There is a legal privilege in this state that protects any information that you share with me and requires me to keep the strictest of confidentiality (See HIPAA consent form). As a professional, I assure you that I maintain strong ethical standards of confidentiality.

There are legal exceptions to this confidentiality. The following situations are ones in which the information you have shared with me may be given to others: (1) suspected abuse of a child, developmentally disabled person, or a dependent adult; (2) potential suicidal behavior; (3) threatened harm to another, which may include knowledge that the client is HIV positive when there is an unwillingness to inform individuals with whom the client is intimately involved; and (4) when required by court order. Information may also be disclosed if a client signs a written release authorizing said disclosure or in the event that a complaint is filed by the client against the counselor. If insurance is sought, confidentiality is waived. No records will be released without written permission on a Release of Information Form or a Court Order.

Consultations: I regularly consult with other professionals and supervisors to gain further knowledge and skill on how to help my clients. Such discussions are done so in a way to maintain confidentiality.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

State Information: Counselors practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is: (A) to provide protection for public health and safety; and (B) to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Unprofessional Conduct: The state brochure called “Counseling or Hypnotherapy Clients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the address and phone number on the following page.

State Contact Information: Department of Health

Counselor Programs
P.O. Box 47869
Olympia, WA 98505-7869
(360) 664-9098

Contacting Me by Phone, Text or Email: You may send an email to julie@juliecake.com, leave me a voicemail or send a text message at (206) 920-1448 at any time. I will check those messages on a regular basis. You will not be charged for brief phone calls; however, after 10 minutes, you will be charged in 20 minute increments my normal rate if you want to continue. Please note that these forms of communication are not fully protected and if you do communicate by phone, text or email that you do so at the risk of your confidentiality. I will do my best to respond to your communication in a prompt manner. Please do not use these avenues to deliver important therapeutic information as your session is the best place to deal with personal issues.

Emergencies: If you are in a general emergency and cannot reach me, then please call one of the following numbers for help:

General Emergencies:	911	
Care Crisis Response Service:	(800) 584-3578	(425) 258-4357
Crisis Clinic:	(800) 244-5767	(206) 461-3222

I have read and understand the information presented in this form.

Client Signature

Date

Client Signature

Date

Therapist

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction to Clients

This notice will tell you about how I handle information about you and your child. It tells how I use this information in my office, how I share it with other professionals and organizations, and how you can see it. I am required to tell you about this because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In most situations I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law or HIPAA. Clients who are 13 or older must sign the written authorization form.

Your Medical Information

Each time you or your child visit me information is collected about you or your child's physical or mental health. It may be information about you or your child's past, present or future health or condition, the treatment or services received, or about payment for health care. This information is called PHI, which stands for Protected Health Information. The information I obtain from you or your child goes into your or your child's medical record at my office. It is likely to include the following:

- Your or your child's personal history
- Reasons you or your child came for treatment: problems, symptoms, needs, goals
- Diagnoses: medical terms for you or your child's problems, symptoms, disabilities
- Treatment Plan: services that I think will help you or your child
- Progress Notes
- Records from others who treated or evaluated you or your child
- Psychological test scores, school records, and the like
- Information about medications you or your child are taking
- Legal matters
- Billing and insurance information

Medical information is used for many purposes. For example I may use it to:

- Plan your child's care
- Decide how well my treatment is working for you
- Talk with other health care professionals who are also treating you or your child, such as your family doctor or the professional who referred you to me
- Show that you actually received the services from me that I billed to you or your health insurance company

How Protected Health Information Can Be Used and Shared

When you or your child's information is read by me or others, it is called "use." If the information is shared with or sent to others outside this office, it is called "disclosure." Except in some special circumstances, when I use you or your child's PHI or disclose it to others, I share only the minimum necessary PHI needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed.

Use or disclosure of the following protected health information does not require your consent of authorization:

1. Uses and disclosures required by law-like *files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence-like *the duties to warn explained in the Disclosure Statement*
3. Uses and disclosures for health and oversight activities-like *correcting records or correcting records already disclosed*

4. Uses and disclosures for judicial and administrative proceedings-*like a case where you are claiming malpractice or breach of ethics*
5. Uses and disclosures of law enforcement purposes-*like if you intend to harm someone else*
6. Uses and disclosures to avert a serious threat to health or safety-*like calling Probate Court for a commitment hearing*
7. Uses and disclosures for Worker's Compensation-*like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim*

Your Rights as a Patient under HIPAA

1. As a client, you have the right to see your file, unless it would endanger your health or another person's health or safety. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.*
2. As a client, you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies a fee for a treatment summary may apply.
3. As a client, you have the right to request amendments to your counseling/therapy file
4. As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees @ \$.20 a page as well as a fee for my time.
5. As a client, you have the right to restrict the use and disclosure of your PHI for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
6. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement. It will be necessary for you to sign a certificate indicating that you have received, read and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement. I will be happy to explain these documents further.

In summary, HIPAA and Washington State law provide you with certain rights regarding your clinical record and disclosure of protected health information about you. These rights include:

- requesting that I amend your record
- requesting restrictions on what information from your clinical record is disclosed to others
- requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized
- determining the location to which protected information disclosures are sent
- having any complaints you make about my policies and procedures recorded in your records
- receipt of a copy of this Notice of Privacy Practices form

I acknowledge that I have received and read the ***Professional Disclosure Statement*** and the ***HIPAA Client's Rights***. I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the ***Professional Disclosure Statement*** and the ***HIPAA Client's Rights***.

Printed name of Client

Signature of Client

Date

Parent Signature

Date