Leslie Vriesman, M.S., LMFTA

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Informed Consent & Disclosure Statement

Welcome. This form will provide you with information about our work together in therapy. It covers your rights as a client, my therapeutic practice, my responsibilities as your therapist and our financial agreement. If you have any questions or concerns about anything in this document please do not hesitate to speak with me about it. Thank you.

Education and Training:
I earned my Masters of Science degree in Marriage and Family Therapy from Seattle Pacific University, where I received training from a family systems perspective. Therefore much of my experience pertains to children, adolescents, adults, couples and families. In addition I have post-graduate training in Functional Analytic Psychotherapy, Adlerian Psychology and Gottman Couple's therapy. Serving my clients to the best of my abilities is profoundly important to me, therefore I continue to take advantage of ongoing therapeutic learning and participate in various consultation groups. I am currently practicing as a Licensed Marriage and Family Therapist Associate (LMFTA), license number MG60636980 in Washington State under the supervision of Thomas C. Saunders, Licensed Clinical Social Worker (LICSW), Washington State license number LW00005060 and Douglas R. Hansen, Licensed Clinical Social Worker (LICSW), Washington State license number LW 00005052. In addition, I am a member of the American Association of Marriage and Family Therapists (AAMFT) and the Washington Association of Marriage and Family Therapy (WAMFT).

Treatment Orientation:
The focus of therapy depends upon your needs therefore therapy is a collaborative effort and exchange. I emphasize the relational aspect of therapy, meaning the relationship and trust between us is vital for growth and change to occur. I utilize a family systems perspective which means I pay close attention to the relational dynamics within your family of origin. I also utilize cognitive and behavioral strategies as needed as well as providing recommended readings and at times homework to supplement our work together.

Course of Treatment:
As each client coming to therapy does so for unique reasons, your course of treatment will be dependent upon your needs. Length of therapy varies and will be assessed throughout your course of treatment. Effective change requires you and/or your partner or family to actively participate in therapy. To this end, honesty and openness are greatly important to our work together. I will make every reasonable effort to create a secure environment, relationally and in terms of protecting your privacy, in our work together. Because I want to be sure that you find our work together to be helpful and effective, I will be checking in periodically to see how you and/or your partner or family are experiencing our time together.

Your Rights as a Client:
1. You have the right to be informed about your treatment. If you have any questions regarding your treatment, feel free to ask me.
2. You have the right to terminate therapy at any time. I may provide a referral should you want or need to see another therapist.
3. You have the right to contact the Department of Health for your protection and assistance.

The Department of Health's phone number is (360)664-9098.

Confidentiality:
Please be aware that I am obligated to protect your safety as well as access to your confidential information. Confidential information refers to any information about you, including demographic information, that may identify you or be used to identify you and that relates to your past, present or future physical or mental health/condition.

Please understand there are some exclusions to confidentiality. I am legally obligated to release confidential information **without** your written permission in the following situations:

1. If I receive a court order to share information with a lawyer or judge.
2. If you give me information that you are likely to hurt yourself or another person.
3. If I receive information that a child, teenager or dependent adult is being neglected or abused.
4. If an involuntary commitment for mental health assessment is needed.
5. If you waive your privilege by bringing charges against me.

As a therapist under supervision, I am required to consult with my supervisors regarding my cases, this is for both my benefit and yours. In addition, I often consult with other professionals, as they provide valuable feedback, which will enhance your therapy and ensure that you are receiving the best care I can offer. In consultation, any personal identifying data will not be shared. Please be aware that these professionals are also obligated to confidentiality.

All other disclosures of your confidential information will require your written authorization.

In my work with couples, I hold a no secrets policy, meaning I will not keep information private for an individual within the couple. Thus, all information shared with me by either partner is open for discussion with both partners present. This allows for trust and openness, which is necessary in our work together and keeps me as your therapist working on behalf of the couple rather than a particular individual. Please ask if you have any questions on my no secrets policy.

Appointments, Scheduling and Fees:
Appointments may be scheduled in person or by calling (206) 802-9070. If you have scheduled an appointment and you need to cancel, I ask that you cancel at least 24 hours before your appointment. If you do not cancel 24 hours before your appointment, and/or you do not show up for your appointment, you will be charged in full for that session. It is your personal responsibility. Failure to pay an account within 60 days may result in a transfer to a collections agency.

My fee is $100 for a 50 minute session and $150 for an 80 minute session.

Fees for counseling are to be paid at the end of each counseling session via cash, check or credit card. If you choose to pay by credit card, there is an additional processing fee of $3 on 50 minute sessions and $4 on 80 minute sessions. If you have two unpaid sessions, you will not be able to schedule additional sessions until your balance has been paid in full. I do not accept any type of health insurance. However, I can provide an invoice for you to file independently for possible reimbursement. Please check with your insurance provider regarding your mental health benefits to see if you have out-of-network benefits and will qualify for any type of reimbursement.

In Case of an Emergency:
In the case that you need to contact me regarding a mental health emergency, call my cellular phone 206-902-0870. If you cannot reach me, please call the Crisis Clinic at 206-461-3222 or dial 911.

Complaints
If you believe I have violated your privacy rights, you may file a complaint with the Secretary of the Department of Health and Human Services. To obtain a copy of your rights as a client in the state of Washington, as well as a list of the acts of unprofessional conduct in my field for which a health profession complaint may be processed, contact the Department of Health – Counselor Programs, PO Box 47869, Olympia, WA, 98504, (360) 664-9098 or www.doh.wa.gov

Counselors practicing counseling for a fee must be registered or certified 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 (WAC 246-81-031).

Consent for Treatment:
I have read and understand the informed consent. I voluntarily consent to treatment as outlined above with Leslie Vriesman, M.S., LMFTA and I understand that I may terminate treatment at any time. I understand that information shared within therapy is confidential, except as listed above and stated in the statutes of Washington State. I understand that if I have any complaint or grievance regarding my treatment, I may file a complaint. I understand and agree to the above financial agreement.

_____ Date_____
Signature of Client

_____ Date_____
Signature of Client

_____ Date_____
Signature of Client

_____ Date_____
Leslie Vriesman, M.S., LMFTA

Note: Client signature required for client 13 or older and for Parent of client 12 or younger and/or parent involved in counseling services.