THERAPEUTIC SERVICE AGREEMENT

Clinician Disclosure Statement

Cossette D. Ahlborn, MA LMHC
Therapist
Washington State Certification: LH 00007516

Philosophy of Treatment:

As your therapist, my goals for your therapy are to empower you to overcome any personal obstacles in order for you to improve your quality of life. I believe the therapeutic relationship that is co-created between therapist and client is a significant portion of the transformative aspect of therapy. I believe you will find that my being present and compassionate with you will make a significant difference. My approaches to helping you achieve your goals in therapy include EMDR, Cognitive Behavioral Therapy, and Solution Focused Therapy.

Course of Treatment:

Treatment & goals begin with you, the client, and your commitment to the process of therapy as a shared responsibility with me, your therapist.
The course of treatment begins with the intake session. In this session, we discuss the issues that bring you to therapy and establish your therapeutic goals. During the intake, an assessment occurs; the assessment is an ongoing process that determines if a therapeutic diagnosis is necessary. Treatment length varies based on your goals and rate of progress. Treatment is discontinued when goals have been achieved and/or when you chose to discontinue services.

A Treatment Update is provide upon your request, when significant changes occur or every ten sessions and is used to evaluate progress, goals, and plan future services.

Fee for Service Agreement:

Cancelation of a scheduled session:

I require 24 hours advance notice for the cancelation of a scheduled appointment/session. Failure to cancel in accordance to the policy will result in a $50 charge for the appointment.

Session Length, Fees, and Billing:
The initial session (Intake Session) is 60 minutes and billed at a rate of $150.00 - $200.00.

A standard therapy session lasts approximately 50 minutes and billed at $ 100.00 - $150.00.

To extend a therapy session the client and therapist must agree.
If the client initiates an extension of the therapy session, the client *shall incur* additional fees and/or charges at the billing rate per the financial contract.

Fees are due on the date of service and will be collected by the therapist.
Fees for client extended sessions are rounded up to every 15min.
If you arrive late to your appointment, the session will end at the standard session time to ensure the clinical schedule is maintained. In addition, you will be required to pay the full fee for the session.

Checks that are returned to as Non-Sufficient Funds (NSF) will have a $50 return fee; the session(s) will be considered delinquent and subject to third party collection. If in the event, there are multiple NSF's this will be considered an attempt to defraud and may result in the following: loss of the payment option, the loss of a reduced fee, and/or legal action to recover the outstanding balance.

Financial Hardship Request
If in the event there is an inability to pay the session fee, the fee enters repayment status and the client agrees to pay the fee in full prior to the next therapy session. If the client is unable to pay the full fee prior to the next appointment, the client agrees to pay 25% of the fee over the following four therapy sessions in addition to paying the current session fees. No more than one session may be in repayment status at a time.

Case Management: I am happy to work with other professionals on your behalf to assist you achieve your goals of therapy. This may include, but not limited to, working with your medical provider, report writing, phone calls, and/or correspondence with other professionals. Case Management is billed at $1/minute

If there is an outstanding balance at the conclusion of therapeutic services, the client agrees to make payment arrangements to repay the remainder balance. If the balance remains outstanding beyond 30 days, the balance will/may be transferred to a third party agency for the purpose of collection.

Financial Policy
Your fee is expected at the time of service. You are responsible for your bill. I do not carry month to month balances.

Crisis:
My services do not include crisis services. If you are in need of crisis services/therapy, you, the client, agree to ***call 911*** or **Crisis lines (24-hour):**

1 (800) 273-8255
National Suicide Prevention Lifeline

Pierce County Crisis Line
Phone: (253) 396-5180 or 1 (800) 576-7764

King County Crisis Line
Phone: (206) 461-3222 or 1 (800) 244-5767

Thurston and Mason County
Phone: 360-586-2800

Kitsap County
Bremerton Crisis Clinic Kitsap Mental Health
Phone: (360) 479-3033 or 1-800-843-4793.

If during the course of therapy a crisis occurs, the client may be referred to Pierce County Services in order to manage the crisis to ensure the safety and well-being of the client.

Litigation:
Cossette D. Ahlborn, MA LMHC, does not, nor will not, participate in legal actions for the purposes of child custody and/or divorce proceedings; this includes testimony and/or release of records for the purpose of such legal action in accordance with state law.

If any party of this agreement, and/or their representative, takes action(s) to involve Cossette D. Ahlborn, MA LMHC, in legal actions, the initiating party, and/or their representative, agree to pay the following fees, for each individual and/or separate action such as, but not limited to, testimony, depositions, declarations, written and/or oral reports.
- 8 hours of billing at the fee of $200.00 per hour;

- Any and all travel related expenses
- A litigation fee of $1500
- Any and all fees for the purpose of legal representation
- If Cossette D Ahlborn, MA LMHC, is subpoenaed and/or required by judicial action, for any purpose of litigation, each signing party, of legal age involved in the legal action, will pay a litigation fee and equally share the cost of billing hours

Failure to pay fees, by any signing party and/or their representative, in full and in advance of such action will constitute an outstanding balance. Any outstanding balance will be referred to a collection service for the purpose of collections.

If legal action is taken against Cossette D. Ahlborn MA LMHC, I will utilize any and/or all resources, to include a counter suit, to defend and/or protect assets and/or personnel, under the law; this may include disclosure of confidential information in accordance with state and federal law.

Oversight & Consultation

As therapeutic practice, I participate with a Consultation & Supervision group. This group consists of a several colleagues to collaborate on cases, ethics, and therapeutic needs/issues for my clients. Your privacy remains a high priority; during such meetings, your anonymity is maintained in the discussion of your case; no identifiable nformation is given to the group.

Confidentiality

Confidentiality and Anonymity are important to providing a safe therapeutic relationship; your privacy is important to me and I take great efforts to ensure confidentiality & anonymity are maintained to protect your privacy. There are several situations that I am mandated by law to breach confidentiality and/or anonymity, those are: (a) if you threaten to harm and/or kill yourself and/or another person, or, (b) you provide information regarding physical abuse, sexual abuse, or neglect of a child or dependent adult, or, (c) if a judge and/or commissioner of a court of law issues a court order.

Clients Rights

You, the client is not liable for any fees for services prior to the receipt of this disclosure statement. In addition, you are free to terminate services with Cossette D. Ahlborn, MA LMHC, at any time without penalty of incurred cost other than those already accrued.
You the client is entitled to:

- Full disclosure regarding services, fees, projected duration of treatment, information about therapeutic techniques, and/or therapist qualifications.
- End therapy at anytime without financial liability other than that already incurred.
- Request in writing copies of the clinical record in accordance with state law and appropriate release authorization.
- Request your therapist to work with other professionals when it is clinically appropriate and you have provided written authorization.
- Request referral to another therapist to transfer services without cost and/or repercussions.
- Full confidentiality and anonymity; there are situations that confidentiality and/or anonymity can be violated without client authorization. These situations are: (a) if you threaten to harm and/or kill yourself and/or another person, or, (b) you provide information regarding physical abuse, sexual abuse, or neglect of a child or dependent adult, or, (c) if a judge and/or commissioner of a court of law issues a court order.

Unprofessional Conduct: The brochure "What to Expect from you Licensed Mental Health Counselors" provides information about Code of Ethics which can be found at the following Website address http://www.doh.wa.gov and can also be found on this website. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at:
Department of Health Customer Service Center Programs:
E-Mail: hpqa.csc@doh.wa.gov
P.O. Box 47869, Olympia, WA 98504-7869, (360) 236-4700 or (360) 236-4818

Consent to Participate in Therapy Services

I grant permission for therapy, testing, and/or diagnostic assessment that is/may be necessary for my process of treatment. While working toward my/our therapeutic goals, I am aware that participating in therapy has the potential to create/increase my emotional, cognitive, behavioral and/or relational distress.

I understand that treatment results are not guaranteed due to the multiple variables that influence the process of therapy and therapy outcomes.

I understand there are differences between treatment philosophies of counselors, therapists, psychologists, and/or psychiatrists and my signature declares I do agree to participate in therapy and can terminate therapeutic services at any time.

I understand my rights of confidentiality and anonymity; I grant permission for my therapist to participate in Supervision & Consultation as necessary for my benefit.

I understand that the case file has one Identified Client exclusively for the purpose of record keeping and all participating members are considered clients; as such are granted the same rights and/or responsibilities of this agreement. The Identified Client is the person who initiated contact for services with Cossette D. Ahlborn, MA LMHC. Unless otherwise requested by participating clients.

The term client refers to the individual person, the couple, the family, and/or the group system that attend therapy services together.

Signature(s):

Family members who will be participating in therapy must provide a signature. This includes children 13 years & older.

In signing this document, you are acknowledging:

- I have and will provide information accurately to the best of my experience and knowledge;
- I have thoroughly read and agree to the Therapeutic Agreement of Cossette D. Ahlborn, MA LMHC.
- I have full understanding of my Client Rights and Responsibilities and have been provided information about how to access the Department of Health brochure “What to Expect from you Licensed Mental Health Counselors” and a copy of the Therapeutic Agreement.
- I have thoroughly read and agree to the section of Consent to Participate in Therapy Services, and agree to participate in therapeutic services with Cossette D. Ahlborn, MA LMHC.

Client Signature: _____Date: _____

Client Signature: _____Date: _____

Clinician Signature: _____Date: _____