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Dear New Client,

Thank you for choosing Vital Mind Solutions, PLLC. This form includes my disclosure statement which provides information you will need to begin counseling services.

My ***Disclosure Statement and Informed Consent Form*** describes:

- (a) how I conduct therapy;
- (b) my education and training;
- (c) fees for therapy services;
- (d) appointment scheduling guidelines;
- (e) your client rights and responsibilities;
- (f) my responsibilities as your therapist and a mandated reporter;
- (g) confidentiality in therapy; and
- (h) how therapy is initiated and terminated.

I have additional forms that I require you read, fill out and initial and/or sign as indicated on each form. The ***New Client Form*** provides me your contact and billing information, and your reasons for seeking therapy. You will also be provided a copy of my ***Notice of Privacy Practices***. Please read, sign, initial and date all the forms where indicated. If you are scheduled for couples therapy, both you and your partner should individually complete the ***New Client Form*** and each sign, initial and date at the bottom of each page of other documents where indicated.

Please feel free to contact me with any questions.

I look forward to meeting you.

Sincerely,
Michelle Barenchi, MA, LMFTA

PROFESSIONAL DISCLOSURE STATEMENT & INFORMED CONSENT

Philosophy and Approach

As a licensed marriage and family therapist associate (License #MG 60622152) my approach to therapy with individuals and couples is tailored specifically to the needs and goals of each person. I believe the therapy process to be a collaborative effort, working together to identify clear goals and taking steps to make positive changes.

I provide therapy services to individuals to address concerns surrounding depression, anxiety, anger and self-esteem as well as personal growth, relationship enhancement and life and career transition. Couples therapy often centers around improvement of relationship quality, communication skills, resolution of infidelity and consideration of divorce. The duration of treatment varies, based on presenting problems, goals for therapy and the client's own dedication to change.

Education

Master of Arts in Psychology Couple & Family Therapy Concentration	Antioch University Seattle	2015
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Bachelor of Arts in Social Science Psychology Concentration	Washington State University	2012 <i>summa cum laude</i>
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Experience

I am licensed in the State of Washington as a marriage and family therapist associate. My education, training, and life experience have prepared me to counsel individuals of all age, ability, ethnicity, race, religion/spiritual backgrounds, gender identity, and sexual orientation. I am a member of the American Association of Marriage and Family Therapy (AAMFT), and continue to seek education and training that will benefit my clients.

Informed Consent

Counseling is understood to be a choice you have made among available options such as (a) other counselors; (b) other therapies; (c) support groups; (d) self-help resources; and (e) other modes of treatment. Counseling can have benefits and risks. Counseling sometimes involves discussing unpleasant aspects of your life, and you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has been shown to have many benefits. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of emotional distress. Some clients require only a few sessions to achieve their goals, while others benefit from long-term counseling. You have the right to terminate counseling at any time; however, it is understood that premature termination may result in the return or worsening of the initial problems and symptoms.

I encourage you to talk with me directly if you are dissatisfied with my services, want a second opinion or referral, or if you are intending to discontinue appointments. If I am not able to resolve your concerns, you have the right to file a complaint with the Department of Health.

Confidentiality

I am providing you with a copy of my *Notice of Privacy Practices* which describes how I may use and disclose your health information. In this document I will highlight some of those disclosures: (1) to report suspected abuse of a child, of a developmentally disabled person, or of a dependent adult; (2) to interrupt potential suicidal behavior; (3) to intervene against threatened harm to another (which may include knowledge that a client is HIV positive but is unwilling to inform others with whom he/she is intimately involved); and (4) when required by court order or other compulsory process.

_____, _____ (Initial and Date Here)

Confidentiality extends to all members involved in therapy. This means I will not release to any third party any information prior to obtaining a signed **Release of Information** from each member. Additionally, I am not bound by confidentiality in joint sessions with information I have obtained in individual sessions. Thus, I reserve the right to discuss in joint sessions the information you share in the individual sessions, if I believe doing so will facilitate the identified outcomes and goals of therapy.

Disclosures may also be made if (a) you sign a written authorization permitting disclosure; (b) you file a complaint against me; (c) you make payment by check or credit card, which permits bank employees to view names of my clients; (d) you have caller identification on your phone and my name appears on the monitor; and if (d) a contracted third-party agent contacts you by mail or phone to receive payment for a balance due that exceeds 90 days.

As a licensed marriage and family therapist associate, I engage in ongoing supervision with Dr. Tina Schermer-Sellers, PhD LMFT (License# LF00001387) and peer consultations with other professional therapists. I consult with other therapists regarding my cases because I believe our collective knowledge may help me provide you the best counseling services possible. I do not disclose names or details that would allow identification of my clients during these processes.

Professional Boundaries

I refrain from entering into a dual relationship with any of my clients. This means the therapeutic relationship is a professional one, not a social or business relationship. Once a therapeutic relationship is established, any other relationship would potentially compromise the efficacy and the outcome plan for therapy. Therefore, I will not acknowledge the existence of a relationship with my clients outside of the therapy session.

Appointment Times and Fees

Daytime and evening appointments are available. The first intake session may require 90 minute, followed typically with 50-minute or 80-minute sessions once per week.

Initial 20 Minute Non-Consultation.....Free
Individual Therapy

50 Minute Session.....\$100

80 Minute Session.....\$135

Couples Therapy

50 Minute Session.....\$110

80 Minute Session.....\$145

Family Therapy (more than two people in session)

50 Minute Session.....\$120

80 Minute Session.....\$155

Pre-Marital/Pre-Union Counseling

50 Minute Session.....\$100

Discounted packages available, inquire from Michelle Barenchi, MA LMFTA

_____, _____ (Initial and Date Here)

I have a limited number of sliding scale appointments available for those with financial hardships. Please contact me directly to discuss your options.

24 hours' notice is required when rescheduling appointments to avoid a \$100 charge. Missed appointments are charged at \$100.

I do not do work concerning legal proceedings; however, time spent in any way on legal proceedings is billed at two hundred fifty dollars (\$250) per hour.

Scheduling Appointments and After-Hours Contact

Please call 206-475-7837 or use my website's scheduler at www.VitalMindSolutions.com to schedule an appointment. I see clients on Monday – Friday from 8AM-7PM, Saturday appointments can be arranged but my available hours on Saturdays fluctuates. My hours of operation may adjust without notification; however, I will attempt to keep you informed in advance of any changes in my schedule. If you wish to speak to me between appointments, please leave a message at 206-475-7837. I check my voicemail regularly during normal business hours. If you are experiencing a clinical emergency, contact 911 or the Crisis Clinic at 206.461.3222.

I will do my best to keep all communications private. However, I cannot guarantee that the contents of electronic communication will remain confidential as email usage can be monitored and others may read the content of personal messages. If you are concerned about the content of your email being read by someone other than me, you should contact me by phone. While I check my email often during regular office hours, I may not receive your message immediately. Therefore, please do not send email you consider urgent and expect an immediate reply.

Vacations

I will give reasonable notice before taking vacation leave. When I am unavailable, a colleague will be on call for emergencies. The name and phone number of this individual will be on my office phone. If you anticipate continuing treatment during this time, I will help you make arrangements with another therapist in advance. If you are experiencing an emergency and are unable to contact my on-call therapists, please contact 911 or King County Mental Health Services, 206.461.3222

Record Keeping

I keep very brief records for each therapy session including:

1. Date of service;
2. Client's name;
3. Fee arrangement and record of payment;
4. Disclosure form, signed by the client and me;
5. Presenting problem(s), purpose or diagnosis;
6. Notation of formal consults, including information obtained from other persons or agencies through a release of information;
7. Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy I use.

If you prefer that I keep no treatment records, you must submit a written request to that effect. Once received, I will place your request in your file and retain only the following records: Your name and signed disclosure statement, the session date and fee for service.

Client Rights

As a client in therapy, you have specific rights in addition to the right of confidentiality. These rights include:

- The right to ask me questions about my qualifications and experience;
- The right to ask questions about any procedures I use in therapy with you;

_____, _____ (Initial and Date Here)

- The right to refuse a particular treatment method or testing;
- The right to discuss your therapeutic progress and treatment goals;
- The right to refuse any psychological testing I recommend;
- The right to request referral to another therapist;
- The right to terminate or suspend therapy at any time without my permission or agreement;
- The right to file a complaint with the Washington State Department of Health if you believe I have behaved in an unprofessional or unethical manner and decide that a resolution to the problem cannot be reached.

Please see the Department of Health Brochure, *Counseling or Hypnotherapy Clients* for information regarding how to file a complaint. You also have specific rights pertaining to how I maintain personal information about you and your health (please review the *Notice of Privacy Practices*).

Terminating Treatment

My goal is to assist you in obtaining your desired therapeutic outcomes. If you have any questions or concerns about any aspect of your therapy, please discuss them with me. If you elect to terminate or suspend treatment, please discuss your decision with me so that we can bring sufficient closure to our work together. In our final session we can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge you have gained through your therapy. We can also discuss any referrals that you may require at that time.

Independent Practice

I conduct my counseling as an independent practitioner. Although I operate my practice individually, I share a common waiting room with other independent businesses.

By signing below, each of us confirms this document to represent the agreement between us, and that you have read, understood and received copies of this disclosure along with a copy of *Notice of Privacy Practices* and the Department of Health Brochure, *Counseling or Hypnotherapy Clients*.

Client or Parent/Guardian _____

Date _____

Client or Parent/Guardian _____

Date _____

_____, _____ (Initial and Date Here)