John Faust, M.A.
Licensed Mental Health Counselor

Terms of Service / Counselor Disclosure Statement

Welcome to my practice. Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

Approach to Therapy:
Selecting a therapist involves obtaining important information about them. Please review my **Profile** form which details useful information regarding my Professional Education and Background, Areas of Specialty, Treatment Philosophy, Licensure, and Certifications.

While most people find therapy to be beneficial, the process of therapy may at times be uncomfortable. New emotions, thoughts and memories may be experienced; changes to beliefs, behaviors and even relationships can occur in order to meet the goals you wish to achieve. Understanding these risks is an important part of consenting to therapy. If ever you or I feel that our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area. You also have the right to refuse treatment.

Therapists practicing for a fee must be registered or certified with the Department of Health for protection of public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

Our Relationship:
Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the sessions you have with me. Please do not invite me to social gatherings, contact me via social networking, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

Confidentiality and Privacy:
You have the right to a confidential relationship with a few exceptions as required by law. During couples or family therapy, I may meet with one of you individually for one or more sessions, or for part of a session. Anything we discuss may be disclosed to those not present, if in my best judgment, doing so is necessary to effectively help your relationship.

Minors age 13 or older may without permission from a parent or guardian consent to mental health treatment, and they have the right to a confidential relationship with a therapist. This means the parent or guardian will not be notified they are in treatment or given any information about sessions without the minors' consent. Serious threats of harm to self or others, however, will not be kept confidential, and steps will be taken to ensure safety of child. This may include notifying the parent or guardian.

Confidentiality and exceptions are defined in our **Notice of Practices Regarding Protected Health Information** document. By initialing below, I acknowledge I have read and understood the information provided on this form.

____ **Initial here to acknowledge receipt**

Billing Information:
Billing practices are explained in detail on a separate **Billing Practices / Financial Agreement** form. By initialing below, I acknowledge that that the Financially Responsible Party (e.g. self or parent) has read and understood the information provided on this form.

____	**Initial here**

Attendance:
Attending scheduled appointments is critical to the success of therapy. Repeatedly missing appointments can be detrimental to the therapy process, and potentially costly if no show fees accumulate. If missing scheduled appointments becomes a concern, I will initiate a conversation about how to remain engaged in services.

Peer Review:
Bayside Therapy Associates is a consultative group of experienced therapists. Good clinical practice requires occasional peer review and consultation within this group. Please be aware that your case may be clinically reviewed in this setting. Also be assured that your personal identity information will be disguised and held to the same confidentiality laws followed by any of our therapists attending consultation.

Emergencies:
If there is an urgent question or concern between sessions, I can be reached by phone at (**360)734.7310 ext. 4417**. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If you are unable to reach me when you feel the need for emergency help, Bayside Therapy Associates also has a **24-hour on-call therapist,** who is either myself or one of our Bayside providers, and can be reached by calling our answering service at **(360) 715-2533**. There is no charge for on-call contacts less than 10 minutes; for calls over 10 minutes you may be charged at the usual hourly rate. In the case of a life-threatening emergency, there is a 24-hour on call crisis line at **1-800-584-3578**, or please call **911**. You may also go to the nearest hospital's **Emergency Department.**

Relationship To Bayside:
I am an independent private practitioner, as well as partner/owner of Bayside Therapy Associates, who provides billing and administrative services. We share on-call coverage and provide clinical consultation for each other in order to provide you with the best possible service.

Complaints:
If at any time, for any reason, you are dissatisfied with my services, please let me know. If I am not able to resolve your concern, you may report your complaint to Department of Health, Health Professions Quality Assurance Division, P.O. Box 47869, Olympia, WA 98504, or call (360) 236-4902.

Treatment Consent:
By signing below, I consent to mental health therapy with John Faust, M.A. I have been informed of the type of therapy I will receive from John Faust, M.A. the methods and techniques used, his education, training and experience on his **Profile** form. I also attest that I have read, understood, and agreed to all information and policies on the **Terms of Service/Disclosure Statement**, **Billing Practices/Financial Agreement**, and **Notice of Privacy Practices** forms. I have received my own copies of these forms. I also give Bayside Therapy Associates and John Faust, M.A. permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

Client's Signature/Printed Name	**John Faust, M.A.**
Date	**Date**