Lisa Jungclas, Ph.D.
Licensed Clinical Psychologist
Bayside Therapy Associates, PLLC

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 on the Bayside Therapy website 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. I believe in fostering a safe, non- judgmental environment where you can feel comfortable to examine the challenges you are currently facing in your life.

You have the right to choose a counselor who best suits your needs and purposes and 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. Additionally, you have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6). And, 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 when your partner is or family member(s) are not present may be disclosed to them, if, in my best judgment, doing so is necessary to effectively help your relationship. 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_____

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 to acknowledge_____

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. At that time, I may request that an attendance contract be discussed and signed.

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**. 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, please call 988 or 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 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 and have been informed of the type of therapy I will receive, the methods and techniques used, education, training and experience from the Bayside Therapy website. I had the opportunity to read, understand, and agree to all information and policies on the **Terms of Service/Disclosure Statement**, **Billing Practices/Financial Agreement**, and **Notice of Privacy Practices** forms. I have been offered my own copies of these forms. I also give my provider and Bayside Therapy Associates permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

_____ _____

Signature of Client/Responsible Party **Signature of Provider**

_____ _____

Date **Date**

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