Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105

NEW CLIENT INFORMATION FORM: CHILD & ADOLESCENT

BACKGROUND INFORMATION **DATE** _____

Client's Name: _____ DOB: _____ Gender: _____

Client's Address: _____

Client's Home Phone: _____ Client's Cell Phone: _____

Parent 1 Name: _____ Cell Phone: _____

Parent 2 Name: _____ Cell Phone: _____

Child lives with: _____

If parents are divorced, describe custody arrangements and structure around medical decision making:_____

_____

_____

Emergency Contact Person (other than parent): _____

Emergency Contact Phone: _____

CLIENT EDUCATION INFORMATION

Current Grade: _____

Name of School: _____

School Address: _____

Name of School Counselor: _____

Problems in School? _____

_____

□ IEP/504 plan?:_____ □ Special Education Services:_____

□ Advanced Placement:

May I contact your current teacher/school staff □ yes □ no

CLIENT MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____)_____

Address: _____ City: _____ Zip: _____

Is your child currently receiving medical treatment? □ Yes □ No

If Yes, Please Specify: _____

List any medical conditions, serious illnesses, allergies or injuries that your child has been diagnosed with or treated for:_____

_____

Previous counseling/therapy? No Yes When? _____

With whom and for how long? _____

Current Medications:	Dosage:	Taking for:

Child Developmental History

- Pregnancy and Delivery

Prenatal Illness, Complications During Birth, or Healthcare Concerns	
Was the Child Premature?	
Weight/Height at Birth	

- First few months of life

Breast-fed? □ Yes □ No	If so for how long?
Sleep Patterns/Problems:	
Personality:	

- Milestones: At what age did your child do each of these?

Sat without support:	Crawled:
Walked without holding on:	Ate with a fork:
Stayed Dry all day:	Stayed Dry all Night:
Was completely toilet trained:	Helped when being dressed:
Dressed self completely:	

- Speech and Language Development

Age when child said 1st word understandable by strangers	
Age when child said first sentence understandable to a stranger	
Any speech, hearing, or language difficulties?	

- Any residential, institutional, or foster care placements?

Dates: From/To	Program Name	Reason for Placement	Problems/Outcomes

Client strengths, talents, and interests:

PARENT 1 INFORMATION

Name: _____ Age: _____ Gender: _____

Relationship to Child: _____

Employer: _____ Occupation: _____

Average Hours Worked per Week: _____Annual Salary: _____

Can you be contacted at work? No Yes Work Phone: _____

Are you currently receiving medical treatment? No Yes

Describe any health issues that require ongoing care: _____

_____

Previous counseling/therapy? No Yes When? _____

With whom and for how long? _____

PARENT 2 INFORMATION

Name: _____ Age: _____ Gender: _____

Relationship to Child: _____

Employer: _____ Occupation: _____

Average Hours Worked per Week: _____Annual Salary: _____

Can you be contacted at work? No Yes Work Phone: _____

Are you currently receiving medical treatment? No Yes

Describe any health issues that require ongoing care: _____

_____

Previous counseling/therapy? No Yes When? _____

With whom and for how long? _____

FAMILY INFORMATION

Does/has anyone in your family had problems with drug or alcohol addiction? □ Yes □ No

If so, who/when: _____

Has anyone in your family (including family friends) attempted or completed suicide? □ Yes □ No

If so, who/when: _____

Has anyone in your family been diagnosed with a mental illness? □ Yes □ No

If so, who/when: _____

Does your family regularly attend a place of worship? □ Yes □ No

If Yes, Where: _____

How important are spiritual matters to you/your family? □ Not at all □ Somewhat □ Very much

Would you like your spiritual/religious beliefs to be included in your child's counseling? □ Yes □ No

List any additional members of your household:

Name:	Gender:	Current Age:	Relationship to Client:

_____

_____

_____

_____

PRESENTING ISSUES

Please tell me why you are seeking counseling for your child: _____

_____

_____

_____

How long have these concerns been causing you distress? _____

Please check the boxes below if you've had concerns with any of the following in your child:

Aggressiveness	□ Past □ Present	Hearing Noises/Voices	□ Past □ Present
Alcohol Abuse	□ Past □ Present	Hopelessness	□ Past □ Present
Anger	□ Past □ Present	Hyperactivity	□ Past □ Present
Anxiety	□ Past □ Present	Impulsive Behavior	□ Past □ Present
Apathy	□ Past □ Present	Interrupts	□ Past □ Present
Arguing	□ Past □ Present	Irresponsibility	□ Past □ Present
Bad Dreams	□ Past □ Present	Irritability	□ Past □ Present
Behavior Problems	□ Past □ Present	Life Transitions	□ Past □ Present
Bossy	□ Past □ Present	Loneliness	□ Past □ Present
Bullied	□ Past □ Present	Making Decisions	□ Past □ Present
Cries Easily	□ Past □ Present	Memory	□ Past □ Present
Change in Appetite/Weight	□ Past □ Present	Moody	□ Past □ Present
Compulsivity	□ Past □ Present	Nervousness	□ Past □ Present
Concentration/Attention	□ Past □ Present	Non-Compliance	□ Past □ Present
Defiant	□ Past □ Present	Pain	□ Past □ Present
Depression	□ Past □ Present	Panic	□ Past □ Present
Destructive	□ Past □ Present	Physical Abuse	□ Past □ Present
Deteriorating Grades	□ Past □ Present	Racing Thoughts	□ Past □ Present
Difficulty Breathing	□ Past □ Present	Rapid Heart Rate	□ Past □ Present
Digestive Upset	□ Past □ Present	School Performance	□ Past □ Present
Dizziness	□ Past □ Present	Serious Illness	□ Past □ Present
Drug Abuse	□ Past □ Present	Sexual Abuse	□ Past □ Present
Eating Problems	□ Past □ Present	Sexualized Behaviors	□ Past □ Present
Emotional Instability	□ Past □ Present	Sleep Trouble/Nightmares	□ Past □ Present
Fatigue	□ Past □ Present	Social Anxiety	□ Past □ Present
Fears	□ Past □ Present	Tics	□ Past □ Present
Fidgets	□ Past □ Present	Trauma	□ Past □ Present
Fighting	□ Past □ Present	Trouble Relaxing	□ Past □ Present
Finances	□ Past □ Present	Unhappiness	□ Past □ Present

Fire Setting	□ Past □ Present	Unwanted Thoughts	□ Past □ Present
Grief/Loss	□ Past □ Present	Verbal Abuse	□ Past □ Present
Guilt	□ Past □ Present	Weakness	□ Past □ Present
Hallucinations	□ Past □ Present	Wetting/Soiling	□ Past □ Present
Headaches	□ Past □ Present	Withdraws/Isolates	□ Past □ Present

Has your child expressed currently having suicidal thoughts? □ Yes □ No

Has your child had suicidal thoughts in the past? □ Yes □ No

Has your child ever attempted suicide? □ Yes □ No

If Yes, when and how: _____

Is there anything else you want to share about your child or your family? _____

_____

_____

Who referred you to me? _____

May I have your permission to thank this person for the referral? □ Yes □ No

INSURANCE

Provider: _____

Policy Number: _____

Subscriber's Name/Date of Birth: _____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my child's personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105
meghanwhitlockcounseling.com

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or "PHI"). I must follow the privacy practices described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal and State of Washington law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in supervision with and consultation so that I may provide high quality services for your benefit. My Supervisor is Paula Best, her contact information is available upon request.

2. Health care operations: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing or credentialing activities. I will notify you in advance of any such disclosure.

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.

e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.

f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national

security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization:

1. Marketing communications: I will not use your health information for marketing communications without your written authorization.

2. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I-A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, to your attorney, or to your health care providers. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.

B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer," as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. It is my obligation to you to inform you if there are any unauthorized releases of your PHI by me. If a breach of your PHI has been made I will explain the possible scope of the disclosure, the risks associated, and the steps I have taken/will take to deal with the breach.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement," based upon your proposed amendment, must be added to your record.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Meghan Whitlock, MA LMHC, by telephone at (206) 707-5105, or in writing at 3417 Evanston Avenue N Suite 212, Seattle WA 98103. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360) 236-4900, P.O. Box 47869, Olympia, WA 98504. I will not retaliate against you if you file a complaint with me or the Department of Health.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on 8/1/18.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will inform you, and you may obtain any revised notice by contacting me.

Acknowledgement of Receipt of Notice of Privacy Practices

Meghan Whitlock, MA LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Meghan Whitlock, MA LMHC.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of Meghan Whitlock, MA LMHC with respect to my protected health information.

_____ _____
Signature of Client Date

This form will be retained in the mental health record.

* * * FOR OFFICE USE ONLY * * *

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the Acknowledgment
□ An emergency situation prevented me from obtaining Acknowledgment
□ Other: _____

_____

THERAPIST DISCLOSURE STATEMENT,
CHILD & ADOLESCENT CLIENT INFORMED CONSENT,
AND PARENTAL CONSENT FOR THE TREATMENT OF A MINOR

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105
meghanwhitlockcounseling.com

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following information is provided to you. Please read each section carefully, and initial at the bottom of each page.

Washington State Law states the age at which a person may consent to counseling/ psychotherapy is 13; *however, it is my policy to provide your parent(s) or legal guardian(s) all of the information below, and obtain their consent as well*. It is my belief that the more informed and 'on board' they are, the more benefit you can potentially gain from participating in therapy.

I. THERAPIST DISCLOSURE TO CLIENT AND LEGAL GUARDIAN(S)

- **Credentials**: I am a Licensed Mental Health Counselor in Washington State (#LH60436315)
- **Education, Training, and Experience:** I received a Bachelor of Arts in Psychology from the University of Montana, with a minor in Human and Family Development. I completed my Master of Arts in in Applied Psychology at Seattle University. I completed my internship hours at Compass Health working with individuals, children and families, and couples. After graduation, I worked as the lead therapist for an Intensive Special Learning Program and in outpatient settings with children and families. I have had experience with children, adolescents, adults, and families in various accredited agencies since 2005.
- **Professional Memberships:** I am a member of the Seattle Counselors Association, Washington Association for Play Therapy, Seattle Play=Peace Pop-Up Adventure Play, and the American Mental Health Counselors Association.
- **Services Provided:** I provide psychotherapy for individuals (children and adults), families, and couples.

II. INFORMATION FOR THE ADOLESCENT CLIENT

- Confidentiality: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

• You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I may take steps to inform a

parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
• You tell me you plan to cause serious harm or death to someone else and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I may inform your parent or guardian, and I may inform the person who you intend to harm.
• You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
• You tell me you are being neglected or abused (physically, sexually or emotionally) or that you have been abused in the past. In this situation, I am required by law to report the abuse to Child Protective Services.
• You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality; if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian the specific things you share with me in our therapy sessions. This includes activities and behavior that your parents would not approve of or would be upset by, but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. *If I feel that you are in such danger, I must communicate this information to your parent or guardian*.

- Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you were a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian.
- Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of a hypothetical situation, like "If someone told you that they were doing ___, would you tell their parents?"

Even if I have agreed to keep information confidential (to not tell your parent or guardian), I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to talk to your parent/guardian and will help you find the best way to tell them. Also, when speaking to your parents, I may describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

■ Health Care Coordination: It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, you should get a physical examination from a physician as soon as possible.

In certain circumstances, it is essential that I have the ability to collaborate with your medical doctors: for instance, if you are being prescribed psychiatric medication, or if you have a diagnosed eating disorder such as anorexia or bulimia. With your written authorization, I can work with your medical provider to begin to coordinate your health care.

■ Risks and Benefits: Most adolescents who decide to participate in therapy are experiencing problems that cause internal distress and problems in relationships. Counseling is intended to help you resolve problems, but sometimes as you get to the root of some issues, you may feel them even more strongly than in the past.

During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your problem areas and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

Teenagers in therapy often benefit from having a support system, including family, friends, a supportive school environment, and in some cases, religious affiliations. Expressive activities, such as music, art, sports/exercise, art, writing/journaling, or participating in extra-curricular activities are also important for the mental health of adolescents. Other types of treatment such as family therapy, group therapy, 12-step groups, support groups, and/or medication may be helpful. Part of our work together will involve the creation and maintenance of a support system for you.

■ Appointments and Cancellations: We will schedule our appointments either via phone or in person at the end of a session. It is likely that your parent(s) or guardian(s) will make and pay for appointments on your behalf, but understand that you are ultimately responsible for attending your appointments.

Please notify me via phone, at (206) 707-5105, as soon as possible if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Likewise, I will notify you via phone if I should need to cancel our appointment.

When you arrive for an appointment, please remain in the waiting room and I will promptly meet you. Our sessions will be 45-50 minutes long, and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

I will have to charge you the full session fee if you do not give me 24 hours notice of any cancellations. You will not be charged if I cancel our appointment. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment.

■ Emergency, Urgent, or Other Contacts: You may call me anytime and leave me a voicemail message. I retrieve messages daily, and whenever possible, I will get back to you within 24 hours. You may also email me with your message; however, if you need to cancel an appointment within 48 hours of the scheduled time, I need to be contacted via phone, either by you or a parent or guardian. Please remember that anything you send over email is not confidential.

I am not able to provide on-call crisis or emergency services. If you have a physically or psychologically life-threatening emergency, please immediately call 911, your parents, and/or the Seattle Crisis Clinic at (206) 461-3222. The Crisis Clinic has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information.

■ Therapy Relationship and Professional Boundaries: It is my intention to maintain a warm, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship; this includes contact on social networking sites, like Facebook. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.
2) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting.

3) I will not, at any time, accept any gifts from you. I may accept a card or note from you.
4) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate visible or audible greeting, I will reciprocate, but I will not attempt further communication unless you request it.
5) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any social media, business, and financial relationships with you or your parents. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.
6) I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to non-healthcare or wellness-related individuals and agencies. I do not accept payments for giving referrals.
7) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

■ Therapeutic Work, Duration, and Termination: If you are 13 years or older, you are legally able to give your consent for therapy in Washington State, you have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may also withdraw from therapy at any time. I respect and promote your right to make your own decisions. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. If you would like to end therapy, I would only ask that we first discuss this in person.

Because your parent(s) or guardian(s) are still legally responsible for you and your medical care, they will also be able to make decisions regarding whether or not you begin, continue, or end therapy. Whenever possible, I will honor your wishes, as you are my client, and not your parent(s). However, in order to provide the best possible care for you, I must take into account the decisions of your parents/guardians.

If more than 30 days has passed since our last contact, and I have not received any word from you or your parent(s) or guardian(s), I will accept that as your notice that you no longer wish to continue counseling, and that our therapeutic relationship is terminated.

III. INFORMATION FOR THE CLIENT'S PARENTS/GUARDIANS

■ The Need for Adolescents to Have Confidential Psychotherapy: As a parent or guardian of a teen receiving psychotherapy, I will involve you in helping your child to the fullest extent possible. However, the content of your child's sessions must be confidential in order to enable them to confide in me. The biggest indicator of successful therapy is a strong therapist-client bond.

In the treatment of adolescents, there are many issues that therapists have no opportunity to address unless adolescents trust that communication in therapy will not be shared with parents or guardians. These issues include use of cigarettes, alcohol, and drugs, sexual concerns or behavior, self-harming behaviors, involvement in gangs, cutting classes or truancy, school failure, unauthorized time with peers, and criminal activity. I will work with your child to help them to behave in ways that are not self-destructive, that do not limit options for the future, and that are considerate of others. If any of these issues rise to the level of serious, imminent danger to self or to others, parents and/or appropriate authorities *will be notified*.

■ Assessment: Psychotherapists must conduct both an initial and ongoing assessment of children and adolescents to understand their psychological needs. As the parent or guardian, it is essential that you cooperate with this assessment process by completing all forms provided to

you and by meeting or communicating with me, your child's therapist, as openly as you can. It is important for you to be completely open and honest about all influences that may be affecting your child, even if doing so is painful or embarrassing. Therapists usually cannot tell when parents or children deliberately conceal things. I can only help clients with problems to the extent that I am provided with the whole picture.

■ Collateral Contact with Parents and Others: I consider all information and issues resented in the course of therapy confidential. However, your contract with me is for the purpose of assisting in your child's treatment. Your child is my client, and not you the parents/guardians, which is an important distinction. This has no bearing on my consideration of your beliefs, concerns, and hopes for your child. By law, information concerning treatment or evaluation may be released only with the written consent of the person treated or such person's guardian. In the treatment of minors (under age 13), the best course is to discuss the limits of confidentiality at the onset in order to reach an agreement that is acceptable to both the parent(s) and the child and that will allow effective treatment to occur. It is essential for children and teens to feel this is a safe place to discuss any/all concerns and issues they may have without the threat of my alerting their parents. Please be aware that their perception of me sharing their private experiences with you may erode the therapeutic alliance and prevent your child from disclosing important information to their therapist. If a child tells me something that I deem important for the parents to know, I will work with that child to decide how we will discuss the issue with their parent/guardian. Should you request it, I can give you referrals for your own psychotherapy, if I believe that therapy might aid you with your own struggles, or allow you to better help and support your child.

■ Free Introductory Session: I offer a free introductory session for all new clients. We can schedule this session by phone or email. All required paperwork should be completed and brought to the appointment. During the first session, we will review paperwork, discuss the reasons why your child is seeking counseling, and talk about your child's goals. Additionally, I can answer any questions you might have about therapy. Participating in an introductory session does not obligate you to continue counseling with me. Please note that this is for *new clients only;* returning or prior clients are not eligible.

■ Fee for Services: My standard fee is $130.00 per 45-50 minute session. This is the same fee charged for any missed or late-canceled appointments. If you are paying the full fee out of pocket with cash the session will be charged at $125.00 per 45-50 minute session. In certain circumstances, I might arrange a reduced fee for you, which we will finalize in writing on a separate Sliding Scale Fee Agreement form. Phone calls made or received on behalf of the client will be billed in 15 minute increments at a prorated rate of $25/hour. I will not charge for one hour of phone time used per month. Additional fees might include: preparation of requested documents (e.g. letters to lawyers, government agencies, etc.) and copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services. Periodically I raise my fees to adjust to the increase in the cost of living and doing business, and I will give you one month's notice of any fee increase. Please be aware that in all cases, payment for my services is always your responsibility.

■ Payment for Services: I accept cash, credit card, or personal check payments made payable to **Meghan Whitlock** or **Meghan Whitlock Counseling**, and will provide a receipt upon your request. Payments are due directly to me at the time of service (at the end of each session. If paying by cash or check is a barrier, I can arrange to have you pay by debit/credit card using Square. If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I will charge a $36 fee for any returned checks. Since the parent or guardian of the client is most often the responsible party for payment, I am able to make other arrangements with you if you will not be transporting your child to/from sessions.

■ Insurance: I am a preferred provider for Premera, LifeWise, and First Choice Health insurance plans. I do accept certain insurance plans and I am an out-of-network provider for others. Please ask me about whether I accept your particular plan. If I am an out-of-network provider for your insurance plan, I am happy to provide you with a receipt and you can submit it to your insurance company for possible reimbursement. However, I cannot guarantee reimbursement and you remain ultimately responsible for all costs and fees.

■ Treating Children of Separated or Divorced Parents: In families dealing with separation and divorce, psychotherapists work to help children and teens cope adaptively with the forces acting upon their lives. Treating children in these contexts is difficult because:

- Parents usually have different views of the child's feelings and needs.
- Parents' views may be affected by their own experiences, issues, and needs.
- Both parents usually fear that the child's psychotherapist will side with the other parent.
- Both parents usually fear that the child's psychotherapist will make custody or visitation recommendations that are not in the best interest of the child or parent.

For these reasons, I abide by the following policies if I am treating a child of separated or divorced parents who share legal custody:

- Both parents must consent to treatment, ideally before the first session with the child, or shortly thereafter. In cases where one parent is given medical decision making authority only that parent needs consent to treatment.
- Both parents will be offered "equal time" in face-to-face or phone contacts, as much as realistically possible. The exception to this would be cases in which I believe that contact with one or both parents might negatively affect the child.
- I may share any information provided by one parent with the other parent.
- I am not qualified to provide custody or visitation recommendations to a court, mediator, and/or psychologist conducting a family evaluation. If your child has a court representative (attorney, guardian ad litem, etc.), or if requested by both parents or ordered by the court, I may discuss observations about the child with these parties.

These policies may not apply when a parent resides out of the area or is incarcerated, when parent-child contact is limited by a court (Juvenile, Family, or Guardianship) or court representative, when there is substantial evidence that a parent might be physically or psychologically harming the child or damaging the therapeutic relationship, or when a parent fails to respond to the therapist's attempts to establish contact with that parent.

■ Confidentiality from Third Parties: Psychotherapy is confidential from parties other than parents with important exceptions. I may release information to designated parties by written authorization of clients, parents, or legal guardians.

Most importantly, I am required by law to report suspected past or present abuse or neglect of children, adults, and elders (including children being exposed to domestic violence). I must report any suspected abuse or neglect to the authorities, including Child Protective Services and/or the police, based on information provided by the client or collateral sources.

■ Termination of Therapy: Terminating therapy with your child should be done over a number of sessions, particularly in cases of a long-term therapeutic relationship. Should you or your spouse decide to terminate therapy against your child's wishes or my recommendation, it is important that your child at least have a final meeting with me. Feel free to discuss this with me further if you have questions about termination.

■ Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints

or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105
meghanwhitlockcounseling.com

Please read each statement, and sign below:

- ✓ I have read the Disclosure Statement for Meghan Whitlock, MA, LMHC and I understand it.
- ✓ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.
- ✓ I agree to follow the terms in the Disclosure Statement.
- ✓ I give my consent for treatment as outlined in this Disclosure Statement.
- ✓ I will receive a copy of this Disclosure Statement with my signature.
- ✓ I understand that my therapeutic relationship with Meghan Whitlock, MA, LMHC may be discontinued if the terms in this agreement are not fulfilled by any party.

_____
Client Name (please print)

_____ _____
Client Signature Date Signed

_____ _____
Parent/Guardian Signature Date Signed

_____ _____
2nd Parent/Legal Guardian Signature (if requested) Date Signed

_____ _____
Clinician Signature Date Signed