Disclosure Statement

Counseling Collaborative LLC
Amanda Terry LCSW
amanda.terry.lcsw@gmail.com
(971)-427-8666
8am-6pm (PST) Mon-Thurs
8am-4pm (PST) Fri

Please take the time to carefully review this disclosure statement. As my client, you have the right to know my qualifications, methods, and mutual expectations of our professional relationship. The information presented here is provided to help you decide if my services are suitable for your needs. Please discuss any questions or concerns you may have either now or during the course of your treatment.

Qualifications:
I am a Licensed Clinical Social Worker in the state of Oregon and Arizona. I received my Master's degree in Social Work from the University at Buffalo in New York. My professional background involves working with (but is not limited to) individuals struggling with substance use disorders, work-life stress, life transitions, anxiety, depression, and anger management.

Therapeutic Approach:
I believe that therapy is about finding your authentic self. It is my goal to develop a genuine relationship with my clients where we can safely and collaboratively work toward achieving your identified goals. I use a person-centered, strengths-based, solution-focused approach and do so using Motivational Interviewing, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, amongst other evidenced-based theories relevant to the specific client needs.
I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your vulnerable issues and building upon your strengths, it is likely that you will see improvements throughout our work together and in the future.
I work with all my clients on a recurring, weekly basis. If you cancel several sessions, in which I perceive as a barrier to a positive therapeutic process, I will have a discussion with you around removal from your recurring appointment time and place you on my on-call list. The on-call list creates sessions based on cancellations. I will reach out to you by phone as times become available. If you do not show up to your appointment without notifying me, all future appointments will be canceled until I hear from you.

Client's Rights and Responsibilities:
Client's have the right to choose a therapist who best suits their needs and purposes.
You may ask questions about treatment at any time and may choose to terminate therapy at any time. Therapy may also be ended when I feel that your needs will be better met by another provider. In that case, I will try my best to make appropriate referrals.

Services:
I offer therapy services for individuals only. I see client's from 21 years of age and above. I **do not** offer case management services, which include but not limited to providing paperwork for disability, unemployment, custody, adoption, foster care, car accidents, and any type of legal issues. I **do not** offer therapy for individuals who are court mandated for treatment or seeking treatment in which disclosure of sessions will need to be provided to an outside entity.

Virtual Sessions:
I _____ (client's name) hereby consent to engage in telehealth services. I understand that "telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For telehealth sessions, we will be connecting using a system that is encrypted to the federal standard and HIPAA compatible. It is my responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the technology that you are interacting with. Additionally, I agree not to record any telehealth sessions. During a telehealth session, we could encounter a technological failure. The most reliable backup plan is to contact one another via phone. I will ensure that I have a phone with me, and I have provided that phone number. I understand that I am financially responsible for all services rendered, late cancellations, and missed appointments.

Emergencies:
As an independent, private practice clinician, I **do not** offer crisis coverage. If you are experiencing emergencies please call 911. If you are having any self-harming thoughts, or are experiencing other forms of crisis, you can also use 988, https://988lifeline.org/. This resource is available 24/7 to support you.

Financial Responsibilities:
If you are unable to pay the associated fees at the time of service for more than one visit, without developing a payment plan, your future appointments will be suspended until unpaid balances are resolved. Your appointment time is reserved specifically for you, and I will ask all my clients to respect this time. A minimum of 48 hours' notice is required to reschedule or cancel without a fee. A fee is assessed for cancellations within 24 hours and no-shows, at my discretion.
I acknowledge that I am responsible for all charges and missed and late cancellation fees. If an unpaid balance of $100 or over remains after 60 days, you will receive a final courtesy phone call and/or letter to remind you of your balance due. If you believe that there is an error in your billing, please let me know as soon as possible so I can research the issue. Unpaid balances without a payment plan or partial payment initiated after 60 days will initiate termination of services. It is very important that you update your contact information with
us to ensure you are aware of your financial responsibility and receive your statements.

Signature of Financially Responsible Party: _____

Relationship to client: _____

Date: _____

Confidentiality and Access to Records:
All information disclosed within sessions is confidential. It will not be disclosed to anyone without your written permission. Disclosure will be required when a client is a danger to self or others. I keep brief notes of our sessions. You have the right to a copy of your medical records at any time. A response to your request will be made within 15 working days; this is in compliance with RCW 70.02.080. The same request information applies to Arizona clients as well.
My signature below is an acknowledgment that I am the client or the person authorized to

consent to mental health treatment for the client and consent to services provided by Amanda Terry LCSW, that I have read and understood the disclosure information and have received a copy of this disclosure form.

Signature of Responsible Party: _____

Printed name of: _____

Date: _____