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DISCLOSURE STATEMENT

Welcome!! This disclosure statement and the enclosed HIPAA Policy Notice (pdf on my website) provide you with important information about my professional services and office policies. Please feel free to ask any questions about this information before signing this disclosure statement.

Therapeutic Orientation

My paradigm as a mental health counselor is based on a philosophy of unconditional acceptance and positive regard. No matter what is going on inside and no matter what the outward appearance I see your wholeness.

My approach is holistic and I enjoy collaborating with other healing professionals, integrating any of your experiences with them into our work together.

I offer individual counseling as well as consultation. My method of counseling is specifically tailored to your individual needs. There may be occasions where we utilize more than one method depending on your intentions and comfort level. I hold a deep authentic commitment to my own growth and healing and am continually expanding my skills as a therapist and healer. I believe counseling and healing work create a space whereby individuals may reconnect with their inner and outer resources remembering wholeness within themselves.

The first sessions may be used to identify the presenting problem, obtain background information including a family map, create goals and outline strategies for meeting them. Depending on your needs, therapy may be brief or more long-term (6 months or more). Progress is best when sessions are on a consistent basis. Please be aware this time is yours. Typically, therapy can occur as often as once a week or every other week. Consultations will be less frequent. We work this out depending on your need.

Because I work from an integrated place, the mental health counseling is informed by my shamanic and spiritual guidance training.

Belief about Healing

I believe everything you seek is already within you. My joy is to re-introduce you to those resources you already possess that can help you live your life to the fullest. The essence of our work together is it enables you to remember the truth of who you are. This does not mean that any discomfort you are feeling is not "real", it simply means it is not the truth of who you

are. I will always look past any challenge you are having and see you in your wholeness. I believe your highest and best self is always finding ways to emerge.

Therefore, our job is to recognize the cues and give those inner resources a voice, assisting you in aligning with your greatest becoming.

Professional Education & Experience

In 1993, I received a Master's Degree in Counseling from the University of Wisconsin. I am a Licensed Mental Health Counselor (LMHC) in the State of Washington, as well as, a Nationally Certified Counselor (NCC). In addition, I am a trained EMDR facilitator. I am also trained as a shamanic healing and energy work practitioner. Other post-graduate work includes extensive training in energy healing modalities (energy work and earth-based shamanism) and expressive arts such as psychodrama. I am also an Ordained Minister. Before graduate school, I worked with children and adolescents with disabilities and behavioral challenges utilizing behavior modification programs. I am currently in private practice since 1995.

Financial Policy Agreement

Professional services will be provided to you at a fee of \$150.00 per 50-minute session. Payment for each session is expected at the time of services rendered, unless other arrangements are made in advance. For those with health insurance benefits, I'm happy to provide receipts for services rendered. You can send to your insurance company for possible reimbursement. I do offer a limited number of need-based sliding scale appointments.

Telehealth sessions are billed at the usual hourly rate and should be paid at the next session or mailed to me within 15 days.

I offer professional services for the primary purpose of counseling and psychotherapy, not for the primary purpose of preparing for litigation. If you are seeking services for preparation of litigation or other legal action, I can provide you with referral resources for a forensic expert. I do not voluntarily participate in legal proceedings. If my participation is requested or required, my regular hourly rate applies to all preparation, participation, travel, and waiting times.

Past Due Balances

I cannot create a situation in which our clinical relationship becomes a creditor/debtor relationship. If you are unable to pay for sessions and to keep your account up to date, I may be required to terminate services. In such cases, I will provide you with appropriate referral resources for low or no-cost alternatives.

Cancellation Agreement

An \$80.00 fee is charged for missed or canceled sessions (less than 24 hour notice), unless I am able to fill the session with another client. I will do my best, but offer no guarantees. The missed or canceled session fee is due at the next session, along with the regular fee for that session.

Confidentiality

Your participation in counseling, the content of our sessions, and any information I maintain about you is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency;
- If I have any other legal duty, obligation, or right to report.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

For additional information regarding your confidentiality rights, please carefully review my HIPAA Notice of Rights and Privacy Practices.

Consultation

I seek ongoing consultation from colleagues in order to provide you with the best services possible. I may disclose information about your counseling session in consultation with colleagues, in which case I will limit the information I disclose to the minimum amount necessary. I have an agreement with Julie McInnis, MA, LMHC (360-357-7446) to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to Julie McInnis, MA, LMHC accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

Working with Minors

If you are the parent or guardian of a minor who is seeking treatment, please know that under Washington State law, any child age 13 or older can independently consent to mental health treatment without your permission. In addition, parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission. If you are 13 years of age or older, you have the legal right to seek mental health treatment without obtaining permission from a parent or guardian. Under certain circumstances, the parent of an adolescent may consent, on behalf of the adolescent, to a mental health or substance use assessment and limited treatment.

I am not able to provide a recommendation, evaluation, or opinion, in any legal forum relating to separation, divorce, child custody, visitation, or parenting plans. For children under age 13, I will need to be provided with a copy of any parenting plan, custody orders, or any other similar documents, including any changes or revisions made during the course of treatment. It is generally necessary that both parents or legal guardians consent to treatment of their minor child.

Technology Assisted Counseling

It is important that you understand the following policies for telehealth services.

Policies

At your request and if it is therapeutically appropriate, we may make use of technology assisted telehealth tools such as telephone communications and internet enabled video and/or audio services if they are clinically appropriate. It is important that you understand the benefits and limitations of such services.

- If you are located outside of the State of Washington, the counseling services I am allowed to provide to you may be limited or prohibited. If you are located outside of the State of Washington, we will discuss what services I may be able to provide to you.
- Telehealth counseling services are not appropriate for all clients and all situations. If you or I determine that telehealth services are not appropriate for you, I will assist you in obtaining appropriate alternative services.
- Due to the nature of telehealth services, I am unable to guarantee the privacy or confidentiality of the environment from which you access services. Clinical services are generally more effective when you are able to have a secure, private, and confidential area from which to access telehealth. If this is a concern for you, please let me know so that we can discuss alternative options.
- Please do not access telehealth services in a location or manner that puts your safety at risk. This may include, but is not limited to, accessing telehealth while operating a motor vehicle. In such situations, I will ask you to disconnect from the session and rejoin as soon as you are able to do so safely.
- Please do not record your sessions or any portion of the session without the explicit consent of all participants. I will not record our sessions without your prior permission.

Risks and Benefits

- Telehealth services may improve your access to counseling, may be necessary for continuity of care, and may support more effective use of in-person counseling.
- Successful use of telehealth services requires a reasonable level of access to computer hardware and software. If you do not have access to such resources, we can discuss available alternatives.
- At times it may become necessary for me to allow access to my computer hardware and software for purposes of system maintenance, repair, upgrades, or other similar purposes. In such cases, I will make every effort to protect your confidential information.
- Telehealth services may not be reimbursed by some insurance plans. In such cases, payment for telehealth services remains your sole responsibility.
- It is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that without sufficient safeguards, third parties may overhear our communications or may gain access to the technology you are using. Some basic safeguards may include communicating only through a computer or device over which you maintain control, with a firewall and anti-virus software, password protection, and a secure private internet connection.

Alternative Modes of Communication

- In case of hardware, software or other system failure, you may reach me by phone to coordinate our continued work together.
Email: Abby@AbbyLeach.com
Phone: 360-481-0791
- Please identify an Emergency Contact Person on the Client Intake form I may contact on your behalf in case of an emergency.
- Please include a current email address, phone number and physical address on the Client Intake form should I need to contact you in case of technology failure or other loss of internet connection during our telehealth session.

Audio-Only Telehealth Billing

Under Washington law, a healthcare provider may bill a client or the client's insurance for audio-only telehealth sessions only with the prior consent of the client. If you would like to have the option to engage in audio-only telehealth services, you may initial below:

_____ (initial) if you consent to billing for audio-only telehealth services.

Request for Electronic Communications

It may become useful to communicate by Email, Text Message (e.g. "SMS"), and Other Non-Secure Means during the course of treatment. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with me
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If there are people in your life that you don't want accessing these communications, please talk with me about ways to keep your communications safe and confidential.

Social Media Policy

Professional ethics standards do not permit me to communicate with clients via personal social media. For this reason, I cannot accept any client requests to connect on Facebook, Instagram or other similar social media platforms.

Office Hours and Availability

Office hours are by appointment only. Please provide at least 24 hours' notice if you need to cancel or reschedule your appointment.

Emergency Procedure

In case of an emergency, please call the National Crisis line at (800) 273-8255, go to the nearest emergency room or call 911 or 988. I do not carry a pager and do not provide 24-hour emergency call coverage.

I check my phone and email messages regularly throughout the business day. If you need to speak with me, leave a brief message with your name and phone number only and I'll contact you as soon as I'm able. Please be sure to discuss with me any questions or concerns you have about this emergency policy.

Termination of Therapy

Therapy is a joint effort between therapist and client. In order for the therapy to work, it is vital to keep the lines of communication open. Please come and talk to me about any concerns you have at any time during our work together. Closure is important to the therapeutic

process. I ask that my clients agree to a closure session to adequately honor the work they have done in therapy.

If, without having made prior arrangements, I have not heard from you in 30 days I will assume that you would like me to terminate our current episode of care and close your active clinical file. In such cases, we may discuss the possibility of re-opening the file and initiating a new episode of care upon your request.

Required Notices

The State of Washington requires that I provide you with the following information:

You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of public health and safety.

Credentialing of an individual with the department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

Attestation

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of the HIPAA Notice of Rights and Privacy Practices (pdf on website), have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in counseling services provided by Abby Leach, MSE, LMHC.

Client Signature

Date

Print Name

Abby Leach LMHC

Abby Leach, MSE, LMHC

Date

If Client is under 13 years of age:

Print Name of Client

Client Date of Birth

Parent/Legal Guardian Signature

Date

Print Name

Relationship to Client

If signing on behalf of a minor child under 13 years of age, do you have legal authority to consent to services on behalf of your child? ____yes ____no