Dana Smith, LICSW, MSW, CMHS, PLLC

Child Mental Health Specialist & Licensed Independent Clinical Social Worker

Smith Counseling Services

714 E. Edison Ave., Suite B
Sunnyside, WA 98944
509-515-0420

Professional Disclosure and Informed Consent

The counseling experience is a deeply personal, yet shared interaction between an individual and therapist. The most crucial aspect of a therapeutic relationship is trust. To assist in developing this trust, I share the following information with you about my professional beliefs, background, and your consumer rights. I welcome you and look forward to working with you.

PLEASE INITIAL each section after reading through to indicate you have read the policy.

_____ Education and Experience:

Masters in Social Work, Eastern Washington University, 2001
Education Staff Associate WA State 2001- present
License # LW 00009250 (Licensed Independent Clinical Social Worker)
Internationally Credentialed Sandtray Therapist 2019- present

I have worked with children, adolescents, adults, and families to increase their quality of life for many years. My professional experience has included working with individuals and groups in a variety of environments including Lutheran Community Services, Excelsior Youth Center, Catholic Family and Child Service, and Smith Counseling Services, PLLC. I also have volunteered as a camp counselor at Camp To Belong WA, as a mentor through Ignite Youth Mentoring in Tri-Cities, and as a tutor/mentor through Extra Mile Student Center of Grandview.

I work to bring clarity and hope to all ranges of mental health issues such as self-harm, suicidal thoughts, depression, anxiety, emotion regulation, self-esteem, relationship struggles, life transitions, grief and loss, and trauma. I have specialized training in working with children and adolescents and have a Child Mental Health Specialist endorsement. It is my desire to discover and utilize the best practices available within the mental health field to promote insight, growth, and change. I continually participate in professional workshops, meetings, and educational classes. I use a variety of counseling modalities, which primarily include, but are not limited to: Cognitive Behavioral Therapy (CBT) for depression, anxiety and behaviors, Trauma Focused CBT, mindfulness and play therapy. I utilize sandtray therapy as well and I am an Internationally Credentialed Sand Tray Therapist through IAST.

I am a member in good standing of the National Association of Social Workers (NASW) and follow their code of ethics and professional guidelines. I am also a member of the Association for Play Therapy.

_____ Counseling Philosophy:

I utilize a solution focused, strengths-based perspective in finding practical solutions for relationships and meeting the needs of everyday living. Christian counseling is also available at your request. Spirituality is part of the person as a whole, and if this is something you lean on in your life for comfort, healing and encouragement, please feel free to let me know that you would like it to be included in your treatment process. Counseling is a collaborative effort and cannot be successful without your hard work, energy and

courage. I agree to come alongside and facilitate healing conversation, enhance coping skills, and provide education and resources encouraging your growth and change.

Together we will decide on the amount of sessions needed to achieve your goals. After the intake assessment, I may ask you to visit a physician to rule out any biological causes for your distress before continuing forward in the counseling process. In the case of issues or concerns beyond my scope of competence, I will make every effort to refer you to more qualified professionals.

For your best interest and to protect your personal rights, our relationship must always remain professional; this means that even though our relationship may seem very intimate, please be aware that I am only sharing with you as a professional and focusing on the goals you have indicated you desire to reach. This is the primary purpose of our relationship.

_____ Small town disclaimer:

We live in a rural area and are bound to see each other in community settings. Your confidentiality is my priority. Please feel free to say hello to me if you so choose and I will kindly reply. I most likely will not initiate and this is nothing personal, only meant out of respect for privacy. My extended family is well known in the community and I ask that you be aware that if you choose to disclose to them that you see me for services, I will not be able to confirm or deny this. This is still your choice however and to whom and what you disclose is up to you. My respect for your privacy will remain.

_____ Social Media:

Social media makes it an even smaller community. Please be advised that I do not “friend” people I see in my practice, however, we may have mutual friends and that may mean we will encounter each other on social media in non-direct ways. Please do not message me through my personal accounts. I do have a professional Facebook page for my practice and I would be happy to give you that link to keep you informed of articles that may be of interest or activities going on in our community.

_____ Essential Oils:

Occasionally, I diffuse essential oils. Please, let me know at intake if you have any allergies to certain scents. If, when you come to the session, you would like me to turn off the diffuser for any reason, please just ask and I will oblige. I do not sell essential oils. I do recommend them from time to time and I do have some on hand to be utilized topically or aromatically during mindfulness exercise or as supplemental intervention. If you choose to utilize these oils during the session, you are giving informed consent and will not hold Dana Smith, LICSW, MSW, CMHS, PLLC liable for any unpleasant reaction to the oils. You choose to use the oils at your own risk.

______ Food/Snacks/Beverages:

I do have a limited number of snacks on hand available to clients as needed, most often, to kiddos after school who may need an energy boost. Please advise at intake if there are any allergies and foods to be avoided. By initialing you agree that it is okay for your child or yourself to consume a snack while at their counseling session. You also agree to not hold Dana Smith, LICSW, MSW, CMHS, PLLC liable for any adverse reactions to food consumption.

Please indicate if there is a food category/allergy that is to be avoided as a snack for your child:

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Outside food/beverages are allowed at times as long as it does not interfere with the therapeutic process.

_____ Fees and Insurance Reimbursement:

My individual/family counseling fee is $160.00 per 53 minute session, $125.00 for a 38 minute session, $100.00 for 16 minute session and $225.00 for the initial intake assessment. I do provide an out of pocket, payment at time of service discount if you have no insurance or decline to use your insurance. This discount only applies if payment is made at the beginning of the session. If you are unable to pay at that time, the full fee will be required. An additional form is required when choosing to not utilize your insurance benefits.

I am an in-network provider for most major health insurance companies. I am also a provider for some state insurance companies. **Please call your insurance company before our first session to ensure you have benefits that include mental health outpatient services and what your deductible and co-pay will be, as you will be responsible for payment that day.**

I would be glad to bill your insurance. If you are submitting your own insurance claims, you will need to make a payment up front. I will provide a receipt for you to send to your insurance company at your request. Dana Smith, LICSW, MSW, CMHS, PLLC does not routinely bill secondary insurance. I can provide you with a receipt of payment that you may then submit to your secondary insurance along with your primary EOB so that you may obtain reimbursement. There are a few insurances that work well together and I may be able to bill secondary at times. We will discuss this at intake. I offer only 1-2 sliding-scale fee slots and those are dependent upon income level.

Each fee, co-pay, deductible etc. is due at the time of service; I accept cash (exact amount), personal check, Visa, Mastercard, American Express, and Discover. Please be aware that if your personal check is returned for non-sufficient funds (NSF), a service fee of $50.00 will be added to the face value of the NSF check.

If you fail to show up to an appointment, I reserve the right to charge the full session fee as insurance does not cover no-shows or late cancellations. If you have state Medicaid, my contract with them indicates you cannot be billed for no show/late cancellations, however, you may see a change in appointment time if it is during after school or evening hours as these are highly utilized slots. After three no-shows/late cancellations, I may choose to discontinue services as the quality and effectiveness of therapy may have been compromised.

____ NOTICE OF PRIVACY PRACTICES

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

I respect your privacy. I understand that your personal health information is sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

The law protects the privacy of the health information I create and obtain in providing my care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use & Disclosure of Protected Health Information for Treatment, Payment and Health Operations

For Treatment:
I may provide information to others providing you care. This will help them stay informed about your care.

For Payment:
I may request payment from your health insurance plan, when applicable. Health plans need information about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations:
I may use and disclose your information to conduct or arrange for services, including: 1) medical quality review by your health plan; 2) accounting, legal, risk management, and insurance services; 3) audit functions, including fraud and abuse detection and compliance programs.

_____ YOUR HEALTH INFORMATION RIGHTS

The health and billing records I create, and store, are the property of Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services. The protected health information in it, however, generally belongs to you. You have a right to: 1) receive, read, and ask questions about this Notice; 2) ask me to restrict certain uses and disclosure in writing and I may not be required to grant the request; 3) request and receive from me a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice"); 4) request that you be allowed to see and get a copy of your protected health information, in writing; 5) have me review a denial of access to your health information – except in certain circumstances; 6) ask me to change your health information and if your request is denied and it will be stored in your medical records; 7) request a list of disclosures of your health information outside of third-party payers; 8) ask that your health information be given to you by another means or at another location requested by you in writing; 9) cancel prior authorizations to use or disclose health information by giving me written revocation for future disclosures.

_____ Confidentiality:

All information shared will be kept *confidential* with the following *exceptions*:
1) If I believe you are a *danger* to yourself or someone else
2) If you give me *written permission* to disclose information
3) In the case of *abuse* to a child or an elderly person confidentiality will be waived
4) If the information is court ordered
5) If you desire to seek reimbursement from a managed care company, the disclosure of Confidential information may be required for reimbursement
6) In case of a *Medical Emergency*
7) These rights are waived if accusations of misconduct are brought

Even under these circumstances only essential information will be revealed and as much as possible you will be informed before confidentiality is broken. In the event the client is a minor, parents or legal guardians may be included in the counseling process as is appropriate, however measures will be taken to safeguard confidentiality, always acting in the best interest of the client.

_____ As a counselor I may receive consultation (with individuals who are bound by the same or similar code of ethics as I am) to continually improve my counseling skills. Any information shared during

consultation will be discussed for professional purposes only and every effort will be made to protect the client's identity.

_____ Therapy Supervision:

At times, I may receive supervision to meet the experience requirements to become a registered play therapist. During supervision I may discuss aspects of your case that are too difficult for an individual therapist to work through alone. If I do so, I will mask your identifying information so that it would be difficult for my supervisor to associate you with any issue we may talk about. If this is a concern for you, please let me know and we can discuss your concerns in detail.

_____ E – mails, Cell Phone, Computers and Faxes:

It is very important to be aware that computers, email, and texting communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. E-mails and texts are vulnerable to unauthorized access because internet servers have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted. I do have a patient portal available through my billing software and you may sign up to receive emails through that forum. Please notify Dana Smith in writing if you decide to avoid or limit in any way the use of any, or all, of this type of communication. If you communicate confidential or private information via e-mail, texting, faxes, etc. I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters in this way. Please do not use E-mail, Texting or Faxes for emergencies.

_____ Client Rights:

You have the right to self-determination, a right to privacy concerning medical information and a right to participate in treatment decisions. All records are the property of Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services; however they are kept for your benefit and are available to you at your request. As stated earlier, you have the right to be informed of your counselor's qualifications as well as the right to decline or accept any suggestions or therapeutic strategies. There are risks and benefits with all counseling, some risks are presenting symptoms/issues are not resolved, or they could worsen. It is possible that during counseling new symptoms could arise. If you ever feel counseling is not helping you, please talk with me. There are many options available that we can discuss. Termination/Discontinuation of the counseling relationship will be made by you or by a collaborative decision between us both.

Additional Rights:

1. Be treated with respect and dignity
2. Develop a plan of care and services which meets your unique needs
3. Refuse any proposed treatment, consistent with the requirements in the Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW
4. Receive care which does not discriminate against you and its sensitive to your gender, race, national origin, language, age, disability and sexual orientation
5. Be free of any sexual exploitation or harassment
6. To know my education, training and treatment orientation
7. To know all financial requirements
8. See a copy of the treatment record that I keep of our sessions. You have the right to request me to correct that record. I will not disclose your record to others without your written consent unless the law authorizes or requires me to do so.
9. The right to Confidentiality, as described in the relevant statutes (chapters 70.02, 71.05 and 71.34 RCS) and regulations (chapters 275-54, 275-55 and 275-57 WAC)

10. File a complaint with the State of Washington Department of Licensing if you feel I have violated your rights.

_____ Emergencies:

If you have an *urgent situation,* which you feel needs immediate support and I am not available by phone, please contact 911, for a mental health crisis in Yakima County call (509) 575-4200 or in Benton/Franklin Counties (509) 783-0544 or go to the nearest emergency room. There may be times when my cell phone is given to you if it is part of your plan of care. This is determined case by case and its use is for emergency situations only. I also ask for an emergency contact during intake that I may contact if I am unable to reach you and have concerns regarding your wellbeing or if there happens to be a medical emergency in my office and I need to alert someone to meet you at the hospital.

_____ Client Responsibilities:

As a client you have the responsibility to set and keep appointments. Please understand that when you make an appointment, I am reserving that time for you. If you are late, there may or may not be a possibility of extending your session to give you your full time. Please give at least 24-hour notice, if you cannot keep an appointment, or as soon as possible, if ill or you have an emergency. Pay your fees in accordance with the schedule you pre-established with the counselor. Help plan your treatment goals and follow through with agreed upon goals. The client is responsible for his/her actions when he/she refuses treatment or does not follow the practitioner's recommendations, this includes but is not limited to follow through with home practice activities or follow up on referrals made to additional medical/mental health services. The client is responsible for following the facility's rules and regulations affecting client care and conduct. The client is responsible for being considerate of the rights of other clients and facility personnel. It is also your responsibility to keep your counselor informed of your progress towards meeting your goals and to terminate your counseling relationship before entering into an arrangement with another counselor.

___ Completion or Termination of Services:

The consumer and counselor will determine together when goals have been met and sufficient skills are in place to "graduate" from services. If you choose to discontinue services for any reason, please inform the counselor in order to provide closure and proper process for closing of your file. If the counselor does not hear from you/consumer within 2 months of the last session, your file will be closed without further contact from the counselor. You are still welcome to contact the counselor in the future to arrange new services.

_____ Complaints/Grievances:

If you believe your privacy rights have been violated, you may discuss your concerns with me. You may also deliver a written complaint to Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services. You may also file a complaint with the U.S. Secretary of Health and Human Services. I respect your right to file a complaint with me or with the U.S. Secretary of Health and Human Services. If you complain, I will not retaliate against you.

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
PO Box 47857
Olympia WA, 98504-7857 Phone Number: 360-236-4700

_____ **My Responsibilities:**

I AM REQUIRED TO:
1) keep your protected health information private; 2) give you this Notice; 3) follow the terms of this Notice. I have the right to change my practices regarding the protected health information I maintain. If I make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it.

Other Disclosures and Uses of Protected Health Information

I may use and disclose your protected health information without your authorization as follows:
For Public Health and Safety Purposes as Allowed or Required by Law:
1) To prevent or reduce a serious, immediate threat to the health or safety or a person, or the public.
To Report Suspected Abuse or Neglect – to public authorities.
For Law Enforcement Purposes – such as when I receive a subpoena, court order, or other legal process, or you are the victim of a crime.
For Specialized Government Functions – for example, I may share information for national security purposes.
Other Uses and Disclosures of Protected Health Information.
Uses and disclosures not in this Notice will be made only as allowed or required by law, or with your written authorization.

_____ Disclaimer of services not provided by Dana Smith, LICSW, MSW, CMHS, PLLC:

It is my policy to NOT get involved in custody or legal matters. This includes, but is not limited to; L&I claims, other lawsuits, court hearings, child custody matters, placement recommendations, provision/support letters, visitation schedules, etc. Additionally, therapy sessions will not be utilized for supervised visitations of any kind. If requested, I will be happy to provide you with recommendations for alternative agencies that are designed to meet this need.

Child Custody: *Please choose **ONE** of the following that best describes your current situation:*

1. By initializing here ________, I am declaring that I/my child am/is **not** involved in a current custody dispute.

2. By initializing here ________, I declare that I/my child **am/is in** a custody dispute at this time and I understand Dana Smith, LICSW, MSW, CMHS, PLLC does not provide recommendations, support letters or visitation regarding custody disputes. Nor provide testimony or appearances at court. I understand that my child's session with Dana Smith is based on trust and safety and will not request documentation for court or custody related purposes.

Legal Matters: *Please choose **ONE** of the following that best describes your current situation:*

1. By initialing here ________, I am declaring that I/my child have/has **no** current or pending legal matters.

2. By initialing here ________, I declare that I/my child **do/does** have current or pending legal matters and I understand that Dana Smith, LICSW, MSW, CMHS, PLLC does not provide documentation, court depositions or appearances per company policy and operational procedure.

_____ Recording of sessions, either audio or video, are not allowed as it breaks confidentiality. If you would like a notebook to take notes regarding skills being taught or homework requested, I would be happy to provide you with one.

DO NOT SIGN UNTIL YOUR FIRST SESSION

Acknowledgement of Notice of Privacy Practices:

My signature indicates that I have read the above HIPAA Notice of Privacy Practices and had an opportunity to ask any questions I may have.

Complaint/Grievance Process:

I read the above grievance process and have asked any questions I may have.

Client Rights, Responsibility and Confidentiality:

My signature attests that I have read, and fully understand my rights as a client, as well as my responsibilities. Additionally, I am aware of the limits of confidentiality.

Consent for Treatment:

By signing below, you indicate that you have read this disclosure, that you had an opportunity for your questions to be asked and answered, that you understand the above information, and that you have been offered a copy of this document. Your signature also indicates that you are consenting to receive counseling services from Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services. No guarantees have been given by Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services as to the results that may be obtained. I indemnify and hold Dana Smith, LICSW, MSW, CMHS, PLLC/Smith Counseling Services harmless from any and all claims arising directly or indirectly from the services rendered by her under this agreement. Such indemnification shall include attorney fees and costs.

____

Individual Signature Date

____

Parent/Guardian signature (if applicable) Date

____

Dana Smith, LICSW, MSW, CMHS Date