Ginger Moriarty , MSW, LICSW

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Disclosure Statement and Consent to Treatment

Welcome. The purpose of this disclosure statement is to provide you with information about myself as a therapist and about the treatment offered so that you may make an informed decision about your therapy. As a client of psychotherapy, you have certain rights that are important for you to know about because this is your therapy- the goal is your well-being. Please read the following and ask any questions that you may have.

My Background and the Process of Therapy. I am a licensed social worker (License # LW 00004048) and Washington Child Mental Health Specialist (CMHS). I earned a Bachelor of Arts in Social Psychology from Tufts University in 1990, and a Master of Social Work from The University of Washington in 1993. I have been practicing in the field since 1991.
The way I do counseling will vary depending on your needs and preferences. I may use talking, cognitive behavioral therapy, relaxation/stress reduction techniques, art and/or play therapy. I use a holistic approach that has been shaped by psychodynamic, developmental, systems, mindfulness, interpersonal neurobiology, and behavioral theory.

My Responsibilities to You as Your Therapist:

I. Confidentiality: With the exception of certain specific instances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone what you have told me, or even that you are in therapy with me without your prior written permission. I will always act so as to protect your privacy even if in writing you permit me to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

The possible legal exceptions to this policy might be:
• Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a developmentally disabled person;
• Where there is a clear threat to do serious bodily harm to yourself or others;
• In response to a subpoena issued by the Secretary of Health that is associated with a regulatory complaint

As an ongoing part of my clinical development and in pursuit of providing you with the best care, I consult regularly with a clinical consult group. Should I discuss your therapy with my consult group or any other clinician, I will only relate the content of our work together. You will not be named, nor will I share any details of your life that might identify you. If you have any concerns or questions about this please let me know.

I may use and disclose your health information in order to bill and collect payment for the services you may receive from me. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I may also use and disclose your basic health information in order to obtain payment from third parties that may be responsible for such costs, such as family members. Usually what is shared is only the type of service I provided as well as a diagnosis from the DSMIV (see below).

Please keep in mind that although every safeguard is in place when communicating, I cannot guarantee that there will be no interception. Nor can I protect your name when depositing your check at my bank. I file all my insurance claims electronically with a program called Office Ally, sharing your protected health information when required.

Voice mail and phone are the only secure methods of communication that can assure I am HIPPA compliant. Be aware that e-mails can be read by third parties and that if you use your work e-mail your employer can intercept. Some clients prefer the convenience of email communication and texting despite their lack of security. I ask that you determine your own preference for security verses convenience in communication. I will only contact you via telephone unless you state otherwise. If you prefer email communication, I will keep my email replies brief.

II. Record Keeping: I keep a record of dates of service and fees as well as notes to assist me in my work. I make a practice of not keeping too much personal data in these notes, and observe security precautions to protect confidentiality. If you prefer that I keep no records, you must give me a written request to this effect for your file. You have the right to review your record if you desire. You also have the right to ask me to correct the record if you believe the information is in error. A copy of your corrections to my record will be placed within your record at your request. You have the right to request that I make of copy of your file available to any other health care provider at your written request.

III. Diagnosis: If a third party such as an insurance company is paying for part of your bill, I am typically required to give a diagnosis to that third party in order for you to be paid. If I do use a diagnosis, I will discuss it with you.

Your Rights as a Psychotherapy Client

I. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I am doing. I will work with you to discuss your specific goals and preferences.

II. You have the right to decide whether the proposed treatment plan will provide you with the treatment that you want. I encourage you to let me know if something does not feel helpful or appropriate for you at any point during

treatment. Your input into the process of therapy is very important. You will not be expected to participate in any activity against your will and you may end therapy at any time.

III. You have the right to confidential and safe treatment.

Your responsibilities as a Psychotherapy Client:

I. You are responsible for coming to your session on time. If you are late, we will end on time and not run over into the next person's session. If you miss a session without cancelling, or cancel with less than twenty-four hours' notice, you will be charged the full amount of time reserved for you.

II. You are responsible for paying for your or your child's session at the beginning of each session unless we have made other firm arrangements in advance. My fee is $130 for an initial assessment and a 55 minute family session, $100.00 for a forty-five minute session, and $115 for a fifty-five minute session. Please let me know if the fee is unaffordable; I may be able to make some adjustments depending on your personal circumstances. If we decide to meet for a longer session, I will bill you prorated on my hourly fee. Emergency phone calls are typically free. If we spend more than fifteen minutes weekly on the phone, I will bill you on a prorated hourly basis. Insurance does not pay for missed appointments or phone calls.

III. Insurance will be billed directly for those companies with whom I am a contracted provider. Please check with me to see if I am a preferred provider for your insurance. If I am not a preferred provider under your insurance you are required to pay my fee and provide me with the necessary forms and information to assist you in getting reimbursed from your insurance company. You are responsible for any portion of the bill that insurance does not cover.

If you end up having an outstanding bill with me and we have terminated therapy, I expect you to pay it. If you refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

Complaints

I you are unhappy with what's happening in therapy, I hope that you will talk about it with me so that I can respond to your concerns. I will take such concerns seriously and with care and respect. If you believe that I have been unwilling to listen and respond, or that I have behaved unethically, you may file a complaint in writing with me, and/or with the Secretary of the Dept of health and Human Services. I will NOT retaliate against you for filing such a complaint.
You may contact the Department of Health at 360-236-4902, or by writing to Department of Health, Health Professions Quality Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869. You can request a copy of the acts of unprofessional conduct, or access this information online at http://www.leg.wa.gov/wsladm/rcw.htm

Your Treatment Contract

I have read this document and asked any questions I have about either its content or my proposed treatment. I consent to the use of a diagnosis in billing, and to release that information to my insurance company if insurance is being billed for services. I agree to pay $115 per 55 minute session at the beginning of each session and $130 for initial and family sessions. I understand my rights and responsibilities as a client, and my therapist's responsibility to me. I agree to undertake therapy with Ginger Moriarty, LICSW. This signed statement is our written contract to enter into the therapeutic process.

I have been offered additional printed information on HIPAA.
Client initials: _____

I understand the cancellations policy and know that if I don't give at least 24 hours notice that I must pay for the cost of the entire session.
Client initials: _____

I am aware of the risks to security with email and texting communication but prefer to utilize this method of communication my (child's) therapist for:

_____ treatment progress and updates

_____ receiving invoices and discussing billing

_____ confirming or changing appointment times

_____ _____
Printed name of client date

_____ _____
Signature of client date

_____ _____
Parent/guardian Signature (if applicable) date

_____ _____
Ginger Moriarty, LICSW date