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Disclosure Statement and Treatment Agreement

The State of Washington requires providers of psychological and counseling services to disclose specific information to their clients. This disclosure provides that information and must, by law, be acknowledged through the parent's signature. If you have any questions about the information contained in this statement, or about any other aspect of your child's counseling, please ask me at any time. Please read the following carefully. I will need to have a signed copy for my files and one for you to keep.

I am a Licensed Mental Health Counselor by the State of Washington. My State Certification number is License #LH 00011132. I am required to tell you that this certification, by the State of Washington's Department of Licensing, does not imply set practice standards or guarantee the effectiveness of any treatment. You have the right to terminate or refuse therapy at any time. You have the right to ask any questions about my professional background and training, my approach to therapy and/or policies. I am not a medical doctor and I cannot make recommendations regarding medication. I can, however, refer you to a medical physician or psychiatrist if you have questions in this regard.

In 1969, I received my Bachelor of Arts Degree and then in 1970 I received my Teaching Credential from San Jose State University, San Jose, CA. I taught until 1988 when I received my Master's Degree in Student Personnel Services from Virginia Polytechnic Institute and State University with an emphasis in counseling children.

I have worked in a school setting since 1970 and with Lake Washington School District as an Elementary Counselor since 1991 until 2012. I have co-facilitated Wally's Club since 1997. There are two locations: Lake Union and Eastside.

I continue my work with children, teens and parents.

Confidentiality:

What individual children say within these sessions will be held confidential. Under State law, information concerning your child's progression may only be released to your other providers with your written consent. The only exceptions are the following: 1) If I am informed that you or your child intend to commit a crime or harmful act to yourself or another person; 2) If I have reasonable cause to believe that a child has suffered abuse or neglect; 3) If I am served a court order which requires me to release my records. It is my policy to discuss these instances of required disclosure to you.

For professional growth, monitoring, and support I consult another professional. In an effort to gain further insights and expand my knowledge base, I may discuss your child's treatment. If this is not acceptable to you, please inform me. In some cases it might be useful to discuss your situation with a profession who has worked with your child or family (1.e. teacher, physician, previous counselor, etc.). Should this occur, I would discuss the benefits of such an exchange of information, and together, determine whether or not it is a suitable contact. In such cases, I will seek your written permission for this exchange of information.

Emergencies:

Messages can be left on my voice mail at (425) 503-3925 or my email at lesliefieldscouseling.com.

I will make every attempt to get in touch with you in a timely manner.

Service and Fees for Individuals

$120.00 set up fee (this includes reading files, contacting other professionals or other persons involved (with written permission), setting up paper work, and working with any other organization involved.)

$120.00 Office Visit (50 minutes)

$120 an hour for additional paperwork, reports, phone calls and collateral contacts and emails.

Sliding Scale is available in some situations.

You are to bill your insurance company

Payment is due at every session unless other arrangements re made. You must cancel within 48-hrs or full payment for the session is due.

Payment Agreement:_____(initial)

Please sign here that you have read and agree to the above as well as that you got the Washington State's HIPPA information.

I have read the above information and have had an opportunity to ask questions and have them answered satisfactorily to clarify the conditions under which I consent to my child's group therapy. I agree to the stated terms and I have received a copy of this agreement.

_____ _____

Parent's signature for minor Date

_____ _____

Printed name Phone number

_____ _____

Therapist's signature Date