Selin Caka, LMFT

Informed Consent for Partner and Family Therapy Services

Starting counseling is a major decision, and you may have many questions. This document is intended to inform you of the policies, state and federal laws and your rights. If you have other questions or concerns, please ask, and I will do my best to give you all the information you need.

Your Therapist: I hold a Master's degree in Psychology and Couple and Family Therapy from Antioch University Seattle, and a Bachelor's degree in Psychology from the University of Washington. I am a Licensed Marriage and Family Therapist in the state of Washington, (credential #LF60820305).

I provide counseling services to individuals, families, and partners age 18 and older. I work within the general conceptual framework of Emotionally Focused, Feminist, and Internal Family Systems theories, but employ techniques and interventions from multiple disciplines, and feel that a collaborative relationship between clients and myself is the key to successful therapy.

Partner and Family Therapy Services: Change is often not easy. In fact, meaningful change can be one of the most difficult things people can tackle. You have decided, however, that you are ready for change, and I am honored to have the opportunity to support you in what changes you wish to make.

While I believe I can help you on your journey to change, it is, in the end, a journey you will have to make for yourselves. I can provide insight, make observations and teach behavioral techniques, but I cannot guarantee that the work will provide the change or results you desire. Therapy can be emotionally intense, even painful, at times. We will be challenging long-held assumptions and beliefs, and this may make you angry, uncomfortable, upset, even confused. These reactions are entirely expected, and are a part of healing, and I encourage you to explore them together as they come up.

Number of Visits: The number of sessions depends on many factors, including the nature of your situation and your level of participation in the therapeutic process. Standard partner and family sessions are 55 minutes in length, though longer sessions are available, should they be appropriate. We will discuss this change before it is made.

Payment for Services: 55-minute partner and family session are billed at $125. By signing this consent for treatment, you understand that you are financially responsible for the cost of treatment. Co-payment for insurance billing is due at the time of service. If you do not use insurance, full payment is due at the time of service, and includes a $25 time-of-service administrative discount. I accept credit cards, cash, or checks as payment. If you have any concern about your ability to meet your payment for service, please discuss it with me.

Insurance

Insurance does not cover partner or family therapy, except to assist in mental health treatment of an individual member of the partnership or family. This person must be covered by insurance for the service to be covered. We will discuss at your first appointment whether using insurance is appropriate. If you do use insurance, I will need to provide your insurer a diagnosis, and your insurer will have access to your records.

Missed Sessions: You are responsible for keeping your scheduled appointment. Appointment no-show or cancelation within 24 hours of session incurs a $50 fee, which is not billable to insurance. Late arrival of 20 minutes or more will be considered a no-show.

Termination of Services: In most cases, our time together will end as a natural result of you completing your treatment goals. However, therapy is entirely voluntary, and you are free to refuse any suggested intervention or treatment, and to terminate therapy at any point. If you're thinking about ending therapy, I encourage you to discuss it with me, and, if you desire, I would gladly provide you with referrals to other providers in the area, and will do all I can to be helpful in the transition process. During our work together, if I assess that I am not being effective in helping you achieve your desired goals, I will discuss this with you and, if appropriate, terminate therapy. In this rare instance, I will also provide referrals to other providers who might better suit your needs.

Confidentiality: Your records are confidential. They are stored in a locked, limited-access area. However, there may be times when disclosure of your records will be compelled by law. By law, confidentiality is waived for reporting purposes:

- if I believe one or more of you are an imminent danger to yourself or others,
- if I know of or suspect current child or elder abuse,
- if I believe that one or more of you have been infected with HIV, or are putting a sexual partner at risk for possible transmission of HIV,
- if one or more of you bring a negligence suit against me or file a complaint with the WA licensing board,

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices you were given along with this form, and to discuss with me any questions or concerns you may have. By signing this form, you are giving me your consent to share confidential information with all persons mandated by law, and with the insurance carrier responsible for providing your mental health care service, if applicable.

Professional Records: Your clinical record will contain Protected Health Information, including contact information and reasons for seeking therapy, and may also include a description of the ways in which your problem affects your lives, the goals for treatment, your progress toward those goals, your medical and social histories, your treatment histories, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that, at your request, have been sent to any outside providers. You may examine and/or receive a copy of your Clinical Record – it is yours. I will ask that you sign and date a release form that will be added to your Clinical Record before doing so. In addition, I may also keep a set of therapy notes that are for my own use, and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record, and are not released to others with your Clinical Record, except in rare legal circumstances.

Risks of Therapy: *"An examined life is painful" - Malcolm X.* As I mentioned before, the therapeutic process can be stressful, and can evoke feelings of sadness, anger, anxiety or fear. Your relationships may shift as you explore new ways of interacting with each other and with your lives. You may feel worse about your situation before you begin to feel better. These experiences are common and normal, and, as your therapist, it is my job to help support you through the bumpy road toward your goals.

Secrets: Therapy is a journey that invites us to learn new skills and gain new perspectives so that we can build honesty and trust in our relationships. The process takes courage, patience and openness. Due to the collaborative nature of partner and family therapy, it is imperative that the therapist maintain a neutral stance toward partners and families. This can only be achieved in the absence of secrets within the treatment group. Therefore, please refrain from asking me to keep secrets from other members in treatment. This applies to all forms of communication (verbal, email, phone and written correspondence).

Emergencies: I am unable to provide emergency services. If you are experiencing a psychiatric or medical crisis, immediately contact 911, the King County Crisis Clinic (206.461.3222), or go to your nearest hospital emergency room. Emergencies are urgent issues requiring immediate action - do not be afraid to ask for help.

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____ We have read, signed and received a copy of the HIPPA Notice of Privacy Practices

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Please sign on the following signature page:

We, the undersigned, have read and discussed this Informed Consent Document, and have been given the opportunity to ask any and all questions we have, and have received acceptable answers, and understand that we will be given copies. I have also been given a copy of, and the opportunity to discuss, the HIPPA Notice of Privacy Practices. I give my voluntary consent for Selin Caka, MA, LMFT to provide me with mental health services as her experience and licensure allow. I understand that I must be an active participant in my care, and that I have the right to end or refuse care or treatment at any time.

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Client Name (please print)

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Client Signature Date

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Client Name (please print)

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Client Signature Date

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Client Name (please print)

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Client Signature Date

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Selin Caka, MA, LMFT Date