

DISCLOSURE INFORMATION AND TERMS OF COUNSELING

The *Compassion Everett Counseling Center* affords training opportunities to your counselor through direct supervision, client contact, case consult, seminars, training classes, and practical ministry. The Center's mission is to provide a learning environment for both your counselor and you through an understanding and appreciation of the theories and practices of marriage and family therapy, while still extending the compassionate ministry help we have always offered.

The fundamental values that guide this mission are:

- To Respect the strengths of clients and the complexity of human problems.
- To Sustain therapists in efforts to improve their client care.
- To Shape the learning experience creatively to engage the intelligence, curiosity, and imagination of both the therapist and the client.
- To Encourage reflection of the strengths, values, and therapeutic tools in order to enhance the renewing of one's mind, removal of sinful obstacles, and encourage individual service to God.

INFORMED CONSENT FOR UTILIZATION OF GROUP CONSULTATION AND SUPERVISION

One of the great advantages of being involved with a therapy program such as CECC is the utilization of group consultation and supervision. We are fortunate to be able to offer you the creativity of a team approach with an experienced therapist and off site supervisor. This team will work with your counselor between sessions of your ongoing therapy with the goal of providing you and others in your relationship with the best possible service. ***Confidentiality is our highest priority.*** This priority is consistent with the standards for the State of Washington and the Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT). All members of the consultation group are required by legal and ethical standards to maintain strict confidentiality in their roles. If you would like to know who would be consulting on your sessions, your counselor will inform you of the names of all people who will be present. We will honor your desire that someone named not be an observer of your session. Please ask any questions you may have regarding this informed consent. Your counselor will work to employ creative and imaginative strategies based on your individual resources that best fit your needs and goals for counseling.

COUNSELOR'S INFORMATION

Karla Campbell has a God-given passion for compassionate psychology and for helping people. She enjoys giving you her full attention in one-on-one sessions while listening empathically and providing encouragement in areas that you need to overcome. Karla graduated from Northeast Missouri State University with a BA in Family Sciences in 1990, graduated from Puget Sound Christian College with a BA in Social Sciences in 2005, and graduated from Northwest University with an MA in Counseling Psychology in August of 2007. Karla also completed the Federally Mandated Domestic Violence Training Program in the spring of 2007, is currently a member of the American Association of Christian Counselors (AACC), and is a registered counselor with the state of Washington. In addition, she is also currently undergoing the supervision process to obtain state licensure. Karla brings a wealth of parenting experience related to divorce, single parenting, blended families, ADHD, learning disabilities, teenagers, trauma, and spiritual growth to the counseling environment. Karla looks forward to the opportunity of listening, supporting, and searching out God's will for your life as you grow.

COUNSELING APPROACH

In the process of counseling Karla will be actively involved in working with you, providing information, and offering guidance and support in helping you to sort through the various issues you bring to the counseling office. Karla utilizes a blend of narrative therapy and emotion-focused therapy techniques with psycho-education and solution-based counseling approaches. These approaches focus on the belief systems and constructions of meaning that relate to the thoughts, beliefs, emotions, and behaviors that contribute to the emotional pain you may be experiencing. Karla also utilizes a family systems perspective which may involve exploring how you handle difficulties in current or past situations and relationships. At times Karla may suggest some activities outside the counseling session to assist you in achieving your counseling goals such as reading books, journaling, attending a support group, or going to a physician or naturopath. It is important to Karla that you feel comfortable with the techniques and methods utilized in counseling. At any time you may ask Karla to discuss her treatment approach or recommendations. You have the right to ignore Karla's recommendations, request to have another counselor, or request to stop therapy. The length of time you participate in counseling is up to you.

AGREEMENT

I have voluntarily entered into counseling with Karla Campbell, MA, RC, PLLC, and I give my permission to her and the people involved in the above mentioned group to discuss and review information gathered in sessions or by video for the purpose of consultation and supervision. I understand my counselor's suggestions, instruction, and counsel to be neither legally or medically binding. I agree to pay \$ 55.00 per session to support the Center's expenses, and to pay the therapist while giving training and helping families. The session's length will be approximately one hour. Payments will be made prior to each session and for cancellations made less than 24 hours prior to a scheduled session.

CONFIDENTIALITY

Matters discussed in the counseling environment are confidential and guarded at all times, remaining between the counselor and counselee. For this reason, if I want my counselor to release any information about my participation in therapy to anyone, I will be required to obtain a signed "Release of Information" form before the information will be released. The following exceptions apply as provided by law:

- A counselor is required by state law to report knowledge of abuse to children, developmentally disabled adults, or minors who are victims of a crime.
- If in the counselor's opinion I become an imminent danger to another person or myself and that threat is perceived to be serious, the agreement may be broken for safety reasons.
- If a judge subpoenas my records, they will be released unless I file a **Protection Order** within 14 days of the subpoena.
- In accordance with RCW 18.19.060, if I choose to file a complaint with the WA Dept. of Health, all my records will be released to be reviewed at the State's discretion.
- In the event of a medical emergency, emergency personnel or providers may be given necessary information.

Minors and Parents: Clients under the age of 18 years of age who are not emancipated, and their parents should be aware that the law permits parents to examine their minor's treatment records. Since privacy in counseling is crucial to successful process, particularly with teenagers, it is common that Karla request an agreement from the parents that they consent to give up access to their child's records. If parents agree, Karla will provide parents only with the general information about the progress of their child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless Karla feels the child is in danger or is a danger to someone else, in which case she will notify the parents or proper authorities of her concern. Before giving the parents any information Karla will discuss the matter with the child, if possible, and do her best to handle any objections the minor client may have.

WAIVER OF LIABILITY

I, the undersigned, having voluntarily entered into advisory counseling, do hereby release from any liability *Compassion Everett Counseling Center*, Bethany Christian Assembly, and its agents or employees from any claim arising from my participation in the counseling situations described above.

HEALTH INFORMATION PRIVACY PROTECTION ACT: You will be given a copy of the Notice of Privacy Practices. Your signature below acknowledges that you received it.

I, _____, agree to enter into counseling with Karla Campbell, MA, RC, PLLC under the conditions stated above.

(Signature)

(Date)

(Spouse or minor guardian's signature)

(Phone)

(Address)

(Karla Campbell, MA,RC)

**Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If a client has any questions or complaints that can't be directly addressed with Karla, then he or she may contact Darleen Kildow, supervisor to Karla, at 360-629-4709 or Pastor Chuck Kinman, Compassion Everett Counseling Center Director, at 425-339-3303. If the matter cannot be resolved through those avenues, then clients are to contact the DEPARTMENT OF HEALTH COUNSELORS PROGRAM, 1300 South East Quince Street, PO Box 47869, Olympia, WA 98504-7869. Phone: (360)664-9098.

Compassion Everett Counseling Center

Karla Campbell, MA, PLLC, RC # 00053277

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 am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (“Protected Health Information” or “PHI”). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. **Permissible Uses and Disclosures Without Your Written Authorization**

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **Payment:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health insurance plan to take certain actions before it approves or pays for treatment services.
3. **Health Care Operations:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation certification, licensing or credentialing activities.
4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosure for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court

order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. **Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you (“Psychotherapy Notes”) will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
2. **Marketing Communications:** I will not use your health information for marketing communications without your written authorization.
3. **Other uses and Disclosures:** Uses and disclosures other than those described in Section 1.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

- A. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. [Note: State law may regulate such charges.] If you are a parent or legal guardian of a minor, please note that certain portions of the minor’s medical record will not be accessible to you.
- B. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
- C. **Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.
- D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after July 1, 2007. This right applies to disclosures otherwise authorized by you, and is subject to other restrictions and limitations.
- E. **Right to Request Amendment.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.
- F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.
- G. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

- A. **Effective Date.** This Notice is effective on July 1, 2007.
- B. **Changes to this Notice.** I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.