DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT

PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGEMENT OF ITS RECEIPT ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.

CONFIDENTIALITY & PRIVACY

YOUR RIGHT TO CONFIDENTIALITY AS A THERAPY CLIENT:

As a client in therapy, you have certain rights that are important for you to be aware of and that there are also certain limits on those rights.

As a client of a counselor licensed by the State of Washington, you have the right to expect our communication to be kept confidential. With the exception of the situations listed below, you have the right to have information you share to be held in strict confidence; even the fact that you are seeing me. This cannot be waived without your consent. I always act to maximize your privacy even when you waive your right to confidentiality.

EXCEPTIONS TO CONFIDENTIALITY:

All issues discussed in the course of therapy will remain in the strictest confidence except those issues which you choose to sign a release of confidentiality of information for (examples: to your medical doctor, other treatment providers, or a family member). Exceptions to confidentiality are provided by law. When Federal and State laws differ, the more stringent law supersedes the other.

Mandatory Disclosure to Public Health Officials/Law Enforcement: the following situations are exceptions to your confidentiality rights.

- If I have cause to think by a client's word/actions that they are at risk of harming themselves or another person(s), I am required by law to protect you and/or the other person(s).
- If I have cause to think based on a client's words or actions that a minor child, dependent adult or elder adult is currently being abused: physically, sexually, or through neglect or if you report information to me about the possible current abuse or neglect of a child, dependent adult, or elder, I am mandated by law to report this to Child Protective Services or Adult Protective Services.
- If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner) I will not release any information to a third party (courts, attorney, etc.) without the signed permission of all parties (age 13 and above) involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents your agreement to this requirement.

Voluntary Referral Disclosure: In some cases, it may be useful for me to discuss your case with other providers, such as your physician, psychiatrist, psychotherapist, or other health care providers. I will always discuss this option with you and will obtain your written permission before seeking any exchange of information.

Supervision: As required by State statutes I regularly consult with a professional colleague regarding my work to further my skills. No identifying information is utilized in these meetings.

SUPERVISION AGREEMENTS

As a Marriage & Family Therapy Associate in Washington State I maintain ongoing required supervision from licensed marriage and family therapist Linda Hanby, LMFT, Washington State License #: LF60256554; Phone 253-398-2023.

EXPECTATIONS OF THERAPY:

Insurance: At this time, I do not accept any form of insurance. I can accept payments from Health Saving Accounts, Flexible Spending Accounts, & health Reimbursement Arrangements.

Drugs & Alcohol: Therapy is undermined when a client is under the influence of drugs, alcohol, or marijuana. In the event you show up to a session intoxicated you will be charged your normal session fee and asked to make an appointment on another day when not intoxicated.

Results: Therapy is complex and multi-factored. Your continual engagement in this self-awareness and discovery process is important. Also, be aware that I as counselor can invite you to think and feel about problems in new ways but I cannot do the mental and emotional work for you or your family members. That is always the client's responsibility. I will assist you in this process as would a coach or a guide based on my training. Your participation is always voluntary. If you believe that you are hitting roadblocks, please let me know so that we can find solutions that work for you. The number of sessions and the decision to continue or terminate therapy is **always** your choice; therefore, I make no guarantee to specific outcomes or to a set number of sessions.

Termination of Therapy: Although you are free to terminate therapy at any time, I do request that you discuss your decision for termination at the beginning of a regularly scheduled session. Termination of therapy can be an uncomfortable topic to bring up but it is important that it is discussed openly. I consider it important that the therapy relationship be closed in a straightforward professional manner and that therapy issues have been concluded to the best of our mutual abilities.

No Secrets Policy: In the event I see you and a spouse/partner as a couple for relationship therapy, I do maintain a strict no-secrets policy. Anything said to me is considered discussable with the other partner. In family therapy I do consider parents to have a right of privacy regarding their relationship separate from their children and vice versa for minors age 13 and up unless I am compelled to disclose information under mandatory reporting laws.

Public Meeting: In the event we meet in a social setting to protect your privacy I will in no way acknowledge that you are or have been my client unless you initiate contact and/or voice that fact to others.

Gifts: Due to possible conflicts of interest the exchange of gifts is generally discouraged.

Social Media: I generally do not respond to social media or video game requests or invitations.

Recording of Sessions: Therapy sessions cannot be audio/video recorded unless I and all parties have signed a recording consent form.

Records: I generally keep records for 5 years from the date of last contact unless I am contractually obligated by a third-party to keep them longer. Request for records need to be made in writing. I reserve the right to provide you with a summary in lieu of actual records. I also reserve the right to refuse to produce a copy of

your record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider of your choice. Fees for copies are based on State Law. Please see the ***Notice of Privacy Practices*** for further information on how I manage records.

Teenagers: State Law allows teenagers age 13-18 to consent for/to treatment and the release of their personal health information. Sharing of any information given in confidence from a teen via therapist to parent can result in lack of trust and negatively impact therapy. Therefore, when working with teens, I do not share information with parents or guardians without a current release of information signed by the teenager. In some cases, scheduling and billing may be discussed with the parent/guardian as the financial guarantor.

Emotional Support Animals: I generally do NOT do evaluations or write letters for Emotional Support Animals (ESA's) due to a blurring of professional roles as a therapist versus an evaluator.

Animals in the office: Due to the possibility of allergies and bathroom accidents in my office space I ONLY allow Service dogs in the office.

Colognes and Perfumes: Many people, including myself are scent sensitive or can have allergic reactions to fragrances such as: cologne, perfume, after-shave, deodorant, and body washes. In addition, sometimes these fragrances linger in the office space or the furniture for days. Please do not use or lightly use these substances when making visits to the office.

LITIGATION

I do **NOT** voluntarily participate in any criminal, divorce, custody or other litigation in which you and another are parties. I have a policy of **NOT** communicating with your attorney and will generally not write reports or sign letters, declarations, or affidavits to be used in your legal affairs. I will generally not provide records or testimony unless compelled to do so. My time spent in dealing with your legal matter will be billed at $250 per hour. This includes making/responding to phone calls, letter writing, reviewing and summarizing case notes, making copies, court room appearances, deposition statements, travel time, and any other activity required to respond to the legal issue presented. Travel start time will begin when this provider leaves the office and arrives at the appointed place and departure from the appointed place to the office (portal to portal).

APPOINTMENT AND FEES

Session Length: A therapy /hypnotherapy session is approximately 45-50 minutes unless we arrange in advance for longer sessions. Longer sessions will be charged proportionately.

Cancellation Policy: The scheduled time is set aside for you. Last minute cancellations or no-shows can impact the progress of your therapy as well as prevent other client's from being able to receive the help they need. My policy is that if you need to cancel a session you can do so with no financial obligation as long as you call, text, or email me no later than **0900am the morning of the session**. Please call my business number **360.471.2302** or email me at mccormack@kitsaphypnosiscenter.com to cancel.

Late Cancellation Policy: If you cancel your appointment after 0900am for any reason other than an emergency (something beyond your control, i.e. car accident; child taken to ER) you will be charged half of your normal session fee. If you have any doubt that you might not be able to make your session please call and give me notice. You can always call and try to make the session if things work out.

No-Show Policy: If you fail to make a session without giving any notice you will be charged your full session fee. Repeated failures to make appointments will result in therapy being terminated and your record being closed. When client's no-show my policy is to attempt to contact the client at least twice using the contacts means listed in the client information sheet. If the client does not respond or show at the next regularly scheduled session time held for them (or within 7 days for bi-weekly or greater clients) then I will try one final contact attempt, if no response I will assume the client no longer wants therapy and close the record.

Fees: My fee schedule for new or returning clients is as follows: Individual Clients are billed at $95 per session. Couples and Family sessions are billed at $105 per session. Individuals that bring in outside parties for a limited number of sessions will only be charged their normal fee unless they decide to change the nature of the therapy: i.e. individual to couple therapy. Couples that do short-term **temporary** individual sessions are still being seen in the context of couple's therapy are charged the Couple and Family rate of $105. Payment is due at the end of the session. currently I accept cash, checks, debit/credit cards (Visa, MasterCard, Amer. Express, and Discover). I utilize Square or Stripe for processing card transactions. There is a $30 fee for returned checks. Unused fees, previously collected will be refunded within 30 days of request to that person designated as the financial guarantor.

Sliding Scale/Reduced Fee: I do not offer sliding scale. I sometimes will accept a reduced fee based on need. However, I generally prefer clients to utilize bi-weekly sessions instead of using reduced fees or sliding scale.

Returning to Therapy: If you return to therapy after your record was closed for more than 90 days you will be asked to update your client information sheet and be required to sign a new disclosure agreement; and acknowledgement of privacy practices **if** these documents have changed since your original agreements were signed or if the format of the therapy is being changed. Current fee rates based on the most current disclosure agreement will apply unless other arrangements are made by agreement.

Identification: I verify the identification of each person seeking therapy age 13 and up. Some form of valid picture identification must be presented. Drivers' license, military id, school id, green card, etc. I keep a photocopy of this in the record.

Financial Guarantor: I do require someone to be designated the financial guarantor for therapy payments. For minors this is usually a parent/guardian. The purpose of this is to protect Kitsap Counseling & Hypnotherapy Center from financial loss if a client refuses to pay a previous balance. It also allows me to identify who is to receive any account balance overage at the termination of therapy. A driver's license number or SSN is needed to complete the financial guarantor information.

TRAINING AND APPROACH TO THERAPY

Approach to Therapy: I work from a systemic-integrative coaching framework that helps clients become aware of, reduce, and balance reactive "fight or flight" emotions so that clients can respond resourcefully to the challenges of life and relationships. Our work together utilizes methods and techniques taken from Bowen Family Systems Theory, Experiential Family therapy, Transactional Analysis, Neuro-linguistic Programming, and Communication Theory.

HYPNOTHERAPY (optional) (see page 8)

I offer hypnotherapy services for those who would like to benefit from that modality. Further description of my use of hypnosis for clinical issues can be found on the Informed Consent for Hypnotherapy addendum of this document.

TELE-MENTAL HEALTH (optional) (see page 9)

I offer video and phone services for those who would like to utilize that modality. Further description of this modality can be found on the Informed Consent for Telemental Health Services addendum of this document.

PERSONAL BACKGROUND

Formal Education and Training:

NorthCentral University, Master of Arts in Marriage and Family Therapy
Charter Oak State College, Bachelor of Arts: History
Hypnosis Motivation Institute, Diploma in Hypnotherapy
Thomas Edison State University, Bachelor of Arts: Psychology
Thomas Edison State University, Associate in Applied Science Administration Studies.

Current Certifications and Licenses:

Associate Marriage and Family Therapist License #MG60982950
State of Washington Registered Hypnotherapist HP60464333
State of Washington Business License #603-396-084
Certified Clinical Hypnotherapist, Hypnosis Union Local 472 #31278985
City of Bremerton Business License #31626

Experience:

Counseling Services, Kitsap Counseling & Hypnotherapy Center	2016-Present
Navy Chief Petty Officer/Personnel Resources Manager	2010-2012
Human Resources/Financial Disbursing Manager	2007-2009
Financial, Career, and Performance Counselor; US Navy	1998-2012

Professional Memberships & Ethics Codes: I am a member of the American Association for Marriage and Family Therapy and registered as a Certified Clinical Hypnotherapist with Hypnotherapists Union Local 472. I work under both organizations' Code of Ethics which are available upon request. I follow all legal and professional standards mandated by the *Washington State Omnibus Credentialing Act for Counselors* and the *Uniform Disciplinary Act for the Regulations of Health Professionals.*

WA Department of Health Statement: 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 implies the effectiveness of any treatment. The purpose of the *Counselor Credentialing Act* is to provide protection for public health and safety; and empower citizens of Washington by providing a complaint process against unprofessional conduct. Clients have the right to choose counselors who best suit their needs and purposes.

Unprofessional Conduct: Washington State considers the following acts unprofessional conduct; misrepresentation or false advertising, incompetence, negligence, malpractice, violation of any state or federal code, willful betrayal of confidentiality, and sexual misconduct, among others. A full list of acts considered unprofessional conduct can be found in *RCW 18.130.180*.

Complaints/Quality of Service: If you think I have conducted services in an unprofessional or unethical manner, please advise me so that I can clarify and help resolve the problem. If this does not resolve the issue to your satisfaction, you may contact either of the following sources:

Supervisor
Linda Hanby, MA, LMFT
19309 68th Ave. S. R101
Kent, WA 98032
253-398-2023

State of Washington
Attn: Quality Assurance
P.O. Box 47857
Olympia, WA 98504
360-236-4700

EMERGENCIES

In the event of an emergency where you need to contact me, please call my business phone at **Kitsap Counseling & Hypnotherapy Center (360) 471-2302**. Due to my work schedule, I usually am not immediately available by telephone; you may leave a voice message. I typically do not regularly check my voicemail on days off, or vacation time. However, I will make every available effort to return your call as soon as possible.

If I am unavailable and if you think you may be a danger to yourself or others please contact the **Volunteers of America (VOA) Crisis Line at 1-888-910-0416,** or dial **911**.

UNSECURED COMMUNICATION

Use of unencrypted e-Fax, SMS Text messaging, and Email is NOT secure and if you use these methods to communicate your personal health information cannot be guaranteed. I do utilize secure HIPAA compliant Email via Hush mail and I prefer that all communications other than voice utilize this method. If you do choose to use a non-secure method to communicate to me, I advise you to limit the communication to administrative issues only (scheduling). If you choose to transmit personal health information via non-secure means you do so at your own risk.

BUILDING ACCESS/PARKING/ACCESSIBLE PARKING

After-Hours Access: The Kitsap Business Center in which my office is located locks its doors at 5pm during the workweek and is locked all day on weekends and holidays. In the event you have a session during these times be aware that there is a doorbell that rings into my office, located at the top left of the outside door that opens to the hallway in which my office resides.

Free 2hr Parking: is located between the Kitsap Business Center and the old Kitsap Bank building. Parking anywhere else in the Diamond Parking spaces is not authorized and may result in you being towed at your own expense.

Accessible Parking: is available at the back of the Kitsap Business Center.

Wheelchair Access: While doors and my office is wheelchair accessible doors are not equipped with automatic openers; if necessary, please arrange with me for assistance.

INFORMED CONSENT FOR THERAPY SERVICES

I have read and understand the information explained to me in Kitsap Counseling and Hypnotherapy Center's *Disclosure of Information, Policies, and Client Agreement*, and understand it, including my rights as a client. I understand that developing a treatment plan with my counselor and regularly reviewing my progress toward meeting treatment goals are in my best interest. I agree to play an active role in this process. I also understand that no promises have been made as to treatment results or of any procedures or techniques utilized by my counselor. Please read and initial your specific understanding of these points:

_____ _____ (Couple Counseling) We understand that my counselor works under a no-secrets policy; that the "relationship" is the "client" and that things divulged in individual sessions can be brought up in couples therapy.

_____ _____ I/We understand that as the client(s) I/we have the right to terminate therapy at any time.

_____ _____ I/We understand that Mr. McCormack works as a coach and can make no guarantee of specific results and that I/We must take responsibility to put insights, techniques, and skills-learned into practice.

_____ _____I/We understand our right to confidentiality and the exceptions to that confidentiality as required by our counselor as a mandated reporter to Washington State.

_____ _____ I/We understand the termination policy of Kitsap Counseling & Hypnotherapy Center.

_____ _____I/We understand the cancellation policy and no-show policy of Kitsap Counseling & Hypnotherapy Center.

______ _____I/We understand that our counselor does NOT willingly get involved in litigation disputes and that if compelled he will ask for compensation at rates specified in this document.

______ _____I/We understand that if I/We utilize unsecured email/fax/SMS text services that this is at my/our own risk.

______ _____I/We understand that Mr. McCormack is an Associate Licensed Marriage & Family Therapist working toward full licensure under the supervision of Linda Hanby, Licensed Marriage & Family Therapist.

Client____ **Date**_______________

Client____ **Date**_______________

Client____ **Date**_______________

Client____ **Date**_______________

Counselor: _____________________________________ **Date:** ________________

AGREEMENT FOR HYPNOTHERAPY SERVICES

The following information is provided to clients who are seeking Hypnotherapy. It is an addition to the Disclosure of Information, Policies, and Client Agreement. Please read this document carefully and in its entirety and note any questions you would like to ask or have clarified before signing this document.

General: Hypnosis works to change patterns in the subconscious mind (autonomic nervous system) to change habitual patterns of behavior. Hypnosis is a powerful tool for accessing the subconscious mind and creating improvement in our lives. While hypnosis may be an effective technique for many purposes, the effectiveness may vary from individual to individual, and no specific results or progress can be promised or guaranteed.

Expectation: During hypnotherapy sessions, clients remain completely aware of everything that is going on. In fact, many people experience a hyper-awareness where sensations are perceived enriched and vivid. The ability to visualize or imagine is often enhanced. Deep relaxation is common. Many describe the hypnotic state as a complete and total escape from physical tension and emotional stress, while remaining completely alert.

Memories: The use of hypnosis or remembering techniques in general could elicit memories of past events which may or may not be literally true. It is possible that events under hypnosis will be distorted or misconstrued. Memories or images evoked under hypnosis are not necessarily accurate and may be a construction or composite of multiple memories. Without corroborating information, it is not possible to determine whether a specific memory is true or false, even if it seems true to the client.

Use of Touch: Hypnosis is often facilitated and enhanced by the use of light and brief touch to the forehead, shoulder, arm, wrist, hand, or fingers. Some interventions may involve a brief holding of your arm at the elbow or wrist. If you have any questions or concerns regarding the use of touch in hypnotherapy please bring this to my attention.

Method/Training/Certifications: I have been trained in Kappassinian Hypnotherapy based on the therapeutic work of the late Dr. John Kappas and the Hypnosis Motivation Institute (HMI) based in Tarzana, California. HMI can be found online at www.hypnosis.edu. Further I follow the ethical guidelines for hypnotherapy promulgated by the Hypnosis Union Local 427 which can be found online at https://www.hypnotherapistsunion.org/codeofethics. I am designated as a Certified Clinical Hypnotherapist (CCht) by said Hypnotherapist Union and I am registered to use hypnotherapy with clients with the Washington State Department of Health.

INFORMED CONSENT FOR HYPNOTHERAPY SERVICES

I hereby authorize James McCormack, MA, LMFTA, CCht, Rht, to render hypnotherapy services to me under the terms and expectations described in the above statements. My signature below indicates that I have reviewed this informed consent document and I agree to the use of hypnotherapy services under the aforementioned policies and procedures.

Client: ____ Date: _________________

Counselor: ____ Date: _________________

AGREEMENT FOR TELEMENTAL HEALTH SERVICES

The following information is provided to clients who are seeking Telemental health counseling. It is in addition to Disclosure of Information, Policies, and Client Agreement. This document covers your rights, risks, and benefits associated with receiving Telemental health services, my policies, and your authorization. Please read this document carefully and in its entirety and note any questions you would like to ask or have clarified before signing this document.

CLIENT RIGHTS

- I understand I have the right to decide to end the use of Telemental health options at any time.
- I understand I have the right to ask questions about Telemental health procedures utilized during therapy.
- I understand that I may benefit from Telemental health services but that results cannot be guaranteed.
- I understand that Kitsap Counseling & Hypnotherapy Center may NOT provide Telemental health services to me if I am outside of the State of Washington, and I understand that I may access Telemental services from Kitsap Counseling & Hypnotherapy Center* from within the State of Washington only.

BENEFITS & RISKS

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. Note: at this time I do NOT do email therapy.

- I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my personal health information could be disrupted or distorted by technical failures.
- I understand that Telemental health-based services and care may not be as complete as face-to-face services.
- I understand if my therapist believes I would be better served by another form of psychotherapeutic service (e.g. in-person services) I will be referred as necessary to those who can provide such services in my geographic area.

In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapist to connect with people who may otherwise not be able to access services; there is an opportunity for more flexibility in scheduling; and convenience in being able to connect from a space of your choosing.

BEST PRACTICES

In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- For a video session, if possible, use a stronger platform such as a PC, laptop, or tablet. Smartphones for video are not stable platforms for long video sessions.
- Always engage in sessions in a private location where you cannot be overheard by others.
- Use a private phone, or device.
- Do NOT record any sessions without prior permission from your therapist.
- Password protect any technology you will be interacting with your therapist on.
- Always log out or hang up once sessions are completed.

CONFIDENTIALITY

The laws that protect the confidentiality of your medical information as described in the Disclosure Agreement for Therapy Services also apply to Telemental health services.
I understand that Kitsap Counseling & Hypnotherapy Center's platform(s) conform to Federal and State HIPAA compliance standards to reasonably protect my privacy and confidentiality.

PAYMENT OPTIONS

Payments for services are accepted via credit or debit card and utilizes either STRIPE for video sessions or SQUARE for phone sessions per the Kitsap Counseling & Hypnotherapy Center's Disclosure Agreement and Acknowledgement of Privacy Practices. Session rates are the same as in-person visits.

DISRUPTION OF SERVICES

In the event of technology disruption or failure, it is important to have a plan on how to reconnect to the Telemental health session, generally the therapist will attempt to contact you via phone in the event of a video conference failure and email in the event of a phone failure or disruption. Generally, in the case of a technology failure sessions are billed in fifteen-minute increments (if a session fails at 15 minutes you would be charged ¼ of the session fee; if session fails between 16 minutes and 30 minutes you would be charged ½ of the session fee, etc.).

EMERGENCY PLAN

Kitsap Counseling & Hypnotherapy Center does not provide emergency services. In the event of an emergency, it is imperative you are aware of local resources in your area. As a precaution, I will ask for your physical location (address) and an alternate way to reach you, as well as an emergency point of contact. These must be in place prior to continuing the session and will be asked for on your Informed Consent Agreement.

INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES

I/We consent to Telemental health services under the aforementioned policies, procedures, and expectations. I/We hereby authorize James McCormack, MA-LMFTA, CCht, Rht, to render therapy, and or hypnotherapy services to me/us under the terms described in the above statements. Signatures below indicate that I/We have reviewed the document and that I/we are satisfied with its content.

Emergency Point of Contact: ____

POC Phone Number: _________________________

Client: ____ Date: ______________________

Client: ____ Date: ______________________

Counselor: ____ Date: ______________________

Version 4.0 / Dated June 1, 2020

This page not used at this time

AGREEMENT OF PARENTS/GUARDIANS IN CASES OF CUSTODY PROCEEDINGS (child therapy ONLY)

Therapy can be a very important resource for children experiencing separation and divorce. The counselor can provide a neutral setting where children can explore their thinking and feelings about these issues. In this case, a child cannot be seen unless both parents agree to the child receiving therapy. An exception to this is if one parent has the legal documentation (e.g., a legally signed parenting plan) stating they have sole decision making for mental and medical treatment for the child. The parent would be required to provide a copy of this document to the counselor. However, the usefulness of therapy is extremely limited when therapy itself becomes an area of conflict between the parents. Any matter that is brought to the counselor's attention by either parent regarding the child may be revealed to the other parent unless otherwise stated in the parenting plan. It is best if all parents/guardians stay in frequent communication with the therapist regarding the child's emotional well-being.

As a therapist I do not choose sides and do not render forensic opinions. The parents must understand completely that I as the therapist am providing treatment NOT acting as an evaluator. The parent must also understand that I as a therapist am not conducting custody, visitation, or parenting evaluations. I want you to understand the reasons why I do not provide your records for custody disputes. I may not possess the professional competency to make a decision about issues besides those I deal with in therapy. Therapy often involves full disclosure of information that our might not want revealed in a court of law. Testifying or making a deposition often changes the therapeutic relationship, and I hold the therapeutic relationship as the most important priority. In those cases where you are seeking custody evaluations and recommendations, I will be happy to refer you to those who specialize in that field.

INFORMED CONSENT OF PARENT/GUARDIANS REGARDING CUSTODY PROCEEDINGS

I/We the parent/guardians(s) am/are aware that requesting the release of treatment notes, plans, or evaluations for forensic purposes or therapist testimony about the content of my child's treatment will interfere with the therapeutic process. Therefore, I knowingly and freely waive my right to request the release of information (beyond attendance, dates, and length of our sessions) to my attorney. I understand that release of clinically significant information to any officer of the court shall only be in response to a court order or subpoena. I understand if records are requested by both parent and the parenting plan states both parents have medical decision making, then the policy is to send records to BOTH parents even if the other parent has not requested records.

I/We have read and understand the issues and points made above. I have discussed those points I do not understand and my questions have been answered satisfactorily. I agree to act in accordance to the aforementioned policies of James McCormack, MA, LMFTA, & Kitsap Counseling & Hypnotherapy Center. I further state that I am the legal custodian of this child and have no court orders in effect that would prohibit me from consenting to the treatment of this child. I also understand that my therapist/counselor can rely on my representation that I am authorized to consent to health care for the minor patient as true without incurring and civil or criminal liability for such reliance, pursuant to RCW 70.02.130. My signature below indicates I agree to all these points and will follow fully to the best of my ability.

IF YOU DO NOT SIGN OR ALL LEGAL PARENTS/GUARDIANS DO NOT AGREE TO THIS AGREEMENT, THEN I CANNOT PROVIDE THERAPY TO YOUR MINOR/CHILD.

____ _______________
Responsible Party/Client Signature Date

____ _______________
Additional Legal Parent/Guardian Signature Date

____ _______________
James McCormack, MA, LMFTA, CCht, Rht Date

______Copy accepted by client ______ Copy accepted by additional person