**Dick (Carl Richard) Mattila M.S., MDiv. LMFT**

**Licensed Marital and Family Therapist**

**2219 Rimland Dr., Suite 301 Bellingham, WA 98226**

**Terms of Service/Disclosure Statement (effective 11/1/2017)**

This document is designed to ensure that you understand key aspects of our professional relationship.

***LICENSURE:***

I am a Washington State Licensed Marriage and Family Therapist (#LF60171972).

OUR RELATIONSHIP:

Although you may at times feel very close to your therapist, it is important to understand that this is a professional relationship rather than a personal one. Professional ethics require that contact be limited to the paid sessions you have with me. Please do not invite me to social gathers, offer gifts, or ask to be related to you in any way other than in the professional context of our counseling sessions. You will be best served when the relationship stays professional and the sessions concentrate exclusively on your concerns.

It is important that you receive enough information to make an informed decision about what will happen if you employ me as your counselor. Therefore, it is very important that you ask questions concerning therapy so that you feel comfortable about what will happen; it is your right and privilege to ask such questions. If at any time my style of treatment does not seem right to you, please tell me. So again, please ask questions if you do not clearly understand something about my practice and procedures! Once we begin therapy it is always your right to discontinue treatment at any time.

***CONSULTATION AND PEER REVIEW:***

DM Counseling LLC uses consultation with licensed experienced therapists. Good clinical practice requires occasional peer review and consultation. Please be aware that your case may be clinically reviewed in a confidential manner.

***CONFIDENTIALITY AND PRIVACY:***

Your therapist will keep confidential anything you say to him or her, with a few exceptions as required by law.

Please read the attached Notice of Privacy Practices for more information about your privacy rights, and initial here to acknowledge that you received a copy of the Notice, or that you were offered the Notice form and declined your own copy:\_\_\_\_\_\_(Please initial here).

***Exceptions to Confidentiality:***

(Revised Code of Washington State Chapter 18.19, Sec.180)

1) With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;

2) That a person registered or certified under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;

3) If the person is a minor, and the information acquired by the person registered or certified under this chapter indicates that the minor was the victim or subject of a crime, the person registered or certified may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;

4) If the person waives the privilege by bringing charges against the person registered or certified under this chapter;

5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or as required under chapter 26.44 RCW.

 This means that I must report any known or reasonably suspected case of ***child abuse*** or ***neglect*** (child or teenager) and/or any serious intent to seriously harm yourself or another person. Failure to report may result in civil and/or criminal prosecution of the counselor. If and when such situations arise, I will inform you of the necessary legal action that must be taken. Again, keep in mind that these laws are for your protection, not the counselor.

***FEES AND PAYMENT:***

Please call for information regarding fees and use of insurance. Please note that as the recipient of services, you are responsible for all charges. Payment is due at the time of your appointment – cash or check. Insurance Companies require that the therapist diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before submitting to your insurance carrier.

***CANCELLATIONS:***

In the event that you are unable to keep an appointment, you must notify me 24 hours in advance (unless there is a reasonable emergency). If I do not receive such notice, you will be responsible for paying half the individual service rate for the missed session. Your insurance company will not pay for missed sessions. If you need to cancel or reschedule you can leave a message at (360) 510-8127. Also please remember to leave your home, work or cell phone numbers with every message so that I can get back to you. Please call back if you do not hear from me weekdays within 36 hours.

***EMERGENCIES:***

If there is an emergency between sessions, I can be reached by phone at (360) 510-8127. In case of a life threatening emergency call 911, go to the Emergency Room at St. Joes. Hospital, or call the 24-Crisis Line: 1-800-584-3578.

***TELEPHONE:***

Telephone conversations should be kept as brief as possible, as it is normally not an appropriate method of conducting therapy. If a call longer than 10 minutes is necessary, you may be charged at the usual hourly rate. E-mail communication should be limited to scheduling appointments. Please be aware that e-mail is not a confidential form of communication.

**COMPLAINTS:**

If at any time or for any reason you are dissatisfied with the services, please let me know. If I am not able to resolve your concern, you may report your complaint to the Health Professions Quality Assurance Division at (360) 236-4902. By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure. I also give DM Counseling permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

*By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure. I also give DM Counseling LLC permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.*

Client’s Signature Dick (Carl Richard) Mattila, LMFT

Date Date