Joseph E. Broome, M.A., LMHC
Individual, Teen & Family Therapy
Washington Licensed Mental Health Counselor # LH60200686
www.InItTogether.org
206.295.0624
In It Together L.L.C.

DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT
PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGMENT 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.

My Training and Approach to Therapy
I am trained as a "Family Systems Counselor," and have a Master of Arts Degree in Applied Behavioral Science with an emphasis on Systems Counseling from the Leadership Institute of Seattle (LIOS) / Bastyr University. "Family Systems," means I look at problems in the context in which they exist rather than exclusively seeing problems existing within an individual. This perspective allows me to take a wide look at the client's problems bringing in many factors that can influence the change desired. I will often suggest that clients bring in other family members, partners, and or significant others into sessions.

I assist people in discovering their strengths and resources to achieve the change desired. I offer challenges and credits as well as ideas for action to assist in your desired outcome. I am trained in Structural, Narrative, Strategic, Solution Focused, Bowen, Lifespan Integration, CIMBS and Adlerian therapy. I will employ a diverse set of resources and modalities of therapy to assist in bringing about change, growth and solutions.

Each course of counseling is unique to those who participate in it. Thus, your experience in psychotherapy is a blend of what you and I do together. I have never worked in exactly the same manner from client to client, or session to session. Each person is unique. Each story is different, though there may be many similarities between people. Together we are responsible for developing and implementing a course of treatment that will most effectively help you reach your goals. I value being in partnership with clients, and I welcome feedback and suggestions as a part of this partnership. Whether or not counseling is successful may depend on a number of factors such as willingness to change, the nature of the desired change, the level of trust between the client and counselor, the "fit" between the client and counselor, and outside influences.

I ascribe and adhere to the Code of Ethics of the American Association for Marriage and Family Therapy.

Your Rights as a Client in Counseling
As a client in counseling, you have certain rights that are important for you to know about. There are also certain limitations to those rights of which you should be aware. As a client of a counselor registered in the State of Washington, you have privileged communications under state law. With the exception of the situations listed below, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The privilege is yours, not mine, and cannot be waived without your consent. I will always act to maximize your privacy even when you waive your right to confidentiality.

The following situations are exceptions to your right of confidentiality:
1. If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.

2. If you reveal that you have committed or are contemplating the commission of a crime, I may report that to appropriate authorities.

3. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective Services, a state agency.

4. If you are currently in litigation, or become involved in litigation during the treatment process or file a complaint against someone for malpractice, I may be asked to disclose information regarding your therapy as part of that process. Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation, so that I can exercise due caution so as to protect your privacy.

5. If you are seeing me in family therapy, and you, your partner or another family member should happen to see me in an individual session, information shared with me in that meeting may be shared by me in a couple or family session if I believe it to be in the best interest of the work we are doing together. I will discuss this matter with you before sharing that information. If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner,) I will not release any information to a third party (court, attorney, etc.,) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together. In some cases, it will be useful to the therapy for me to discuss your situation with others such as your physician, your former therapist, your attorney, etc. In such cases, I will seek your written permission for this exchange of information.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed in formal or informal sessions with my colleagues or staff here, or with other professionals. During these consultations, neither your last name nor other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services and I will thank them for the referral. I will not discuss your situation with them unless I have your written permission. You always have the right to request a change in the treatment process or refuse treatment. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist.

My Voice Mail number is (206) 295-0624**.** I check my voice mail at regular intervals throughout the day. If you are unable to reach me and are not responded to by one of my colleagues and are urgently in need of help, call the **Seattle Crisis Clinic at (206) 461-3222** (if outside of this area, you may need to contact another local area crisis line,) or call **911** for immediate help.

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to you that the counseling relationship be closed in a straight forward manner, ensuring that all counseling issues

have been dealt with to the best of your and my ability. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice of rescheduling, notice of termination will be assumed and your time slot will be given to the next available client.

Appointments and Fees
Appointments are usually scheduled once per week or once every other week. The session lasts for 55 minutes unless we arrange in advance to meet for a longer time. The scheduled time for your session is set aside for you. **If you miss a session without canceling or if you cancel with less than 24-hours notice, I will bill you in full for that time**.

If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate.

My standard fee is $140 per session and $170 for the intake session. I also see a limited number of reduced fee sliding scale clients. The sliding scale is based on your household income and the number of dependents on that income. Please ask me about availability for reduced fee counseling and to see if you qualify. This fee is standard regardless of the number of people attending the session. My policy is that the first session fee be paid in full at the time of service. Subsequent session fees must be made after each session. I accept checks, cash Visa and MasterCard. A $25.00 fee will be charged for returned checks.

The agreed upon fee is $_____ ($140 per session and $170 for the intake session if left blank)

If I am doing work related to your treatment that is outside the bounds of our scheduled counseling, I will bill you on an hourly basis for all the time I spend on your case, including travel time to another location (such as the hospital, your home, an attorney's office, or another setting,) meeting with other professionals regarding your case, writing reports, preparation time, etc. My fees vary for this type of work but I do charge the maximum allowable by law. I will inform you if your request for additional services will have fees associated with it.

If for some reason I am unable to make our scheduled appointment time due to an illness or an emergency Justus D'Addario will provide backup coverage. Heather Broome, M.A., LMHC is the custodian of my records in case of an emergency. Justus can be reached at 206-877-3188 and Heather at 206-295-0624.

Following the completion of our work together, your complete financial and clinical records will be stored and available for review. After three years a clinical summary and full financial record will be maintained for an additional four years. After seven years all records will be deleted from our computer systems, as well as the physical files shredded.

Quality of Service
If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that this does not resolve the issue, you may contact the following agency:

Washington State Department of Health
Health Systems Quality Assurance
P.O. Box 47865
Olympia WA 98504-7865
360) 236-4700

Client Consent to Use Electronic Mail (E-Mail) as a Form of Communication.
Initial on the line below if you permit the use of e-mail as an acceptable form of communication. Please note that e-mail may not be a secure form of communication and you may be compromising your confidentiality by using it to communicate with me.

_____/_____
Initial Date

Social Media Disclosure
I am unable to connect with clients in any way via social media due to confidentiality issues. My policy is to ignore any "friend" requests via any and all social media platforms.

Client Consent to Counseling
I have read or have had satisfactorily explained to me Joseph Broome's Disclosure of Information, Policies, and Client Agreement and understand it. I have asked any questions that I had about this statement, and about statements regarding fees and payment policies. (For clients under the age of 13, consent must be given and this form must be signed by a parent or legal guardian.) I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above with Joseph Broome and understand that I have the right to terminate counseling at any time. I also understand that Joseph Broome requests notice of termination at the beginning of a regularly scheduled session so that the reasons for termination may be discussed. My signature below indicates that I have received a copy of this agreement.

_____/_____ _____
Client Signature (13 and over) Date Client Name (Please Print)

_____/_____ _____/_____
Client Signature (13 and over) Date Parent or Guardian Signature Date
(For Client Under 13)

_____/_____ _____/_____
Client Signature (13 and over) Date Client Signature (13 and over) Date

_____/_____ _____/_____
Client Signature (13 and over) Date Joseph E. Broome, MA, LMHC Date

Notice of Privacy Practice has been offered to me, and I

____Declined a copy Printed Name_____

____Accepted the hard copy Signature_____

____Accepted the electronic version Date_____

Rev. 8/16/2017