Joanna Darsey-Moss, MA, LMHCA
2722 Eastlake Ave E, Suite 300
Seattle, WA 98102
206-427-1459
joanna@joannacounseling.com

Disclosure Statement & Therapy Contract

Methods of therapy used:

I offer individual, couple, and family therapy. I am a systemic therapist, which means that during our sessions we will discuss multiple aspects of your life in addition to your presenting concern. Your community, your relationships, your family of origin, and the greater world in which you live all impact your current situation. My focus is client-centered with an emphasis on mindfulness. My practice is aware and affirming of LGBTQ+ identities and all forms of consensual non-monogamy.

Education:

I am a Licensed Mental Health Counselor Associate regulated by Washington State (Credential Number MC60697099). This means that I am in the process of obtaining independent Washington State licensure under the guidance of a supervising clinician. I received a Masters in Counseling Psychology from the Leadership Institute of Seattle (LIOS) Graduate Program of Saybrook University. I completed my internship at Sound Mental Health. I worked with adults and specialized in working with LGBTQ+ individuals and couples.

I seek ongoing supervision and consultation from colleagues in order to provide you with the best services possible. I may disclose information about your counseling session in consultation with colleagues, in which case I will withhold your name and other easily identifiable information. I have a current supervision agreement with Jeremy Hulley, MA, LMHC, SEP (Credential Number LH00011252) and I may disclose information about your counseling session as part of ongoing supervision. I also have an agreement with this clinician to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to Jeremy Hulley, MA, LMHC accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

Professional Affiliations & Associations:

I am a member of or affiliated with the American Counselors Association, Seattle Counselor's Association, the Ingersoll Gender Center Therapist and Physician Consult Group, and other professional consult groups.

Fee information and Cancellation Policy:

Fees for a fifty minute session in my office:

Individual Therapy	$100.00
Couples Therapy	$100.00
Family Therapy	$100.00

I offer a limited number of need-based reduced fee sessions. Please feel free to ask me for more information if your situation might warrant a reduced fee.

Reduced Fee: $_____

I am considered an out of network provider for insurance plans. Upon request, I can provide you with a monthly statement that you can submit for possible reimbursement with your insurance company.

Payment is accepted at the end of each session in the form of cash in the exact amount, check, or credit card. You are responsible for payment for all services received. Delinquent accounts will be sent to collections.

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If you must cancel your appointment please contact me at least 24 hours in advance. This ensures that I can see other clients in the opening and can plan accordingly. You will be responsible for the fee when cancellations are received less than 24 hours in advance. The only exception to this is medical emergencies.

Please be aware that rates are subject to change. They are evaluated periodically and may be adjusted. However, you will be informed at least 30 days in advance of any rate adjustment and it is your decision to continue or discontinue therapy at this time.

Communication:

You may leave me a voice mail or send a text or email at any time. I will respond as soon as possible. I am not available after hours. I do not provide on call crisis or emergency services. ****In an emergency always call 911 and/or King County Crisis Clinic at (206) 461-3222****

I do not usually charge for occasional brief (less than ten minute) phone conversations. I do charge for extended or multiple phone calls. Note that text and email are not considered confidential methods of communication. Please use them only to schedule appointments and do not leave crisis information.

Social Media:

I do not accept friend or contact requests on Social Media from any current or former clients. I believe that adding clients as friends or contacts can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Risks & Benefits:

During the course of therapy, you may notice a change in symptoms. As we work through some challenging topics, you may experience greater difficulty in some aspects of your life for a time. While a goal of therapy is to decrease this discomfort, I cannot guarantee results. If you commit yourself to working through these challenges, it is likely that you will see the benefits both during and after our work together.

Confidentiality & Ethics:

I hold as my highest ethical concern the confidentiality of my client. I will do everything I can to maintain the confidence and security of my clients' information, both spoken and written. Personal information will be held confidential, visible only to the client and the therapist, except with express written permission or where required by law.

Your participation in counseling, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;

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- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency;
- If I have any other legal duty, obligation, or right to report.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

State of Washington Disclosures:

The State of Washington requires that I provide you with the following information.

You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of public health and safety. Credentialing of an individual with the department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

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 agency below.

A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

Understanding and Consent:

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in counseling services provided by Joanna Darsey-Moss, MA, LMHCA.

_____	_____	_____
Name (Print)	Client Signature	Date
_____	_____	_____
Name (Print)	Client Signature	Date
_____	_____	_____
Name (Print)	Clinician Signature	Date