NOTICE OF CLIENT RIGHTS, PRIVACY PRACTICES AND STATEMENT OF CONFIDENTIALITY

Client Name: ____ DOB: _________

Scheduling: Appointments can be scheduled through Simple Practice, by telephone, text or email. Counseling is most effective if carried out on a regularly scheduled basis. Clients are encouraged to attend once a week sessions for the first three months of treatment. This can be re-evaluated after the initial treatment period.

Travel: Please note that I often travel for extended periods of time. Any time away from the office will be discussed with relative notice and adjustments will be made to ensure your therapeutic services continue uninterrupted.

Termination: It is my desire to promote and support your self-determination. Clients 13 years and older have a right to refuse evaluation or treatment. You have a right to ask questions concerning the findings of any evaluation and treatment, and the right to raise questions about the therapist, the therapeutic approach, and the progress made at any time.

It is your right to terminate treatment at any time or to seek services with another provider who best fits your needs, with or without notice to me. However it is my hope that we mutually seek to heal and interrupt disposability or "ghosting" culture. A discussion prior to termination can be beneficial for the therapeutic relationship and for both of our personal and professional growth as well as offer us an opportunity to practice repair. I also understand if you prefer to not have a conversation about ending services; a text, voicemail or email will suffice.

If communication does not take place and/or you miss an appointment and do not respond to my attempt (1X) to contact you or if you do not reach out to re/schedule, I will assume that you are taking a break from sessions or terminating services. If I do not hear from you within one month of our last appointment, I will close your account and I will hope that together we have at least planted seeds for further healing. Please note that your account may be reopened at any time simply by reaching out to me. The door is always open to reengage and I look forward to catching up on what has happened in your life since the last time we met.

Record Keeping: I keep brief notes regarding the content of our sessions. I will document the minimum necessary to meet the legal and ethical standards of my profession. I will abide by all other state requirements (WAC 246-810-035) for record keeping which requires me to keep, at the very least: the client name; fee arrangement & record of payment; dates counseling received; signed disclosure form and signed notice of privacy practices and confidentiality.

Washington State Law allows the client to choose whether or not they want written records of their sessions to be documented by their therapist. If you should chose to NOT have the therapist keep a record please inform your therapist now and Initial below. I, Diana Mena, LICSW, do reserve the right to document sessions that I believe to be high risk or concerning; such as suicidal thoughts and attempts, any type of abuse including substance abuse, etc.

In accordance with WAC 246-810-035, I, (print name)______________________, request that no records be kept of my treatment other than the intake forms, a fee arrangement for services rendered, a record of dates of services rendered and payments for these services, for insurance purposes or deemed professional necessary by Diana Mena, LICSW. Initials_________

Protected Health Information (PHI): During the course of treatment the therapist will have access to protected health information (PHI) about the client that will be used for diagnosis, treatment, and billing. This information may also be used to contact client, run the therapist's practice, improve client care, and for professional consultation or supervision. This information may also be used to support public health and safety issues, research and in order to comply with the law. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

- The therapist is required by law to maintain the privacy and security of client PHI.
- The therapist will let client know promptly if a breach occurs that may have compromised the privacy or security of their information.

Client's Rights Related to Privacy and Confidentiality:

- The client can request confidential communication
- The client can request to limit the information shared
- The client can file a complaint if they believe their privacy rights have been violated
- The client can request a copy of their paper or electronic medical record
    - This may require an additional appointment to review record prior to releasing a copy
    - This may take up to 30 days
- The client may ask to correct their paper or electronic medical record
    - This request may be denied but client will receive final decision in writing
- The client can request a copy of this Notice of Privacy Practices

Legal exceptions to Confidentiality:

- The client gives written permission to share confidential information (ROI).
- In the event of a medical emergency, necessary information may be given to emergency personnel or services.
- The client is threatening suicide or major self-harm and the therapist is unable to obtain their agreement to not to engage in such acts.
- The client is threatening to severely harm another person. In some cases the therapist is obligated to warn the person or persons who are in danger. This is known as "duty to warn."
- The client brings charges against the counselor or files a complaint with the Department of Health.
- In response to a subpoena by an attorney in the State of Washington, records will be released unless you file a protective order within 14 days of the subpoena.
- In addition, as a mandated reporter, the therapist is 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.

*We will discuss any exceptions to confidentiality if necessary.

Professional Consultation & Supervision: Health care providers who are treating the same individual are allowed to share information that may be helpful in that treatment. My preference is to obtain your verbal or written consent to speak to any other healthcare professional that may be involved in your care, if such care is relevant to our work together.

It is a regular part of my practice to consult with other mental health professionals regarding my work as a therapist. This ensures my continued growth as a professional and allows me to gain other perspectives and ideas as to how to best help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

Communication and Confidentiality:

Email Communication: If you elect to communicate by email, please be aware that email is not completely confidential. All emails are retained in the logs of your and/or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be considered part of your treatment record. Please limit email communication to scheduling. Do not email content related to our therapeutic relationship or work.

Telephone and Voicemail Communication: Please be aware that telephone and voicemail communication are not completely confidential. Calls can be hacked and voicemails are retained in the logs of your and/or my telephone provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the telephone company. Please limit telephone communication to scheduling. Do not include content related to our therapeutic relationship in voicemails.

Video Conferencing: Per client request we may conduct sessions over internet through different channels including FaceTime, Skype, Zoom, Doxy depending on client preference. Please be aware that this method of communication is not completely confidential and may be monitored by unknown subjects. I am not responsible for any breaches in confidentiality related to use of such methods.

Telehealth: In 2020, there was a transition to telehealth as a result of COVID19. Services will continue through a video platform in order to maintain the wellbeing of the collective. I will communicate once I decide to return to in person sessions.

Please be aware that I regularly access email communications via my password-protected mobile phone and laptop. It is theoretically possible that if my mobile phone or laptop is lost or stolen and the password is somehow circumvented our email communications could be accessed.

Social Media Policy: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective

privacy. It may also blur the boundaries of our therapeutic relationship. Please do not contact me or message me through any of these public online services since it may create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If by chance I discover that we are friends on social media, I will unfriend or unfollow you in order to respect our therapeutic relationship moving forward.

The therapist reserves the right to update and change this notice; please view an updated copy on the therapists website www.esperanzapllc.com

Your signature below indicates that you have read the intake documents fully and understand your rights and responsibilities regarding privacy, confidentiality, fees and billing. You had the opportunity to ask questions and have received clarification. You have been provided with a copy of these forms.

Your signature represents your consent to mental health intake and treatment.

Client Signature: ________________________________ Date: _____________

If signed by another responsible person, specify relationship _______________________

Therapist Signature: _______________________________ Date: _____________