Selin E. Caka, MA, LMFTA

Informed Consent for Individuals

Starting counseling is a major decision, and you may have many questions. This document is intended to inform you of the policies, state and federal laws and your rights. If you have other questions or concerns, please ask, and I will do my best to give you all the information you need.

Your Therapist: I hold a Master's degree in Psychology and Couple and Family Therapy from Antioch University Seattle, and a Bachelor's degree in Psychology from the University of Washington. I am a Licensed Marriage and Family Therapy Associate in the state of Washington, (credential #MG 6316774).

I provide counseling services to individuals age 13 and older, couples age 18 and older, and families with children of all ages. I work within the general conceptual framework of Emotionally Focused Therapy and family systems theory, but employ techniques and interventions from multiple disciplines, and feel that a collaborative relationship between clients and myself is the key to successful therapy.

Mental Health Services: Meaningful change can be one of the most difficult things a person can tackle. You have decided, however, that you are ready for the challenge – it's not often that people seek therapy when they're perfectly contented with their situation! I am honored to have the opportunity to support you in what changes you wish to make.

While I believe I can help you on your journey, it is, in the end, a journey you will have to make for yourself. I can provide insight, make observations and teach behavioral techniques, but I cannot do the work for you, nor guarantee that the work will provide the change or results you desire. Therapy can be emotionally intense, even painful, at times. We will be challenging long-held assumptions and beliefs, and this may make you angry, uncomfortable, upset – even confused. These reactions are entirely expected, and are a part of healing, and I encourage you to explore them as they come up.

Number of Visits: The number of subsequent sessions depends on many factors, including the nature of your situation and your level of participation in the therapeutic process. Standard sessions are 50 minutes in length, though longer sessions are available, should they be appropriate. We will discuss this change before it is made.

Payment for Services: By signing this consent for treatment, you understand that you are financially responsible for the cost of treatment. Payment must be made in full, by cash or check, at the end of the therapeutic hour. There will be a $20 fee assessed for any returned checks. If you have any concern about your ability to meet your payment for service, please discuss it with me. Fees for services are:

50-minute individual session - $80.00
90-minute couple or family session - $120.00

Insurance: I am unable to bill insurance directly, but am happy to provide any necessary documentation for you to submit a claim yourself. If you choose to use insurance, I will need to provide the insurer a diagnosis, and your insurance company will have access to your records. You are responsible for any portion of my fee not covered by insurance.

Appointments: Appointments are made or changed by calling 206-701-6801.

Missed Sessions: You are responsible for keeping your scheduled appointment. If you need to change or cancel an appointment, you must do so at least 24 hours in advance, or you will be charged the usual fee for the session. Chronic no-shows may result in termination of therapy.

Termination of Services: In most cases, our time together will end as a natural result of you completing your treatment goals. However, therapy is entirely voluntary, and you are free to refuse any suggested intervention or treatment, and to terminate therapy at any point. If you're thinking about ending therapy, I encourage you to discuss it with me, and, if you desire, I would gladly provide you with referrals to other providers in the area, and will do all I can to be helpful in the transition process. During our work together, if I assess that I am not being effective in helping you achieve your desired goals, I will discuss this with you and, if appropriate, terminate therapy. In this rare instance, I will also provide referrals to other providers who might better suit your needs.

Confidentiality: Your records are confidential. They are stored in a locked, limited-access area. However, there may be times when disclosure of your records will be compelled by law. By law, confidentiality is waived:

- when necessary for supervision or consultation,
- if I, or my supervisor, believes you are a danger to yourself or others,
- if I, or my supervisor, knows of or suspects child or elder abuse,
- if I, or my supervisor, believe that you have been infected with HIV, or are putting a sexual partner at risk for possible transmission of HIV,
- if you bring a negligence suit against me or the agency; or file a complaint with the licensing board,
- if you are under 18 years of age, be aware that the law provides your parents or legal guardians the right to examine your treatment records.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the HIPPA Notice of Privacy Practices you were given along with this form, and to discuss with me any questions or concerns you may have. By signing this information and consent form, you are giving me your consent to share confidential information with all persons mandated by law, and with the insurance carrier responsible for providing your mental health care service, if applicable.

Professional Records: Your clinical record will contain Protected Health Information, including contact information and reasons for seeking therapy, and may also include a description of the ways in which your problem affects your life, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that, at your request, have been sent to any outside providers. You may examine and/or receive a copy of your Clinical Record – it is yours. I will ask that you sign and date a release form that will be added to your Clinical Record before doing so. In addition, I may also keep a set of psychotherapy notes that are for my own use, and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record, and are not released to others with your Clinical Record, except in rare legal circumstances.

Risks of Therapy: "*An examined life is painful" - Malcolm X.* As I mentioned before, the therapeutic process can be stressful, and can evoke feelings of sadness, anger, anxiety or fear. Your relationships may shift as you explore new ways of interacting with your life and those around you. You may feel worse about your situation before you begin to feel better. These experiences are common, and, as your therapist, it is my job to help support you through the bumpy road toward your goals.

Emergencies: I am unable to provide emergency services. If you are experiencing a psychiatric or medical crisis, immediately contact 911, the King County Crisis Clinic at 206.461.3222 ,or go to your nearest hospital emergency room. Emergencies are urgent issues requiring immediate action - do not be afraid to ask for help.

Coordination of Treatment: In order to provide you with the best possible care I request your permission to speak with your Primary Care Physician and/or Psychiatrist to inform them that I am providing treatment for you. Any information discussed will conform to all HIPAA and state guidelines for disclosure of information and confidentiality.

_____ Yes, please contact my PCP/Psychiatrist

_____ No, I do not want you to contact my PCP/Psychiatrist

Audio/Video Consent: By signing this form, you understand that I hold an Associate Marriage and Family Therapy license (WA License #MG60316774), and that your sessions may be audio/video taped for the purpose of training and professional development. These recordings will be shared only with my supervisor and professional consult group, and will be destroyed after consultation, except with your express written consent, separate from this consent document.

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I, the undersigned, have read and discussed this Informed Consent Document, and have been given the opportunity to ask any and all questions I have, and have received acceptable answers, and understand that I will be given a copy. I have also been given a copy of, and the opportunity to discuss, the HIPPA Notice of Privacy Practices. I give my voluntary consent for Selin Caka, MA, LMFTA to provide me with mental health services as her experience and licensure allow. I understand that I must be an active participant in my care, and that I have the right to end or refuse care or treatment at any time.

____ I have read, signed and received a copy of the HIPPA Notice of Privacy Practices

_____ _____

Client Name (please print) Date

_____ _____

Client / Legal Authorized Representative Signature Relationship to Client

_____ _____

Selin Caka, MA, LMFTA Date