Endurance Family Therapy, PLLC
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Informed Consent to Therapy

Therapeutic Relationship: A therapeutic relationship needs to function under professional guidelines to provide maximum benefit. Our contact will be limited to therapy sessions and other professional concerns such as scheduling and/or emergencies. If there is contact in another setting, I will protect your confidentiality by allowing you to initiate any interaction that occurs.

Education and Credentials: I am a licensed marriage and family therapist (LMFT) with a Master of Arts in marriage and family therapy from Whitworth University. I approach treatment from a systemic perspective based in clinical training and theory including structural family therapy, Bowen family systems theory, emotionally focused couple therapy, the Gottman method, lifespan integration and discernment counseling. I am certified in lifespan integration, have completed the core skills training in emotionally focused couple therapy (EFCT), and Level 1 and Level 2 training in the Gottman method. I hold licenses in Washington (LF61130147) and Idaho (Idaho LMFT-9086).

Good Faith Estimate of Costs: Per session rates are $160 for individual therapy (50 or 80 minutes), $180 for couple or family therapy (50 or 80 minutes) and $220 for discernment counseling (90 or 120 minutes). Clients are responsible for payment at the time of service. Intake and assessment for couples includes the Gottman relationship checkup, at the cost of $39+ tax per couple. Couples will schedule one individual session each as part of the intake and assessment process. I am not able to propose a diagnosis or course of treatment for clients until we have spent some time together. I will discuss a diagnosis and appropriate course of treatment with you as soon as I am able to. Services are generally provided on a weekly basis until treatment is terminated. Additional services may be recommended. This estimate of your costs is only an estimate, and your actual charges may differ. You have the right to initiate a dispute resolution process if billed charges exceed the expected charges in this estimate. You may contact me directly if billed charges are higher than this Good Faith Estimate, or you can start a dispute resolution process with the U.S. Department of Health and Human Services (HHS) directly. If you choose to use the dispute resolution process, it will not adversely affect the quality of health care services provided to you. This estimate of costs is not a contract and does not obligate you to obtain clinical services from me. This Good Faith Estimate is effective through the end of 2024. My provider numbers are EIN 813790378 and NPI 1538619218. For more information on your right to a Good Faith Estimate go to www.cms.gov/nosurprises or call 800-985-3059.

Insurance: I am an out-of-network provider, and do not accept payment from or bill any insurance providers. Please contact your insurance provider to learn if they offer an out of network reimbursement benefit. I can provide a monthly super bill, which includes your personal contact information, a clinical diagnosis, dates of service and the amount you paid per session.

Reduced Rate: A reduced rate may be offered, depending upon availability. Please let me know if this is a concern for you.

Cancellation Policy: Clients are expected to cancel sessions at least 24 hours in advance to allow for other clients to use that time. Failure to do so outside of emergency situations will result in a charge for the full session fee.

Effects of Counseling: While benefits are expected from therapy, no specific outcomes are guaranteed. Part of the treatment process is to establish goals and a plan for reaching them. Your time in therapy may lead to major changes in how you choose to view important issues in your life. The exact nature of these changes is not predictable and could affect your relationships, your job, and your view of yourself. During therapy there may be periods of increased discomfort and strong feelings. The intent is to facilitate the best possible outcome based on your goals for therapy. Therapeutic interventions will be focused on the presenting issues and goals for therapy.

Client Rights: Length of time in therapy varies based on the needs and goals of the client. You are in complete control of the decision to be in therapy, and you may terminate therapy at any time. If you decide to terminate therapy, I ask that you participate in a termination session. You may refuse, discuss modifications, or seek a second opinion regarding therapeutic decisions or interventions at any time. If you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, I will help you locate another therapist to continue treatment. If you feel an ethical violation has occurred, you can file a complaint without fear of retaliation with the agency that regulates my practice: Washington State Department of Health, Health Professions Quality Assurance Office at (360) 236-4700 or the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists at (208) 334-3233.

Telephone Accessibility: If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours, or the next business day. My voicemail is kept up to date of my availability, including times I may not have ready access to voicemail. If an emergency situation arises, please call 911 or go to the nearest emergency room.

Electronic Communication: I cannot ensure the confidentiality of any form of communication through electronic media, including email and text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response, and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Social Media: Due to the importance of your confidentiality and minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise both your confidentiality and our respective privacy, as well as create a dual relationship.

Referrals: In order to maximize the quality of care during therapy, you will be expected to allow contact with other professionals such as physicians, counselors, and psychiatrists. There may be times that I refer you to other professionals to provide services that will enhance therapy. If at any time you and/or I believe that a referral to another therapist is needed, I will provide you with names of other providers who may assist you. You will be responsible for contacting and evaluating those professionals for assistance.

Records: Adult client records are disposed of five years after the file is closed. Minor client records are disposed of seven years after the client's eighteenth birthday. Only my designee or I may disclose copies of written client information or release client information over the phone. In the event of my death or incapacitation, all client records become property of my designee.

Confidentiality: Most communication in a therapeutic relationship is confidential, however Washington state law mandates that I report certain information, and therefore limitations to confidentiality do exist:

- Risk of harm to yourself or someone else. This may include requesting emergency assistance, transportation to a medical facility, physical restraint from self-harm, contacting authorities and/or contacting a person who is intended harm.

- Abuse or neglect of a child, elderly person or disabled person.

- Sexual misconduct with a mental health provider. Sexual conduct with a client is never appropriate and should be reported to the state agency responsible for regulating the practice of mental health providers.

- Order by a court, subpoena or requirement by law to disclose information.

- Insurance or third-party payer requests information to authorize coverage and payment for services.

- You direct me to release your records through a written authorization form.

Consultation: I do consult with other therapists as needed. I do not share client information as part of the consultation process unless written authorization is provided by the client.

Minors: In the state of Washington, any minor 13 years or older may request and receive outpatient treatment without the consent of a parent or legal guardian, and the same laws as for adults cover confidentiality. When the minor is under the age of 13, communication of confidential information between the therapist, client and parents or legal guardian is at the discretion of the therapist. The age of consent for sexual conduct with an adult is 16 years old in the state of Washington.

No Secrets Policy: Honesty is essential in the therapeutic process and therefore I have a "no secrets policy". I ask that couples and family members share with me only what can eventually be discussed within therapy. If secrets are shared with me, I reserve the right to terminate our therapeutic relationship and provide referrals as necessary.

COVID-19: Due to the changing nature of the COVID-19 public health crisis, telehealth will remain available as an alternative to in-person sessions as long as it is clinically appropriate. I may determine at any time it is best to move to telehealth sessions in accordance with state public health mandates or out of an abundance of caution for you, myself, and others. When you schedule in-person sessions, you understand that meeting in-person could increase your risk of contracting COVID-19. I take precautions at my office to help reduce the spread of the coronavirus, but I cannot guarantee you will not become infected with COVID-19. If you have any questions or concerns about meeting in person or meeting through telehealth, please let me know.

Telehealth: State laws allow for me to provide telehealth services to clients who are in the states of Washington and Idaho. Telehealth is the mode of delivering psychotherapy via phone and internet to facilitate the diagnosis, treatment and care of a client while the client is at the originating site where the client is residing and the therapist is at a distant site where the therapist is residing. The telehealth service I use meets federal HIPAA requirements for security and confidentiality. All laws regarding confidentiality and rights to healthcare information also apply to telehealth. If you or I determine that consistent audio and video connectivity cannot be maintained throughout the session, you or I may terminate the session. I may decide to terminate telehealth sessions if your treatment requires a level of care that is unsuitable for telehealth. Potential benefits to telehealth include access to care when meeting in person is not a viable option, flexibility to accommodate work schedules and reduced time traveling to sessions. Potential risks to telehealth include that the session may not be secure or confidential unless you

make it so. I will be located in a private office for your privacy and security. Please locate yourself in a place that you know is private and secure. Initiating a session from a public place is not private, confidential, or secure. Many things can be missed in a telehealth session that would otherwise be helpful to your treatment progress such as body language, facial expressions, physical appearance, and appropriateness of dress. An unstable connection may cause the video to freeze, audio may be dropped, and the connection may be lost. Please make sure you have a strong connection, the latest operating system and security updates installed on your device. Crisis support services may not be available where you are located. If you are in crisis, my ability to help will be limited, but I am responsible to take steps to identify resources to help you based on your address. It will be entirely up to you to access and utilize those resources.

Discernment Counseling: Discernment counseling is a short-term approach that is generally completed in 1 to 5 sessions. The focus is on working with couples that are considering divorce, but are not certain if ending the marriage is the best path for them. Different from marital therapy, the goals are to help the couple develop a deeper understanding of what has happened to the marriage, identify what might be possible for the future, and gain clarity and confidence about what path to take going forward.

- The terms of confidentiality outlined in this informed consent also apply to discernment counseling, with the exception of my standard "no secrets policy". If secrets are shared with me in discernment counseling, I will hold the information until the person keeping the secret shares it within the couple relationship. If the person keeping the secret does not share the information within the couple relationship by the end of discernment counseling, then I will provide referrals as necessary.

- Discernment counseling is not a legal service and no legal advice is provided. Please consult with an attorney or visit a court self-help center in your county if you have questions about legal issues related to divorce. Participation in discernment counseling does not relieve you from any obligations you may have in an ongoing divorce case.

- By participating in discernment counseling you agree that you will not seek to use any statements made by the other party or by the counselor as part of any discernment counseling session in a court proceeding. You also agree that you will not call as witness or seek to obtain any of the notes or documents prepared by the discernment counselor for court purposes.

This informed consent to therapy may be updated at any time in the future. By your signature, you are indicating that you have read and understand this informed consent to therapy, and that any questions you have were answered to your satisfaction.

By my signature, I understand and I am aware of the risks associated with therapy. I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Date of Birth: _____

Client Name: _____

Client Signature: _____Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Therapist Signature: ____ Date:_______________