Amy M. Nuttbrock, LICSW

P.O. Box 1313, Washougal, WA. 98671
(360) 602-6842
amynuttbrock@gmail.com
www.amynuttbrocklcsw.com

DISCLOSURE STATEMENT AND SERVICE CONSENT

DISCLOSURE STATEMENT

This is a statement of your rights and responsibilities for our therapeutic relationship. The RCW 18.19.060 and WAC 246-810-031 require counselors to provide written disclosure of the following information to clients before therapy begins. Please read this statement thoroughly and then sign the consent for treatment. If you have any questions or concerns, please tell me and I will be happy to discuss them with you.

NOTICE TO CLIENTS

As required by RCW 18.19.060, this will inform clients of a licensed or registered therapist in the State of Washington that they may file a complaint with the Department of Health at any time they believe a therapist has demonstrated unprofessional conduct. Therapists practicing therapy for a fee must be registered or licensed with the Department of Health for protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, or necessarily imply the effectiveness of any treatment. It is every client's right to discontinue treatment at any time, with or without notice to the treatment provider. Questions or complaints may be directed to Department of Health, Health Professionals Quality Assurance, P.O. Box 47868, Olympia, WA 98504-7869. Phone: 360-236-4700, E-mail: HSQAComplaintIntake@doh.wa.gov.

CONSUMER RIGHTS

Washington State Law provides that as a consumer:

1. You have the right to be treated with respect and dignity.
2. You have the right to develop a plan of care and services that meets your unique needs.
3. You have the right to refuse any proposed treatment, consistent with the requirements in the Involuntary Treatment Acts, Chapters 71.05 and 71.34 RCW.
4. You have the right to receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability or sexual orientation.
5. You have the right to be free of any sexual exploitation or harassment.
6. You have the right to receive an explanation of all treatments provided
7. You have the right to review your clinical record and be given an opportunity to make amendments or corrections.
8. You have the right to confidentiality, as described in relevant statues (Chapters 70.02, 71.05, and 71.34 RCW) and regulations (Chapters 275-54 and 275-55 WAC and this chapter.)
9. You have the right to lodge a complaint or grievance; you shall be free of any act of retaliation. The ombudsperson may, at your request, assist you in filling a grievance. The Ombudsperson's phone number is: (253) 302-5311 or toll free at 1-800-531-0508 or TDD at 1-800-531-0508.

QUALIFICATIONS/EDUCATION

Active Washington State Licensed Independent Clinical Social Worker (LICSW) #LW60926883
Active Oregon State Licensed Clinical Social Worker (LCSW) #L7835
Master of Social Welfare (MSW), University of California, Berkeley, Berkeley, California
Bachelor of Arts (BA) in Writing, Literature, and Publishing, Emerson College, Boston, Massachusetts
Level I Accelerated Experiential Dynamic Psychotherapy (AEDP) Training (October 2019)

CLINICAL FOCUS

My clinical work integrates many different therapeutic styles and techniques depending on what fits best with the client and situation. I tend to work through a lens of attachment theory and trauma-informed care. My therapeutic approach is drawn primarily from Accelerated Experiential Dynamic Psychotherapy (AEDP), as well as somatic experiencing therapies, cognitive and dialectical behavior therapies, motivational interviewing, and psychodynamic models. Primary areas of expertise include depression, anxiety, Post-Traumatic Stress Disorder, adolescent identity formation and development, as well as issues related to loss and transition.

I maintain a referral list of other therapists with a wide range of specialties. I will provide you with a referral to another therapist if I feel your needs are beyond the scope of my expertise, or if you request such referral information.

CONFIDENTIALITY

Clients can rely on me to maintain confidentiality regarding our work together with these few exceptions:

1) I may consult with other therapists, who are required to keep client information confidential, for case consultation purposes.
2) Washington State Law requires that suspected abuse or neglect of a child, dependent adult, or developmentally disabled person be reported.
3) Washington State Law also requires that others be informed if a client threatens to harm herself/himself, or others. If that threat is perceived to be serious, the proper individuals must be contacted: this may include the individual against whom the threat is made.
4) In the event of a court order, counselors may be required to disclose information in the presence of a judge.
5) Information which may jeopardize my safety will not be kept confidential.
6) In the event of a medical emergency, emergency personnel may be given necessary information.
7) If you bring a complaint against me with the State of Washington, Department of Health, information will be released.
8) In the event of the client's death or disability, the information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

ETHICS AND STANDARDS

Professional ethics require that our contact be limited to the sessions you have with me. Please do not invite me to social gatherings, contact me via social networking, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

I follow the code of ethics of the National Association of Social Workers (NASW), as well as the ethical and professional standards of the Washington State Social Work Licensing Law (RCW 18.225, 18.130; WAC 246-809). These documents are available in my office for your review.

WORKING WITH MINORS

According to Washington State Law, the age of consent is 13: "Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent" (RCW 71.34.530). **For clients aged 13 and older most communications with parents will require the child's authorization**. I make every effort to maintain privacy, in accordance with creating a positive therapeutic alliance with the child. Information provided to parents will be a general overview of our work together, unless there are concerns about personal safety or the safety of others, in which case I will address my concerns first with the child so that we can discuss questions or objections prior to notifying parents. I recognize, however, that therapy is most effective when the therapist, child and parents work together. Parental involvement ensures that, as

the therapist, I obtain updates on the child's behaviors, emotions, and any other factors which may be impacting him or her or them. I may also provide parental guidance and support. This collaboration allows for the opportunity to strengthen relationships between children and their parents.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, the therapist's role is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena your therapist to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that your therapist write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

RISKS AND BENEFITS

Individual therapy is beneficial, but as with any treatment, there are inherent risks. During therapy, you will discuss personal issues which may bring up emotions such as anger, guilt, and sadness. The benefits of therapy can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, but it is my goal is to create a safe environment where, together, we develop a treatment plan, and work to achieve your goals.

FINANCIAL REQUIREMENTS

Under Washington State law, you are not liable for any fees or charges for services rendered prior to receipt of this Disclosure Statement. Counseling sessions are 60 minutes in length unless otherwise agreed upon. **The cost of each session is $150.00**. Payment is due at the end of each session. **If your insurance company is accepted by me, please contact your Plan directly to confirm covered costs, as well as information on copayments, deductibles and coinsurance amounts. You'll pay your deductible payment and/or co-pay directly to me at time of service.** If you are unable to keep your appointment, you must give me 24 hours advanced notice, or you will be charged for the session. Please be aware that insurance companies do not reimburse for missed sessions. If you are filing insurance claims, I will provide you with an invoice that you can submit to your insurance for possible reimbursement.

COMMUNICATION

In the regular conduct of my practice, I may make use of email and cellular phone, communication with clients. In such cases, I will limit the information I store in any portable communication device to the least necessary. Please be aware that such forms of communication do have inherent risks to client confidentiality. If you would prefer that I do not store your name and telephone number in a portable communication device, or if you would prefer that I do not communicate with you via cellular phone or email, please inform me so that we can make alternative arrangements. In the case of an emergency, I use a voice mail system to ensure confidentiality of your messages and to allow you to leave a more extended message when necessary. I check my voice mail often. Calls received after 7:00 p.m. may not be returned until the next business day; other arrangements can be discussed. If I am unavailable and you require immediate attention, please call 911 or the Clark County Mental Health Crisis Line: (800) 626-8137 or (360) 696-9560. You may also go to your local hospital emergency room.

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CONSENT FOR TREATMENT

Disclaimer by the State of Washington: "Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of public health and safety. Registration does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment."

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, and that you are consenting to participation in counseling services provided by Amy M. Nuttbrock, LICSW.

_____

Printed name of client

_____ _____

Signature of client Date

_____ _____

Amy M. Nuttbrock, LICSW Date

FOR CLIENTS 13 YEARS OF AGE OR OLDER

I authorize the exchange of information regarding my clinical care needed to coordinate treatment with my parent/guardian _____. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 1 year after last contact and I may cancel it in writing at any time.

_____ _____

Signature of client (between the ages of 13-17) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____