

# DISCLOSURE STATEMENT

Caroline Plummer M.S., LMHC (LH60193567)

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Welcome! Before we start counseling it is both my desire and a requirement of Washington State law to provide you with the following information. Signing this form establishes our contract for therapy services.

*The Washington State Counselor Credentialing Act (WAC 246-810) requires that any counselor practicing counseling for a fee must be certified by the Department of Health. However, registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment (WAC 246-810-031). The counselor credentialing act is to (A) provide protection for public health and safety and (B) to empower the citizens of Washington State by providing a complaint process against those counselors who commit unprofessional conduct. It is every individual's right and responsibility to choose the provider and treatment modality which best suits their needs.*

**Formal Training & Background:** I have a M.S. degree in Counseling Psychology from the University of Wisconsin Madison. I have extensive training in domestic violence and am a certified domestic violence counselor by WAC standards (388-60). I am a credentialed child mental health specialist and ethnic minority specialist. I have completed advanced training in EMDR and Lifespan Integration, modalities which follow the client's body-mind system to integrate them more fully. I am also highly trained in cognitive therapy orientations, with certifications in trauma-focused, AF-CBT cognitive behavioral models, and dialectical behavioral therapy. (DBT). I am a certified in parent child interaction therapy. (PCIT). I believe that our experiences within our family have a profound effect on us, and I watch for these related themes in our work together.

**Confidentiality:** I am bound by professional ethics to protect client rights to confidential communications in regards to their involvement in counseling. All issues discussed in the course of counseling are strictly confidential. By law, health care information pertaining to you may be released only with your written consent. For this reason, if you want me to release information about your participation in therapy, I will require a signed "Release of Information" from you. A release is legally valid for ninety (90) days from the date of your last appointment

However, the law (RCW 18.19.180) provides exceptions to client confidentiality where information may release without your consent:

1. In the event of a medical emergency information necessary for treatment may be released.
2. In the event of a threat of harm to oneself or someone else.
3. In the event of suspected abuse of a child, dependent adult or elder.
4. If you register a complaint with the Washington State Department of Health, information will be released as requested or required by the State to resolve the issue.
5. If ordered by a judge or judicial officers, information regarding your treatment must be disclosed.
6. If an attorney in the state of Washington duly subpoenas your records, they will be released unless you file a protection order within 14 days of subpoena.
7. In the event of a client's death or disability, information will be released as authorized by the client's beneficiary.
8. A counselor is not required to treat as confidential a communication that reveals the contemplation of a crime or harmful act.

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As a mandated reporter, I am required by law to disclose certain confidential information included 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

**Records Review and Correction:** I keep a record of the health care services that I provide to you. I keep written records from session in your clinical file and also may keep records in your electronic file. You have a right by law (RCW 70.02.070) to see and copy that record. Also, you may ask that I make corrections to your record.

**Case Consultation:** I advocate and practice professional consultations for the purposes of professional training, accountability and providing the best counseling services to clients. I may at times discuss your situation with other professionals being careful not to disclose your identity.

**Termination:** It is every client's right to disengage from counseling with or without notice to the treatment provider. I reserve the right to terminate clients at any time for reasons of nonpayment, safety, optimal care, and necessary progression. If your file remains inactive for 6 weeks, I will assume you would like me to terminate our current episode of care and close your current case. We can discuss initiating a new episode of care once we meet again in person.

**Cancellation of Appointments:** If you need to cancel your appointment, please let me know at least 24 hours in advance. Missed sessions will be charged at your hourly fee. Insurance does not reimburse for missed sessions.

**Grievances:** The state brochure called, "What to Expect from your Licensed Counselor" lists ways in which counselors may work in an unprofessional manner. The link for that brochure is here.

<https://www.doh.wa.gov/portals/1/Documents/Pubs/670125.pdf>

If you suspect that my conduct has been unprofessional in any way, please discuss this with me if you feel comfortable. If you do not feel safe speaking with me about this, it is within your right to contact The Department of Health at the address and phone number listed below:

The Department of Health  
Health Professions Quality and Assurance Division  
PO Box 47869  
Olympia, WA 98504-7869 360-236-4700.

**Phone Consult:** I am available for phone consultation. Fees for phone consults are billed at your hourly rate.

**Email Communications:** I am not available to read and respond to emails unless we agree it is necessary for crisis management and stabilization, on a short-term basis. I charge a flat fee of \$25 for every email, which takes me about 10 minutes of my billable time to read and respond to. My computer is currently not encrypted so please be aware that I cannot guarantee confidentiality if my computer is hacked or compromised. My computer is password protected.

**Telehealth:** If it is therapeutically appropriate, I may make use of technology assisted telehealth tools, such as telephone communications and internet enabled video/audio as an adjunct to our in-person work together. It is important that you understand the benefits and limitations of such services.

- Telehealth services may improve your access to counseling, and may support more effective use of in-person counseling.
- Telehealth services are not appropriate for all clients and all situations. If you or I determine that telehealth services are not appropriate for you I will assist you in obtaining appropriate alternative

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services.

- Successful use of telehealth services requires a reasonable level of access to computer hardware and software. If you do not have access to such resources, we can discuss available alternatives.
- At times it may become necessary for me to allow access to my computer for purposes of system maintenance, repair or upgrades. In such cases, I will make reasonable efforts to protect your confidential information.
- In case of hardware, software, or other system failure, you may reach me by phone to coordinate our work together.

At the beginning of each session, I will ask you to provide me with the following information:

- Your physical location and address
- A phone number I can use to contact you in case of technology failure.
- An email address I can use to contact you as an alternative.

### Working with Minors

If you are a parent or guardian of a minor who is seeking treatment, please know that under Washington State law, any child age 13 or older can independently consent to mental health treatment without your permission. In addition, parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission. If you are 13 years or older, you have the right to seek mental health treatment without obtaining permission from a parent or guardian.

### Social Media Policy

Professional ethics standards do not permit me to communicate with clients via personal social media.

### Emergencies

If you are experiencing an emergency or crisis, please call 911, the King County Crisis Clinic (206.461.3222), your primary care physician, or go to the hospital emergency room.

**Payment of Fees:** Payment of fees are expected at the time of the appointment. Sessions begin at the scheduled time. The standard individual (50 minute) session fee is \$150.00 for individual therapy, Fees for phone consults are \$150 per hour. Therapy may be discontinued for non-payment. Please feel free to discuss fees or payment options with me at any time.

**Insurance:** As your insurance policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. **If your insurance fails to pay, for whatever reason, you are responsible for the full billed amount.**

**Court Related Services:** I charge increased fees for clients involved in Court proceedings. My hourly rate for an Individual and family sessions for Court-involved clients is \$175.00 --\$210.00 for a 60-minute session. If a GAL or another Court-appointed individual has requested my services to help your family, I will charge you a retainer based on the complexity of your situation. I bill you for my time (collateral contact with GAL, providers, reading legal documents, etc). and use retainer for payment. I will provide you with an itemized bill.

**Course of Treatment** \_\_\_\_\_

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Caroline Plummer M.S., LMHC (LH60193567)

My signature affirms that I have received the Notice of HIPPA Privacy Practices and that I have received and understand Caroline Plummer, LMHC Disclosure and Informed Consent. I authorize Caroline Plummer M.S. LMHC to engage in counseling services with me. I agree to the conditions of the therapy contract.

Client Printed Name \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature (client under 13 years old) \_\_\_\_\_ Date \_\_\_\_\_

Counselor's Signature \_\_\_\_\_

Date \_\_\_\_\_