Allison Huffman, MA, LMFT
1140 10th St, Suite 211, Bellingham, WA 98225
allison.lmft@protonmail.com
(360) 480-7048

THERAPIST DISCLOSURE STATEMENT

Name: Allison Huffman, MA, LMFT, MHP
Masters of Arts (Marriage and Family Therapy), Licensed Marriage and Family Therapist, DSHS designated Child Specialist and Mental Health Professional, Registered Hypnotherapist

WA State Certificate #: LMFT: LF60289641

Education/Training/Experience: Ms. Huffman received her Bachelors of Arts from Pacific University in Forest Grove, OR and her Masters in Marriage and Family Therapy from Pacific Lutheran University in Tacoma, WA. Ms. Huffman's work experience includes providing therapy services to adolescents and adults since 2008. Sites in which she has provided therapy services include: Good Samaritan, Greater Lakes, Sea Mar and Pathways Mental Health Services. Ms. Huffman is a member of the American Association for Marriage & Family Therapy and Washington Association of Marriage & Family Therapy. Ms. Huffman is a Registered Hypnotherapist with focused study in guided imagery.

Therapeutic Process: Ms. Huffman provides couples, family and individual therapy for adolescents and adults. Using the lens of Narrative and Cognitive Behavioral Therapy, Ms. Huffman believes the messages you tell yourself are powerful. In therapy, she will try to facilitate healing, to explore past patterns for answers and to help you create a hopeful construct for the future.

Therapy begins with your goals, followed by development of a treatment plan specific to your needs. Progress in treatment is reviewed with you periodically and goals revised as necessary. Length and course of treatment is discussed and determined by the clients need. Understand that during therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong emotions. If this occurs, please tell Ms. Huffman so she can assist in developing coping skills that can be immediately employed. Change may appear slower than you wish, but with dedication to the therapeutic process positive change can occur. However, there is no guarantee that psychotherapy will yield what the client perceives as a positive or intended results. Ms. Huffman is bound by the ethical code of the American Association of Marriage and Family Therapy, federal laws and Washington State laws, which can direct certain aspects of therapy.

Termination: Ms. Huffman will assess if she can be of therapeutic benefit to you. If at any time Ms. Huffman does not believe, in her opinion, she cannot help she will provide a referral. In most cases therapist and client will work cooperatively on when the client is ready to end services. However you have the right to end services at any time. In the event that you feel dissatisfied, please address this with Ms. Huffman immediately. You have the right to file grievances regarding unprofessional conduct (RCW 18.130.180), Department of Health, P.O. Box 47857, Olympia, WA 98504-7857.

Client Right and Responsibilities: You have the right to appropriate care, to a referral, to terminate therapy at any time (though payment will be due for services rendered), to change your mind, to access a summary of your records or to release your records to a third party (except in limited legal, emergency circumstances or if it is judged by Ms. Huffman to be of harm to you). Psychotherapy requires your active involvement and feedback to help Ms. Huffman focus the direction of therapy. No

weapons are permitted in this facility and/or office. If you have a weapon with you at that time of your therapy appointment, the session may terminate at your cost. Ms. Huffman will not see clients under the influence of drugs/alcohol. If you come to a session and Ms. Huffman believes you are impaired by drugs/alcohol, then the session will be immediately canceled at your cost.

Communication & Emergency Procedures: If you need to contact Ms. Huffman between sessions, please call (360) 480-7048. This is a confidential line. If there is no answer, leave a message and your call will be returned as soon as possible. Ms. Huffman checks her messages regularly and will attempt to reply within 24 hours. It is important to be aware that video software and e-mail as means of communication could be accessible to unauthorized 3rd parties and hence privacy and confidentiality could be compromised. Ms. Huffman's e-mails are not encrypted. If you communicate confidential information via e-mail, Ms. Huffman will assume that you have made an informed decision, will view it as your agreement to take the risk described and will engage in limited communicate via e-mail. Please do not use e-mail or fax for emergencies. For emergency situations, if you need to talk to someone right away call the Crisis Line of Whatcom Counties 1-800-584-3578 or the police at 911 for 24 hour help. Please do not use e-mail, text, or faxes for emergencies.

Cancelations: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. Unless client and therapist reach a different agreement, a $60 fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

Fee Policies: Ms. Huffman has the following fee options available to you in order to keep counseling affordable and convenient. Please note payment is due at the end of the session unless otherwise arranged. Ms. Huffman accepts cash, check or all major credit cards. Your credit card information is processed on the phone via Square. Insurance billing is provided through Allison Huffman directly or though Medical Billing Solutions and is stored on Office Ally.

- ➔ Initial intake and standard individual/couples/family sessions around 50 min long are $130
- ➔ Standard individual/couples/family sessions around 45 min long are $125
- ➔ Time spent in session beyond allotted time can be prorated at $130 per hour in 10 min increments.
- ➔ Letters written on the behalf of the client (at your request) are prorated at $130 per hour.
- ➔ All phone calls made to the therapist that exceed 5 minutes are prorated at $130 per hour. This includes calls to professionals such as lawyers, schools, doctors, and phone therapy sessions.
- ➔ If a session is missed/canceled/rescheduled with less than 24-hour notice $60 will be charged.
- ➔ Legal profession fees are as follows: Any subpoenas to court result in a charged fee of $1500 plus any travel, mileage and incidentals, per day in advance. Days may not be prorated. Cancellation of court subpoena must occur at least 24-hours in advance or client agrees to pay the full day rate.
- ➔ Client agrees to pay a fee of $25 should any checks be returned due to client's insufficient funds or account closure.
- ➔ Client also agrees to pay any legal or collection fees for services rendered by this agreement and not paid. This may include fees or services not paid for or those referred to collection. Clients agree to the disclosure of basic information for any items being referred to a collection agency for the purpose of collection of debt. Refusal to pay fees as agreed and being referred to collection may be reported to credit bureaus and have a negative impact on your credit.

Let Ms. Huffman know if a problem arises regarding your ability to make timely payments.

Insurance: Ms. Huffman accepts most forms of Kaiser, Premera, Regence BlueShield, and United Behavioral Heath Care, which she can bill directly. However if your insurance does not pay Ms. Huffman you will be responsible for the therapy costs. She also accepts private pay with a sliding fee scale. For clients who have other insurance, upon request Ms. Huffman can provide a billing summary at the end of the month, which clients can submit to insurance for reimbursement. However Ms. Huffman does not guarantee that your insurance will reimburse you for payments made.

Limitations: Ms. Huffman works only on Saturdays. With these limited hours a client enters into therapy with Ms. Huffman understanding that if they currently have or develop acute mental health challenges such as being actively suicidal or homicidal, are engaged in a domestic violence situation or experience other challenges Ms. Huffman deems beyond the level of care she can provide, a referral will need to be made to another mental health care provider that can better meet the client's needs. If road conditions are such that they may not be safe to travel or another urgent issue occurs Ms. Huffman may cancel your appointment in the early AM without the cancelation fee charged to you.

Ms. Huffman does not conduct and will not provide assessments, evaluations, recommendations, letters or communications to 3rd parties regarding child custody, psychological fitness, disability assessment, fitness for duty/work, documentation to request accommodations at work or a leave of absence. I do not provide domestic violence or anger management classes/treatment.

I have carefully read and received a copy of The Therapist Disclosure Statement, which includes information about Client's Rights and Responsibilities, Fees, Contract and Description, Consent for Treatment and Description of Services. I understand the provided information and agree to comply with them. I further consent to receive behavioral health treatment from Allison Huffman MA, LMFT:

Client Name (Print)	Client Signature	Date

Client Name (Print)	Client Signature	Date

Allison Huffman, MA, MHP, LMFT	Date

"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment." WAC 246-810-030 and 246-810-031. The Counselor Credentialing Act is to provide protection for public health and safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

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NOTICE OF PRIVACY PRACTICES & RELEASE OF INFORMATION

This form provides you, the client, with information about confidentiality and privacy in therapy. It is compliant with HIPAA rules and regulations.

Confidentiality: All information disclosed within sessions and the written or digital records pertaining to those sessions are confidential and may not be revealed to anyone without the client's written permission, except where disclosure is required by law. In couple and family therapy (even in cases where there are some individual session times within the family therapy) confidentiality and privilege do not apply between the parties or among family members, unless otherwise agreed upon. In family or couples therapy Ms. Huffman will not release records to any outside party (expect when required by law) unless she is authorized to do so by all members, 13 years of age or older, involved in treatment. When more than one client is involved in treatment, such as in cases of couple and family therapy, Ms. Huffman will release records only with the signed authorizations from all members involved in therapy 13 years of age or older. If Ms. Huffman sees a client outside of therapy she will not initiate a conversation beyond a smile/nod. If a client chooses to engage in a conversation Ms. Huffman will not discuss the context she knows you or therapeutic knowledge unless disclosed by the client.

When Disclosure is Required By Law:

➔ **Imminent Perceived Danger to Self or Others -** If Ms. Huffman believes a client poses an imminent threat to themselves or others she can and will disclose your relevant information to the proper law enforcement/mental health agencies without consent/authorization from client to help increase safety. If Ms. Huffman perceives a client is making a threat to another she has the obligation to warn the person threatened if she feels they are in danger (Tarasoff). These standards have recently been expanded by the Washington State Supreme Court ruling of Volk vs. DeMeerleer (No. 91387-1). Ms. Huffman is obligated to try to honor this expansion.

➔ **Perceived Abuse of a Child, Vulnerable Adult or Human Trafficking -** If Ms. Huffman has reasonable cause to believe that a vulnerable adult or child has or will suffered abuse or neglect (including financial exploitation for vulnerable adults), she is compelled by law to report it to law enforcement and the Washington Department of Social and Health Services (CPS) or Washington Department of Social and Health Services (APS). Upon request Ms. Huffman can review what is defined as abuse and neglect and when she is mandated to report. This includes Human Trafficking.

➔ **Alleged Abuse by Therapist –** If a client alleges a mental health professional harmed or engaging in sexual contact with a client Ms. Huffman has to report this.

➔ **Emergencies –** Within the first sessions Ms. Huffman will request that a limited Release of Information be completed naming a contact person in case of an emergency. If a client has a medical or emotional emergency, Ms. Huffman may engage in limited communication with this contact person in order to assist her client during the perceived emergency.

➔ **As Required within Legal Issues -** Disclosure may be required pursuant to a legal proceeding by or against a current/former client. If a client places mental status at issue in litigation initiated by the client, the defendant may have the right to obtain the psychotherapy records and/or testimony by Ms. Huffman. If a legal case or complaint is filed against Ms. Huffman regarding therapy services rendered she has the right to release records to the proper governing board in her own defense. A client will be informed in advanced if records are being released for legal reasons.

- ➔ **Health Insurances and Confidentiality of Records –** Disclosure of confidential information may be required by a clients health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Ms. Huffman will provide this information to the client's insurance with an ROI. After Ms. Huffman submits information to a health insurance carrier Ms. Huffman has no control or knowledge over what the insurance company does with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality and privacy. The client is advised to contact their insurance provider directly to review their privacy practices. If you would like to use your insurance, confirm your deductible, the number of behavioral health sessions allowed and your co-pay. You are responsible for verifying coverage. Your co-pay is due at the time of service.
- ➔ **Consultations -** Ms. Huffman may consult with other professionals regarding her clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.
- ➔ **Your Records and Right to Review or Release Information to a 3rd Party -** Both the law and the standards of Ms. Huffman's profession require that she keep appropriate treatment records for at least 6 years. Unless otherwise agreed as necessary, Ms. Huffman retains clinical records only as long as is mandated by Washington state law. Concerns regarding the treatment records need to be discussed with Ms. Huffman. Clients have the right to review or receive a summary of their records, except in limited legal or emergency circumstances or when Ms. Huffman assesses that releasing such information might be harmful in any way, then with ROI the records can be sent to an appropriate mental health professional of your choice. Considering all of the above exclusions, upon your request, Ms. Huffman will release information to any agency/person you specify with a written release. Ms. Huffman will be allowed a week to release any records requested.
- ➔ **Minors -** According to Washington state law, RCW 71.34.530, a minor 13 years or older may receive mental health therapy without parental consent. All minors 13 years and older also have all the same confidentially rights and responsibilities that are listed above. Ms. Huffman will only be allowed to release information about treatment provided to a client 13 years and older with a signed form of consent from the client.
- ➔ **Billing and Office Ally** – Ms. Huffman at times keeps physical signed paperwork/notes in a locked box, which only she has access to. To comply with the federal mandate for electric medical records Ms. Huffman primarily keeps digital notes/billing information/client information on Office Ally. Medical Billing Solutions assists with billing and has access to client information but has signed a HIPPA agreement with Allison Huffman to insure client confidentiality.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, judgment for fitness to work, social security disability, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Ms. Huffman to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon in writing.

I have read the above descriptions of confidentiality and privacy; I understand and agree to comply with them:

Client Name (Print)	Client Signature	Date
Client Name (Print)	Client Signature	Date
Allison Huffman, MA, MHP, LMFT		Date

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Additional Confidentiality-No Subpoena Agreement

The therapeutic process is confidential in nature with the exceptions discussed/signed in the Notice of Privacy Practices & Release of Information form. Due to this I agree that neither I, my attorney or anyone else acting on my behalf will call on Ms. Huffman to become a witness to testify in court, communicate with child custody evaluator/s or involve Ms. Huffman in any other legal proceeding. I understand that Ms. Huffman works to create case notes that meet legal requirements but to help protect confidentiality they are brief and general in nature. I understand and agree that releasing psychotherapy records can jeopardize my confidentiality and I will not request that they be disclosed in the future to the court system.

Discloser Statement Regarding
Use of Phone, Video Software or Other Multimedia Portals

I understand that Ms. Huffman will use reasonable precautions to guard my confidentiality when phone, Video Software or other multimedia portals are used during therapy. However I acknowledge and understand that the employment of these methods of communication mean that confidentiality cannot be completely guaranteed. By requesting the use of phone, Video Software or other multimedia portals in my therapy I accept the risk of a breach of confidentiality from a third party/s beyond Ms. Huffman's control.

Client Name (Print) Client Signature (agreeing to all above) Date

Client Name (Print) Client Signature (agreeing to all above) Date

Allison Huffman, MA, MHP, LMFT Date

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INTAKE INFORMATION

Please write your personal answers to the following questions. There are no expected or "right" answers. Case records are strictly confidential with the exceptions explained in the Notice of Privacy Practices and Release of Information.

Name: ____Date of Birth: ____________________

Address: ____________________________ City: ______________ State: ______ Zip:____________

Primary Phone #: ________________________ Secondary Phone #:__________________________

Do you consent to have messages about your therapy treatment left at these numbers?

☐ No ☐Yes *If Yes, initial for consent*_____________

E-mail: ____

Do you consent to have messages about your therapy treatment left at this address?

☐ No ☐Yes *If Yes, initial for consent*_____________

Current Primary Care Doctor and Contact Info: ____

Who Lives in Your Household With You?:

Name	*Relationship to the Person*	*Age (Roughly)*

Have You Ever Received Mental Health Therapy Before?

If Yes:

Problem Addressed	*Where*	*Therapist*	*Dates*	*Did you find it helpful?*

List Medications You Are Currently Taking (if any):

Medication	*Dose*	*Prescriber*	*1st Prescribed*	*Outcome*
___________________	________	______________	_________________	________________________
___________________	________	______________	_________________	________________________
___________________	________	______________	_________________	________________________

List Of Past Prescribed Psychiatric Medication (if any):
____

Are You Currently Suicidal?: ☐ No ☐Yes* In the Past 3 Months?: ☐ No ☐Yes*

If Yes to either, please describe: ____

Are You Currently Homicidal?: ☐ No ☐Yes* In the Past 3 Months?: ☐ No ☐Yes*

If Yes to either, please describe: ____

Have You Ever Been Treated for Alcohol or Substance Abuse Issues? ☐ No ☐Yes

If Yes, please describe: ____

Please Note the Areas Of Concern That You Would Like to Address in Therapy:

Abuse Issues*

If Yes, then ID type: current relatively recent past childhood
emotional physical sexual

Addiction*

If Yes, then ID type: current relatively recent past teenage years
alcohol drug gambling pornography sexual
video game/media related other:

Eating Related*

If yes then ID type: current relatively recent past childhood
anorexia bulimia binge-eating other

Anger
Anxiety/Panic/Stress
Attention/Concentration
Career Concerns
Childhood Issues
Communication Issues
Depression
Grief
Infertility
Infidelity
Isolation
Life Transitional Issues
Loneliness
Marital Problems
Self Esteem
Parenting Challenges
Physical Health Issues
Sexually Related Issues
Sexuality Related Issues
Sleep Problems

Other/s: ____

What Issues Are Important We Address Promptly Within Therapy:

Concern #1 ________________________________:
At What Level Would You Estimate the Severity of the Concern? (*Place "X" On the Line Below*):

I--I
Mild Moderate Serious Severe

Concern #2 ________________________________:
At What Level Would You Estimate the Severity of the Concern? (*Place "X" On the Line Below*):

I--I
Mild Moderate Serious Severe

Concern #3 ________________________________:
At What Level Would You Estimate the Severity of the Concern? (*Place "X" On the Line Below*):

I--I
Mild Moderate Serious Severe

Is There Anything Else You Want to Convey?:

____

____

* If an emergency situation arises or if you need to talk to someone right away call the Crisis Line of Whatcom Counties 1-800-584-3578 or the Police at 911.

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AUTHORIZATION TO RELEASE INFORMATION IN CASE OF EMERGENCY

Client's Name (Print): ____

Client's Date of Birth ______________________________ Phone #:___________________________

I hereby authorize Allison Huffman, MA, LMFT to exchange information with the below listed:

Name of Person to contact in case of an emergency: Phone #:

Address:

I consent to the use of confidential information about me to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to Allison Huffman, MA, LMFT and the above listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, fax or hand delivery.

(*Please initial each item relevant to this consent.)

____ Emergency Contact ***(*Please initial)***

Disclosure of information authorized herein is required for the following purpose: Situations in which Ms. Huffman deems an Emergency need

- I hereby consent to the release of above information, including mental health records and HIV/AID related information obtained in the course of my treatment. I understand that such information cannot be released without my specific consent.
- I have been informed of the specific type of information requested, and understand the benefits and disadvantages of releasing the information. Also, I have been informed that treatment services are not contingent on my decision concerning this release.
- I give my consent voluntarily.
- A copy or fax shall be considered valid in lieu of the original.
- I understand that any cancellation, modification or revocation of this authorization must be in writing.

Client Signature: ____ Date: __________________

Parent/Guardian Signature (*if client is under 13*): ____________________________________ Date: __________________

Witness: ____(Allison Huffman, MA, LMFT, MHP) Date: __________________

Records obtained as authorized by this consent form/information release, will be maintained in accordance with state confidentiality regulations WAC 275-57 which prohibits re-disclosure. By law, all records of the identity, diagnosis, prognosis or treatment of consumers utilizing services must be kept confidential.

This authorization shall remain valid for: One year

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AUTHORIZATION TO RELEASE INFORMATION TO A PARENT OR GUARDIAN

Client's Name (Print): ____

Client's Date of Birth ______________________________ Phone #:___________________________

I hereby authorize Allison Huffman, MA, LMFT, MHP to exchange information with the below listed:

Name of Parent/s or Guardian/s: Phone #: ___________________________

I consent to the use of confidential information about me to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to Allison Huffman, MA, LMFT, and the above listed parent or parents to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, fax or hand delivery.

____The parent or parents (listed above) may schedule or cancel appointments on my behalf, coordinate services, and may pay for therapy. My therapist may engage in conversations about therapy with my parent or parents which therapist judges beneficial. ***(*Please initial)***

Disclosure of information authorized herein is required for the following purpose: Situations in which Ms. Huffman deems an Emergency need and/or coordination of care and/or for reasons the Ms. Huffman believes would enhance client's care

- I hereby consent to the release of above information, including mental health records and HIV/AID related information obtained in the course of my treatment. I understand that such information cannot be released without my specific consent.
- I have been informed of the specific type of information requested, and understand the benefits and disadvantages of releasing the information. Also, I have been informed that treatment services are not contingent on my decision concerning this release.
- I give my consent voluntarily.
- A copy or fax shall be considered valid in lieu of the original.
- I understand that any cancellation, modification or revocation of this authorization must be in writing.

Client Signature: ____ Date: __________________

Parent/Guardian Signature (*if client is under 13*): ___________________________________ Date: __________________

Witness: ____(Allison Huffman, MA, LMFT, MHP) Date: __________________

Records obtained as authorized by this consent form/information release, will be maintained in accordance with state confidentiality regulations WAC 275-57 which prohibits re-disclosure. By law, all records of the identity, diagnosis, prognosis or treatment of consumers utilizing services must be kept confidential.

This authorization shall remain valid for: One year