Malone Therapy PLLC
Mallory Malone, MA, LMHC, LMFT
13303 NE 175th St., Suite A
Woodinville, WA 98072
P: 425.329.6177

DISCLOSURE STATEMENT, OFFICE POLICIES, AND CLIENT INFORMATION

This disclosure statement provides information about Malone Therapy, PLLC and its services, to assist you in choosing the treatment and the provider best suited to your needs.

Relevant education and training. I am a Licensed Mental Health Counselor and Licensed Marriage and Family Therapist. I hold a Master of Arts degree in Marriage and Family Counseling from Gonzaga University, and a Bachelor of Arts degree in Psychology from Gonzaga University. I am experienced and trained in working with teenagers, adults, and families, and I have worked in private practice, mental health agency, and school-based settings.

Treatment modality. I practice Emotionally Focused Individual Therapy (EFIT), an attachment science-based approach. I further use evidence-based practices (EBP's) such as Acceptance and Commitment Therapy (ACT), Cognitive Behavior Therapy (CBT), and Solution-Focused Brief Therapy to provide mindfulness and additional coping strategies to individuals. I am also trained in Cognitive Behavior Therapy Plus (CBT+), which is used to treat symptoms of anxiety and depression in teens. I follow the American Counseling Association (ACA) Code of Ethics.

Course of treatment, when known. After between 1 – 3 sessions, including an initial assessment, you and I develop individualized treatment goals that will address the issues that you have identified as troubling. In addition, other issues regarding stress, family conflict, marital problems, career/planning decisions, or unresolved grief issues and difficult life transitions may also become apparent during the assessment. You and I will reach an agreement about what to focus upon during treatment before proceeding.

Licensure. I am licensed through the Washington State Department of Health (DOH). My license numbers are LH60550478 and LF61001102.

Complaint. If you are concerned that I have violated your privacy rights, or you wish to discuss a clinical issue with me, please speak to me about it in a session, or contact me by writing. You may also write to the Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake, P.O. Box 47857, Olympia, WA 98504-7857. Phone contact may be made at 360.236.4700.

Clients' Rights and Responsibilities. Under the law, clients of counseling services have the following rights and responsibilities:

1. The right to refuse evaluation or treatment, to change counselors or receive a referral to another counselor.
2. The responsibility to choose a provider and treatment modality that best suits your needs.
3. The right to raise at any time, any question about the counselor's training, the therapeutic approach and/or the progress of treatment.
4. The right to access and review the record of the health care services provided to you.

Confidentiality and Limits to Confidentiality: Generally, clients have the right to confidentiality and privileged communications. Information only can be released to others with your signed consent unless an exception established by the law should arise. Some of those exceptions include: a) Mandatory reporting if I have reasonable cause to believe a child, elderly, dependent, or disabled person has suffered abuse, exploitation or neglect, requiring a report to the appropriate authorities; b) If you become a danger to yourself or others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities; c) If you become unable to take care of your basic needs; or d) if a court orders release of your treatment records or my testimony. Additionally, e) I may disclose information to a person who I reasonably believe is providing health care, or for treatment, payment purposes, or health care operations; and f) If you file a complaint with the Department of Health, information about you may be

disclosed to the Secretary. Last, g) I may report information about you to any person if I reasonably believe disclosure may avoid or minimize an imminent danger to the health or safety of you or any other person.

COUPLES/FAMILIES/SECRETS:
When the couple or family is my client, I have found that it is not therapeutically productive for me to hold secrets between/among family members. Thus, if a couple or family member should speak to me or write to me individually, you must do so with the knowledge that the information may be revealed in the next session. If you believe that disclosure could cause harm to you or anyone else, it is your responsibility to tell me explicitly.

Clients engaging in group, couples, and family counseling should be aware that confidentiality may not be private to the extent of an individual session, and therefore may not be protected by law in the same way an individual session may be protected. To participate in couples or family therapy, consent is required by all participants who are capable of consent (age 13+).

Insurance. Insurance companies vary in terms of their coverage for counseling services. It is your responsibility to contact your insurance company to learn whether my services are covered under your plan.
It is also your responsibility to collect your insurance reimbursement or to negotiate a settlement or dispute. Insured patients are expected to pay for services before each appointment.

Fees and Payment. You are responsible for all financial obligations, including if your insurance does not cover your therapy sessions. As a courtesy, I (or my biller) will bill your insurance company, responsible party, or third party payor for you. It is important that you provide me your information on all primary and secondary insurance policies at the beginning of therapy, or upon commencement of a new policy. I cannot bill an insurance plan if I does not know about it, and many insurance companies do not allow backdating claims, especially beyond 90 days. This means you will be responsible for costs should you fail to notify me about such insurance policies and I cannot seek reimbursement.

Payment of your co-pay, co-insurance, or deductible is expected at the beginning of each session. If your insurance company denies payment for any reason whatsoever, the entire fee is your responsibility. In the event that an account is overdue, services may be discontinued.

If you need to cancel or reschedule an appointment, please provide 48 hours' notice. In the event that you do not provide 48 hours' notice, you will be charged my full hourly rate (see rates below). Insurance carriers and other third party agents will not pay for missed appointments; missed session fees will be your sole responsibility.

If you have any questions regarding insurance, fees, balances, or payments please contact me at 425-329-6177 or malonetherapypllc@gmail.com. If you are not using your insurance, total payment of fees is due at the time of service. The fees for services are as follows:

Counseling initial appointment (60-minute) $170
Individual adult $130 (55-minute) and $110 (45-minute)
Couple session $140 (55-minute)
Phone calls to clients or other professionals on client behalf at $10 per 5 minute increments

Acceptable forms of payment are cash, credit card, or personal check. If you'd like to keep a credit card on file and have your balance automatically charged, please sign the credit card authorization below.

Credit card authorization: I use Cayan Merchant Services for all credit card processing. Cayan is PCI compliant and interfaces with our EMR (electronic medical record) system to maintain HIPAA compliance and full security of your credit card information. Your signature below authorizes me (Malone Therapy, PLLC) (or my biller) to charge your credit card for any outstanding balances, co-insurance, co-pays, or other charges. If there is an outstanding balance on the account, your signature authorizes me to send an email invoice on the last day of the month. Outstanding balances will be charged one week thereafter. Client agrees and understands that client will be responsible for all session fees, late cancel and missed appointment fees, and outstanding balances. With the signature below, client authorizes me to run the charges at the end of the month. It is your responsibility to let me know right away if you contest any charges.

Supervision and Consultation. I may utilize supervision or consultation regarding your case. With this informed consent,

you authorize me to retain resources I deem beneficial or necessary. Information about you will be described only to the extent necessary. Confidentiality will be maintained to the extent possible.

Professional Records. You are entitled to have a copy of your records or request a summary with a written request. Couples or families have treatment records with more than one person's name on them. All couples and family members agree that treatment records will be released only with the joint consent of all clients who can legally give consent (age 13+). In the event of a disagreement, the records will not be released without a court order. Reasonable fees may attach to your request.

Scheduling: For **scheduling and billing questions**, you may contact me by calling 425-329- 6177 or emailing me securely through the Therapy Appointment patient portal. If you choose to email directly and not through the portal, please know that it is not a secure form of communication.

Cellphone Communication and Electronic Correspondence. To ensure prompt receipt of information, communication is generally handled through cellphone or email. This may, however, pose some risks to privacy. If you would like to discuss therapeutic issues, please phone me or speak to me in person. I will not respond to emails about treatment issues. With full knowledge of these risks, your signature below authorizes electronic communication to the extent necessary.

Social Media: I do not participate on social media of any kind with my clients. Please do not take offense if I do not respond to requests or outreach from you or others.

Termination: Non-payment of fees may result in termination of my services. Non- attendance may also trigger termination. If you cancel two appointment(s) without re-scheduling, or have not attended sessions within a month's time, I may close your file. If you would like to resume services, please feel free to call. I may terminate services if I determine I lack the competence to be of professional assistance to you or believe I cannot best suit your needs. In such a case, I will provide appropriate referrals.

Legal Proceedings. Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters of a personal and confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to, divorce, custody disputes, injuries, or lawsuits), neither you (clients), nor your attorney, nor anyone acting on your behalf will call on me to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy or counseling records be requested. If subpoenaed or ordered by an authorized court of law, I may be required to release confidential information. Time for preparation and/or attendance in court, even if settlement occurs and I am not actually called to testify, will be charged at a rate of $180 per hour, including transportation time and all other costs incurred.

Risks and Benefits of Counseling. My role is to provide counseling services to you. Counseling varies depending on the personality of the client and the counselor/therapist. Treatment requires active effort on your part. This process may require talking about unpleasant aspects of your life. You will need to work on solutions to problems in session and at home. Treatment has benefits and risks. Risks may include feelings of sadness, guilt, anxiety, frustration, or anger. Benefits may include reduced stress, better relationships, and enhanced problem-solving skills. There are no guarantees as to results. It is your responsibility to evaluate the treatment goals that may be proposed, along with your own assessment about working with me. It is important for you to choose a treatment provider carefully. If you have questions about procedures, please ask. If you have concerns, please bring them up before difficulties arise. If you feel you would work better with another provider, I will help with referrals. Likewise, if I feel that I cannot help you or that you might be better served by another provider, I will suggest referrals, if you wish.

Dual Roles. The ACA Code of Ethics warns against dual roles. Counselors are obligated to establish and maintain appropriate professional boundaries with clients. These relationships do not allow for business, social, romantic, or any other dual relationship that impairs clinical objectivity, effectiveness, or client's welfare. I provide no recommendations or opinions as to legal or custody purposes.

Separate Practice. I am a solo practitioner. Although I may share office space, marketing methods, or work closely with Momentum Therapy Services or others, I am not legally associated nor in partnership with Momentum Therapy Services

or others.

Crisis Contact Information. Your safety and wellbeing are important to me. While I will attempt to be available to you in a crisis, please know that I do not carry a pager and cannot always be reached immediately. If you are experiencing a crisis and cannot reach me, please call or connect with one the following resources below:
King County 24-Hr Crisis Line at: 866-427-4747
National Suicide Prevention Lifeline: 1(800) 273-8255
911, or go to the nearest emergency room

Consent to services. By signing this document, the person signing below hereby acknowledges that s/he read the disclosure statement and received/was offered a copy of it. S/he had the opportunity to ask questions, and understands the terms to satisfaction. Client gives permission for evaluation and treatment and agrees to follow the terms of this agreement.

I understand that if use my insurance, the insurance company has the right to access my diagnosis, symptoms, and treatment goals, as well as documentation of my treatment. I consent to the use or disclosure of my protected health information by Malone Therapy, PLLC for the purpose of providing services to me, obtaining payment for bills for services I receive, or to conduct health care operations.

If insurance is being used: The insurance company to be billed is: _____. By signing below, I authorize Malone Therapy, PLLC to share information relating to health care to obtain payment for services received or to conduct health care operations.

My protected health information (PHI) refers to health information that I have provided as well as information that has been shared about me. PHI may include past, present or future health, condition, or services. It includes information that could be used to identify me/us even if names were not used. My signature below indicates that I am aware of this and consent to these uses of PHI.

I have received and read the disclosure statement. I have had an opportunity to clarify my concerns and questions with my therapist. I understand and agree to all of the policies and procedures.

_____ _____
Client(s) Name Printed Client(s) Signature Date

_____ _____
Parent(s) Name Printed Parent(s) Signature Date

_____ _____
Mallory Malone, Owner, signing for Malone Therapy, PLLC Date

**Client refuses to acknowledge receipt:

_____ _____
Mallory Malone signing for Malone Therapy, PLLC Date