CeBell Berry, MA, LMFTA

Dear New Client,

Thank you for choosing CeBell Berry, PLLC. This packet includes the information you will need to begin counseling services.

My ***Professional Disclosure Statement*** describes:

(a) how I conduct therapy
(b) my education and training
(c) billing and insurance
(d) fees for therapy services
(e) appointment scheduling guidelines
(f) your client rights and responsibilities
(g) new client intake form
(h) my responsibilities as your therapist and a mandated reporter
(i) confidentiality in therapy
(j) how therapy is initiated and terminated.

Other forms included are the Email/texting consent, Notice of Privacy Practices, and Counseling or Hypnotherapy Clients (WA State Clients' Rights Statement by the Department of Health). Additional forms that are given if needed include Consent for Minors and Guidelines for Children from Two-Family Homes.

Each adult and minor, age 13 years and older involved in therapy, needs to read, sign, initial, and date each of the forms where indicated.

If you are scheduled for family therapy, each adult involved in the care of the children and each minor 13 years and older, should individually complete, sign and date the New Client Intake Form where indicated. Minors should complete the form to the extent they are able and seek parental assistance where necessary.

If you are scheduled for couple's therapy, you and your partner should individually complete pages 6-8, and jointly sign, initial and date the bottom of each page where indicated.

Feel free to contact me with any questions.

I look forward to meeting you.

Regards,
CeBell Berry, MA, LMFTA

CeBell Berry, MA, LMFTA
4500 9th Ave NE Seattle, WA (206) 388-9630
cebell@cebellberry.com | cebellberry.com

PROFESSIONAL DISCLOSURE STATEMENT

Philosophy and Approach

My goal in therapy is to promote the growth and well-being of couples, individuals, and families who seek help for stressful situations or new transitions in life. I work through a holistic, strength-based, collaborative, and client-centered approach. Each client is unique their therapeutic goals and interventions are unique. Together we will generate effective ways to approach life's stressors and create positive change. My specialties include working with children and adolescents, co-parenting issues, and individuals with anxiety and depression.

Education

• Masters of Psychology, Marriage and Family Therapy	Antioch University	Seattle, WA	2015
• Bachelor of Arts, in Elementary Education and Early Childhood	West Florida University	Pensacola, FL	1993

Experience

I am a licensed marriage and family therapist associate in the State of Washington (License # 60622943). I have provided therapy to individuals, couples, and families for one year in community mental health. My education, training, and life experience have prepared me to counsel individuals of all age, ability, ethnicity, race, religion/spiritual backgrounds, gender identity, and sexual orientation. I am a member of the American Association of Marriage and Family Therapy (AAMFT), and continue to seek education and training that will benefit my clients.

Informed Consent

Counseling is understood to be a choice you have made among available options such as, other counselors, other therapies, support groups, self-help resources, and other modes of treatment. Counseling can have benefits and risks. Counseling sometimes involves discussing unpleasant aspects of your life, and you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has been shown to have many benefits. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of emotional distress. Some clients require only a few sessions to achieve their goals, while others benefit from long-term counseling. You have the right to terminate counseling at any time; however, it is understood that premature termination may result in the return or worsening of the initial problems and symptoms.

I encourage you to talk with me directly if you are dissatisfied with my services, want a second opinion or referral, or if you are intending to discontinue appointments. If I am not able to resolve your concerns, you have the right to file a complaint with the Department of Health.

Confidentiality

I am providing you with a copy of my *Notice of Privacy Practices* which describes how I may use and disclose your health information. In this document I will highlight some of those disclosures: (1) to report suspected abuse of a child, of a developmentally disabled person, or of a dependent adult; (2) to interrupt potential suicidal behavior; (3) to intervene against threatened harm to another (which may include knowledge that a client is HIV positive but is unwilling to inform others with whom he/she is intimately involved); and (4) when required by court order or other compulsory process.

Confidentiality extends to all members involved in therapy. This means, I will not release to any third party any information prior to obtaining a signed ***Release of Information*** from each member. Additionally, I am not bound by confidentiality in joint sessions with information I have obtained in individual sessions. Thus, I reserve the right to discuss in joint sessions the information you share in the individual sessions, if I believe doing so will facilitate the identified outcomes and goals of therapy.

_____,_ _____ **(Initial and Date Here)**

Disclosures may also be made if (a) you sign a written authorization permitting disclosure; (b) you file a complaint against me; (c) you make payment by check, which permits bank employees to view names of my clients; (d) you have caller identification on your phone and my name appears on the monitor; and if (d) a contracted third-party agent contacts you by mail or phone to receive payment for a balance due that exceeds 90 days.

As a licensed marriage and family therapist associate, I receive ongoing supervision from Dr. Kirk J. Honda, PsyD., LMFT (License# LF00001679). In addition, I participate in peer review and case consultation with other professional therapists. I consult with other therapists regarding my cases because I believe our collective knowledge may help me provide you the best counseling services possible. I do not disclose names or details that would allow identification of my clients during these processes.

Professional Boundaries

I refrain from entering into a dual relationship with any of my clients. This means the therapeutic relationship is a professional one, not a social or business relationship. Once a therapeutic relationship is established, any other relationship would potentially compromise the efficacy and the outcome plan for therapy. Therefore, I will not acknowledge the existence of a relationship with my clients outside of the therapy session.

Appointments Times and Fees

Daytime and evening appointments are available. After the free 20-minute meeting, the initial session works best with a 90 minute session, followed typically with 50-minute sessions once per week. You will be provided with the recommended course of therapy and number of required sessions at the conclusion of your first appointment. I have a limited number of sliding scale appointments available for those with financial hardships. Please contact me directly to discuss your options.

My fees

Individuals--$100.00 for 50-minute sessions and $120 for a 90-minute session
Couple--$110 for a 50-minute session and $135 for 90-mintue couple's session
Family--$120 for a 50-mintue session and $155 for a 90-minute family session.

24 hours' notice is required when rescheduling appointments to avoid an $100.00 charge. Missed appointments are also charged at $100. If you miss two consecutive sessions without prior notification, I will assume you no longer wish to obtain therapeutic services, and will mail you my notice of termination, and 30-days emergency coverage.

Financial Responsibility: I will provide you with a receipt you can summit to your insurance company. However, should the insurance deny payment for any reason, you will be responsible for any outstanding financial debt associated with therapy services.

Financially Responsible Party_____ Relationship to client_____
Signature_____Date_____

Scheduling Appointments and After-Hours Contact

Please call 206-388-9630 to schedule an appointment. I see clients Monday-Thursday 8am-6pm If you wish to speak to me between appointments, please leave a message at 206-388-9630. My hours of operation may adjust without notification; however, I will attempt to keep you informed in advance of any changes in my schedule. I check my voicemail regularly during normal business hours. If you are experiencing a clinical emergency, contact 911 or the Crisis Clinic at 206-461-3222.

I cannot guarantee that the contents of electronic communication will remain confidential. I will do my best to keep communications private; however, email usage can be monitored and others may read the content of personal messages. If you are concerned about the content of your email being read by someone other than me, you should contact me by phone. While I check my email often during regular office hours, I may not receive your message immediately. Therefore, please do not send email you consider urgent and expect an immediate

_____,_ _____ (Initial and Date Here)

reply. I do not offer online therapy nor do I engage in communication via social media with clients or families of clients.

Vacations

I will give you reasonable notice before taking vacation leave. When I am unavailable, a colleague will be on call for emergencies. The name and phone number of this individual will be on my office phone. If you anticipate needing continuing treatment during this time, I will help you make arrangements with another therapist in advance. If you are experiencing an emergency and are unable to contact my on-call therapists, please contact 911 or King County Mental Health Services, 206-461-3222.

Record Keeping

I keep very brief records, noting only that you have met with me, what interventions happened in session, and the topics discussed. If you prefer that I keep no treatment records, you must submit a written request to that effect. Once received, I will place your request in your file and retain only the following records: Your name and signed disclosure statement, the session date and fee for service.

Client Rights

As a client in therapy, you have specific rights in addition to the right of confidentiality. These rights include:

- The right to ask me questions about my qualifications and experience;
- The right to ask questions about any procedures I use in therapy with you;
- The right to refuse a particular treatment method or testing;
- The right to discuss your therapeutic progress and treatment goals;
- The right to refuse any psychological testing I recommend;
- The right to request referral to another therapist;
- The right to terminate or suspend therapy at any time without my permission or agreement;
- The right to file a complaint with the Washington State Department of Health if you believe I have behaved in an unprofessional or unethical manner and decide that a resolution to the problem cannot be reached. (Please see the attached Department of Health Brochure, *Counseling or Hypnotherapy Clients* for information regarding how to file a complaint).

You also have specific rights pertaining to how I maintain personal information about you and your health (please review the Notice *of Privacy Practices).*

Terminating Treatment

My goal is to assist you in obtaining your desired therapeutic outcomes. If you have any questions or concerns about any aspect of your therapy, please discuss them with me. If you elect to terminate or suspend treatment, please discuss your decision with me so that we can bring sufficient closure to our work together. In our final session we can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge you have gained through your therapy. We can also discuss any referrals that you may require at that time.

Independent Practice

I conduct my counseling as an independent practitioner. Although I operate individually, I share a common waiting room with other independent businesses.

By signing below, each of us confirms this document to represent the agreement between us, and that you have read, understood and received copies of this disclosure along with a copy of *Notice of Privacy Practices* and the Department of Health Brochure, *Counseling or Hypnotherapy Clients*.

Client Name (please print) _____
Client Signature (or authorized representative) _____ Date _____
Client Name (please print) _____
Client Signature (or authorized representative) _____ Date _____
Client Name (please print) _____
Client Signature (or authorized representative) _____ Date _____

_____,_ _____ **(Initial and Date Here)**

CLIENT EMAIL/TEXTING INFORMED CONSENT FORM

1. Risk of using email/texting The transmission of client information by email and/or texting has a number of risks which clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts This therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. This therapist is not liable for improper disclosure of confidential information that is not caused by this therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations.
b. This therapist cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
c. Email and texts should be concise.
d. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
e. Email may be printed and filed into the client's medical. Texts may be printed and filed as well.
f. This therapist will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
g. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
h. This therapist is not liable for breaches of confidentiality caused by the client or any third party.
i. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and I consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text. I consent that the types of emails/text messages and frequency of emails/text messages I may receive from my therapist includes, but is not limited to:

- Appointment reminders
- Cancellation notices
- General notifications regarding services offered by therapist
- Responses to my emails and/or text/SMS messages

Furthermore, I am aware that standard text message and data rates may apply. If I wish to "opt out" of receiving text messages and/or emails from my therapist, I agree to supply notification, in writing, directly to my

_____,_ _____ (Initial and Date Here)

therapist. By signing below, I consent to communicate, as necessary, with my therapist via: _____text/SMS messages at the number(s) listed below _____email(s) listed below

Client name: _____
Client signature: _____ Date:_____
Authorized email address:_____
Authorized Text/SMS mobile number_____

Client name: _____
Client signature: _____ Date: _____
Authorized email address:_____
Authorized Text/SMS mobile number_____

_____ Date: _____
CeBell Berry, MA, LMFTA

NEW CLIENT INFORMATION

Name _____ DOB ____/____/_____ Age _____
Preferred Phone _____ □CellPh □HmPh □WkPh □Other: _____
Email _____ Preferred Communication □Cell □HmPh □WkPh □Email
O.K. to leave a message on my: □ Home □Cell □ Work number □ Other
Residential Address _____ City _____ Zip _____
May I send mail to this address? □ Yes □ No
Email _____May I use email to confirm appointments? □ Yes □ No
Employer _____ Type of Work _____
Relationship Status □Single □Married □Partnership □Divorced □Separated □Widowed □Other
Household Members (Name/Age/Relation/Gender) _____
_____
Emergency Contact _____Relationship_____Phone_____

What prompted you to seek therapy?

_____

_____

_____

_____

Who is impacted by the issue?

_____

_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____

_____

_____

Have you had any prior counseling or psychiatric treatment? □ No □ Yes If yes:

1. When? _____ Where? _____

Reason for and length of counseling_____

Check one: Therapy was □ helpful □ not helpful. Please explain:

_____

_____,_ _____ (Initial and Date Here)

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:

_____

_____Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

ALCOHOL AND SUBSTANCE USE

Have you ever been treated for alcohol or drug dependence/abuse?	□Yes	□No
Have you ever felt like you should cut down on alcohol or other drug use?	□Yes	□No
Has a friend or relative ever discussed concerns about your drug use?	□Yes	□No
Is there a history of problems with alcohol or drug use in your family?	□Yes	□No

Have you received help for drug or alcohol dependency? □ No □ Yes If yes:

1. When? _____ Where?_____

Check one: Treatment was □ helpful □ not helpful. Please explain:

_____

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____,_ _____ (Initial and Date Here)

COUNSELING OR HYPNOTHERAPY CLIENTS

Client and Counselor Responsibilities and Rights

Counselors must provide disclosure information to each client in accordance with chapter 18.19 RCW prior to implementation of a treatment plan. The disclosure information must be specific to the type of counseling service offered; in language that can be easily understood by the client; and contain sufficient detail to enable the client to make an informed decision whether or not to accept treatment from the disclosing counselor.

If you have concerns about being dependent upon your counselor or hypnotherapist, talk to him or her about it. Remember, you are going to that person to seek assistance that helps you learn how to control your own life. You can and should ask questions if you don't fully understand what your counselor or hypnotherapist is doing or plans to do.

Requirement for Registration or Licensure

Your counselor or hypnotherapist must be either registered under chapter 18.19 RCW or certified under chapter 18.25 through the Washington State Department of Health unless otherwise exempt. To be registered, a person fills out an application and pays a fee. To become licensed, a person fills out an application form and pays a fee, but he or she must also show proof of appropriate education and training. There are some people who do not need to be either registered or certified because they are exempt from the law. You should ask your counselor or hypnotherapist if he or she is registered or licensed and discuss his or her qualifications to be your counselor or hypnotherapist.

Definitions

Counseling means using therapeutic techniques to help another person deal with mental, emotional and behavioral problems or to develop human awareness and potential. A registered or certified counselor is a person who gets paid for providing counseling services.

Confidentiality

Your counselor or hypnotherapist cannot disclose any information you've told them during a counseling session except as authorized by RCW 18.19.180:

1. With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary or an insurance policy on the person's life, health, or physical condition;
2. That a person registered or certified under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;
3. If the person is a minor, and the information acquired by the person registered or certified under this chapter indicates that the minor was the victim or subject of a crime, the person registered or certified may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
4. If the person waives the privilege by bringing charges against the person registered or certified under this chapter;
5. In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or
6. As required under chapter 26.44 RCW.

Assurance of Professional Conduct

Thousands of people in the counseling or hypnotherapy professions practice their skills with competence and treat their clients in a professional manner. If you and the counselor agree to the course of treatment and the counselor deviates from the agreed treatment, you have the right to question the change and to end the counseling if that seems appropriate to you.
We want you to know that there are acts that would be considered unprofessional conduct. If any of the following situations occur during your course of treatment, you are encouraged to contact the Department of Health at the address or phone number in this publication to find out how to file a complaint against the offending counselor or hypnotherapist. The following situations are not identified to alarm you, but are identified so you can be an informed consumer of counseling or hypnotherapy services. The conduct, acts or conditions listed below give you a general idea of the kinds of behavior that could be considered a violation of law as defined in RCW 18. t130.180.

1. The commission of any ac involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilty of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purpose of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceeding

_____,_ _____ (Initial and Date Here)

s in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

2. Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
3. All advertising which is false, fraudulent or misleading;
4. Incompetence, negligence, or malpractice which results in injury to a patient, or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
5. Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
6. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
7. Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
8. Failure to cooperate with the disciplining authority by:
   (a) Not furnishing any papers or documents;
   (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
   (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceedings;
   (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
9. Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
10. Aiding or abetting an unlicensed person to practice when a license is required;
11. Violations of rules established by any health agency;
12. Practice beyond the scope of practice as defined by law or rule;
13. Misrepresentation or fraud in any aspect of the conduct of the business or profession;
14. Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
15. Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;
16. Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
17. Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
18. The procuring, or aiding or abetting in procuring, a criminal abortion;
19. The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand of the disciplining authority;
20. The willful betrayal of a practitioner-patient privilege as recognized by law;
21. Violation of chapter 19.68 RCW;
22. Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
23. Current misuse of:
   (a) Alcohol;
   (b) Controlled substances; or
   (c) Legend drugs
24. Abuse of a client or patient or sexual contact with a client or patient;
25. Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

_____,_ _____ (Initial and Date Here)

This publication should not be considered as the final source of information. If you want more information about the law regulating counselors and hypnotherapists or want to file a complaint, please write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington 98405-7869.

If you want to contact someone by phone to discuss the law or talk about a possible complaint, call 206.898.8450, Monday through Friday, 8:00 am to 5:00 pm.

_____,_ _____ (Initial and Date Here)