**Jennifer Szolnoki, MSW, LCSW**

WA State Department of Health, Social Worker Independent Clinical License: #LW 60242478 Licensed Clinical Social Worker
**PO Box 52, Underwood, WA 98651** **Telephone: 509.281.1008** **www.tworiverscoaching.com**

# Disclosure Statement and Office Policies

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions. Once you are confident that you understand this information, sign this copy and return it to me at our first session. When you sign this document, it will represent an agreement between us.

## *My Background:*

**Credentials**: I am a Licensed Clinical Social Worker in the State of Washington (#LW 60242478).
**Education:** I earned my Master's of Social Work (MSW) from the Univeristy of Washington. I have 15 years of clinical experience working with clients including: Youth & Family/General Counselor (3 years); Psychiatric Assessment Team Evaluator (2 years); Crisis Line Volunteer (5 years); Child Protective Services and Child Welfare Services Intern (1+ years); Coordinator of an At-Risk Youth Mentor Program (2 years); Permanency Planning Social Worker (1 year); Life and Career Coach (6 years); Faculty teaching Life Skill Workshops for adults on welfare (1 year); and Private Practice Counselor (6 years)

- I am trained in 36+ hours of CEU training every two years.

**Professional memberships:** I am a member of the National Association of Social Workers. I am a member of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT)
**Services Provided:** I provide counseling (therapy) to individuals age 13 and older; couples/marriage counseling; life coaching to individuals age 16 and older. I also offer counseling groups, consulting services, career coaching, and workshops.

*The Process of Therapy:* Successful therapy is a joint effort between you and your therapist and so it is important that you enlist the help of a therapist whom you feel comfortable with. I encourage you to discuss the therapy process and your goals with me, and ask about anything that you have a question about, particularly if you feel it is in the way of your proceeding. The process of developing a good working relationship takes time. The more I know about your concerns, the more effective I can be. Therapy is most beneficial when guided by your goals. I will review your goals as well as your thoughts and feelings expressed regarding the therapy process. I like to begin by getting to know you and hearing about your concerns, what you have tried so far, what has not helped and what has improved your situation. Then we will usually discuss what successful completion of therapy would look like for you. **Using this plan, we will know what you want to achieve, and when you are done**. The more active role you take in describing the problem and the goals you want to achieve, the better. If at any time you are uncomfortable with the way things are going, please let me know.

*Theoretical Orientation and Approach:* My respect for you is fundamental to our work together. My role as a counselor is to provide you with opportunities for growth, change, insight, learning new skills, and accessing/developing internal and external resources. I see you within the context of your whole self: mind, body, spirit, past experiences, relationships, and environment. Our work together may address some or all of these aspects. I use a number of approaches to help you achieve your goals. These include: cognitive-behavioral, emotionally focused therapy, psychodynamic, mindfulness, solution-focused, developmental (adult, child, family), humanistic, psycho- educational, and others. I do not provide medication, prescription recommendations, or legal advice, as these activities do not fall within my scope of practice.

*Risks/Benefits:* From time to time the process of therapy can be uncomfortable as you work to achieve your goals. You may experience uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for you may at times be challenging for others in your life. Therapy is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. There is no guarantee that therapy will yield positive or intended results. I have found that open and honest feedback from you can be a turning point in getting you the results you desire. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

*Duration*: Therapy can be as short as one session, or as long as a few years, depending upon the breadth and depth of your goals, and your own personal change process. There are many people for whom therapy is a deeper, longer-term process that may require a longer course of treatment to achieve their goals. Additionally, many clients come for a course of treatment, finish up, and then return later to achieve other goals or for "tune- ups."
You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person. If more than 30 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

***Termination:*** If necessary, I can offer referrals to other providers in any of the following instances. If you request it and authorize it in writing, I will talk to the counselor of your choice in order to help with transition:

- After the first couple of sessions, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help.
- As well, if at any point I assess that I am not effective in helping you reach the therapeutic goals, I will discuss it with you, and if appropriate terminate treatment.
- You have the right at any time and for any reason to decide that you do not wish to continue therapy. I encourage you to discuss your decision to end treatment, as it is an important part of the therapeutic process.

***Fees for Service*:** My standard fee is $120 per 50 minute session. This is the same fee charged for late, missed, or late-cancelled appointments. Unless otherwise arranged, payment is due at each session. You can pay by check, credit card or cash. Checks can be made out to Jennifer Szolnoki. The initial intake session is $165. Please notify me if any problems arise regarding your ability to make timely payments. Please inform me of any change in your financial situation that impacts your ability to pay for services. I will charge a $30 fee for any returned checks.

*Other Services:* Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information (copying and sending records), reading records, longer sessions, travel time, etc. will be charged at the same rate ($120/50 minutes), unless indicated and agreed upon otherwise.

*Insurance:* I am a preferred provider (in-network) for and only accept Blue Cross, Blue Shield, Lifewise, and TriCare. I am an out of network provider for most other insurance companies. If you are intending to use insurance mental health benefits to pay for all or part of your treatment costs, you should be aware that my contract is with you, not your insurance company. Although I am happy to assist you with billing your insurance company if I am in-network (or providing you with a monthly statement you submit yourself for out-of-network benefits), you are financially responsible for all fees. You should also be aware that there are certain circumstances for which insurance companies do not provide payment: i.e., missed but scheduled sessions telephone consultations, services that are no medically necessary.

**I understand Jennifer Szolnoki is not responsible for the amount my insurance reimburses or whether they cover services provided. Insurance does not cover missed appointments. If I miss an appointment I am responsible for the full fee.**

*Medicare:* I have opted-out of the Medicare Program and am not a Medicare provider. By signing this document, you agree ***not*** to submit a claim nor will the provider submit a claim to Medicare or to any Medi-Gap program and you agree that neither Medicare's fee limitations nor any other Medicare or Medi-Gap reimbursement regulations apply to charges for services provided to you. Clients 62 years old and older must review and sign the Medicare opt-out form in this document in order to receive services.

*Sliding Scale:* In certain circumstances, I might arrange a reduced fee for you, which we will finalize in writing on a separate Sliding Scale Fee Agreement form.

*Legal:* If I were ever subpoenaed to testify in court regarding you or your child, my base fee is $375.00/hour and additional fees may also apply.

*Cancellations:* When we make an appointment, I am committing to hold that time for you. If you are unable to keep your scheduled appointment for any reason, please give me at least 24 hours advance notice or you will be charged the full amount for the time reserved for you. If I miss a scheduled appointment without notifying you in advance, I will make up the session with you, without charge. Insurance does not cover missed appointments. If I miss an appointment I am responsible for the full fee.

***Confidentiality:*** All aspects of my work with a client are confidential. I will not disclose information without your written permission, except as required by law. *There are exceptions to this.* See my HIPAA Notice of Privacy Practices for more detailed information about confidentiality and disclosure exceptions.

- ***Your Confidentiality in the Community:*** The Columbia Gorge is a fairly small community. Consequently you may see me out in the community or bump into someone you know leaving my office. I will never acknowledge working with you without your verbal permission. In other words, if I see you outside the office I will not acknowledge you (unless you do so first or verbally agree to it.) I will never say I know who you are in any other context. If any issues arise, please bring them to me so I can address them. Please respect the confidentiality of anyone you see entering or leaving my office.
- ***Litigation Limitation:*** Due to the nature of the therapeutic process and it often involving a full disclosure with regard to many matters of a confidential nature, it is agreed that, should there be legal proceedings such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc., neither you nor your attorney, nor anyone else acting on your behalf, including but not limited to parenting evaluators and guardian ad litems, will call on me to testify in court or at any other proceeding, nor will a disclosure of your therapy records be requested unless otherwise agreed upon.
- ***Duty to Warn:*** **The law requires that I report** if: a reasonable suspicion of child, dependent or elder abuse or neglect; where you might be in danger of harming yourself, others, property, or are gravely disabled, or when your family members or other person(s) communicate to me that you present a danger to self or others. If there is an emergency during our work together, or in the future after termination, I may also contact the person whose name you have listed as your emergency contact.

- *Health Insurance & Confidentiality of Records:* If you use your health insurance, I may need to disclose confidential information to your health insurance company. Only the minimum necessary information will be communicated to them. **I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. Submitting a mental health invoice for reimbursement carries some risk to confidentiality.** When you pay me for the full cost of any sessions (without using your health insurance to pay part of the cost) you can ask me to not send information about that treatment to your health insurance company and I won't do so. However, if you want to buy life insurance or long-term care insurance I will have to send the information about those sessions.

*Telephone & Emergency Procedures:* **Please do not use e-mail, texts or faxes for emergencies.** You may reach me confidentially at 509-281-1008. I will make every effort to return phone calls within a 24-hour period during business hours. If an emergency situation arises, indicate it clearly in your message. **Please do not use e-mail, text or faxes to contact me in an emergency.** I check my messages Monday through Friday *during the daytime only*, unless I am out of town. You will be informed in advance of my vacation time. **In the case of an emergency (including being unable to manage thoughts of harming yourself/others), call:**

- **Mid-Columbia Center for Living, 541-386-2620, they have 24 hour crisis line**
- **Call 911 or go to local Emergency Rooms**
- **Suicide Prevention Lifeline Phone: 1-800-273-TALK**

*Emails, Cell phones, Computers and Faxes:* Computers, e-mail and cell phone communication can be accessed by unauthorized people and can compromise confidentiality. **My e-mails are not encrypted**. Faxes can be sent to the wrong address. Some texts are never received. Please notify me if you decide to avoid or limit the use of any or all communication devises. **If you communicate confidential information via e-mail or text, I will assume that you have made an informed decision that such communication may be intercepted**, and I will assume you desire to correspond on such matters via e-mail. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell-phone or faxes. Please, be aware that emails are part of your medical record. **Please do not use e-mail, text or faxes for emergencies.**

*Mediation & Arbitration:* If a dispute arises I will seek mediation before, and as a pre-condition of, the initiation of arbitration. The mediator will be a neutral third party mutually agreed up by you and myself. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Skamania County, Washington in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed.

*MEDICARE:* I have opted-out of the Medicare Program and am not a Medicare provider. By signing this document, you agree not to submit a claim nor will the provider submit a claim to Medicare or to any Medi-Gap program and you agree that neither Medicare's fee limitations nor any other Medicare or Medi-Gap reimbursement regulations apply to charges for services provided to you. Clients 62 years old and older must review and sign a Medicare opt-out form in this document in order to receive services.

## Fee Agreement

1. **Fee:** I agree to enter into treatment with Jennifer Szolnoki at a cost of **$120 per 50 minute session** unless otherwise noted. I agree to pay at time of service for my payment. **I understand the initial intake session is $165**.

   **Client Signature: ________________________________________ Date: _________________________**
2. **Billing:** I authorize Jennifer Szolnoki, MSW, LCSW to furnish my insurance company with any/all information requested or necessary concerning my present claim. I understand I am responsible for the full fee at the time of service and if my insurance company will reimburse me.
3. **Insurance**: If Jennifer Szolnoki is a provider with my plan, she will submit claims for me, but at my session I must pay any portion not covered by my plan (i.e. copay, coinsurance). If she is not a provider for my plan, I agree to pay her in full at the session and Jennifer can give me an invoice so I can seek reimbursement from my plan.
4. **Emergency calls:** I understand that I will be **charged for emergency telephone consultations** at the hourly office visit rate, prorated up to the nearest tenth of an hour for all calls over 5 minutes.
5. **Other professional services:** I agree to pay Jennifer Szolnoki, MSW, LCSW her hourly office fee of $120/hour, prorated up to the nearest tenth of an hour for other professional services that I may require such as report writing, telephone conversations, attendance at meetings or consultations with other professionals which you have requested, or the time required to perform any other service which I may request of her.
6. **Legal:** If I become involved in a legal matter that requires Jennifer Szolnoki's participation (although it is recommended that I discuss this fully before I waive my right to confidentiality), I will be expected to pay for the professional time required at $375/hour even if Jennifer Szolnoki is compelled to testify by another party.
7. **Extended Sessions:** I understand that I will be **charged at the prorated hourly rate for extended sessions**.
8. **Late Cancelation:** I understand that **I am responsible for paying the full fee of $120** from **late cancellations without 24-hour notice**. My insurance will not cover missed appointments. Benefits quoted are no guarantee of payment. Exceptions to this policy are cases where sudden illness and legitimate emergencies occur.

### Please sign if you are using your Insurance or Employee Assistance Program:

I authorize the release of any information necessary (including notes, treatment summaries, and diagnosis) to my insurance pan or EAP to process claims, determine medical necessity, or to request additional sessions. I authorize payment of benefits to my provider.

______________________________________________________________________

Client name (print) Date Signature

______________________________________________________________________

Client name (print) Date Signature

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# Communication Policy
# Email/Text Informed Consent

**Phone and After-Hours Contact:** Due to my work schedule, I often am not immediately available by telephone. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please include good times to return your call. If I go on vacation I will discuss options for counseling support in my absence.

**Email and Text Communication:** In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when I communicate this way and to document that you are aware of these and agree to them.

| Initial | |
|---|---|
| | I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. |
| | I understand that my e-mail communications with my therapist will NOT be encrypted and, therefore, my therapist **CANNOT** guarantee the confidentiality and security of any information sent via e- mail. |
| | I understand that SMS (text) messages are even less secure than e-mail, and the same conditions apply**.** |
| | **I understand that for this reason my therapist has advised me not to send sensitive information via email or SMS message**. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information. |
| | I hereby give permission for my therapist to reply to my messages via e-mail, including any information that my therapist deems appropriate, that would otherwise be considered confidential. |
| | I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet. |
| | I understand that my therapist will limit SMS messages to brief inquiries or responses regarding scheduling. |
| | I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail. |
| | I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. |
| | If I believe I need a response within 48 hours, I will not use e-mail but will call my therapist. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call my therapist. I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. |
| | I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or SMS by notifying my therapist in writing. |

## Agreement

I,______________________________, have read and understand the Disclosure Statement and Office Policies, Fee Agreement, and Communication Policy. Any questions I had have been discussed with Jennifer Szolnoki, MSW, LCSW and answered to my satisfaction, and I give my consent for services at the specified fee and payment schedule.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Therapist Signature Date

I have been supplied with a copy of this statement as well as the HIPPA Notice of Privacy Practices.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Client Date