Counselor Disclosure Statement

As outlined by WAC 246-810-031

Spira Counseling
Katie Kapugi, MA
LMHC (LH60947980)
ATR-P (18-403)
CDP-T (CO60867330)

Kapugi@spiracounseling.com
(360) 329 7226

Qualifications:
University of Florida B.A. English Literature
Antioch University Seattle M.A. Mental Health Counseling and Art Therapy
Spokane Falls Community College Certificate Training for CDP

Counselors practicing counseling for a fee must be credentialed with the department of health for the protection of the public health and safety. I am licensed under the DOH in Washington state as a mental health counselor my license number is: LH60947980
Credentialing of an individual with the department of health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

Approach:
I focus on the individual needs of my clients; working collaboratively to establish treatment plans and goals. I incorporate a variety of theoretical orientations including, but not limited to: CBT, Mindfulness based therapies, transpersonal theories, existential theories, art therapy, relaxation therapy, autonomic nervous system education, and motivational interviewing. I have worked with children and adults in a variety of setting including: community mental health systems, hospitals, and schools. My philosophy is to listen deeply to others to establish an ongoing understanding of the whole person. I believe the beauty in each of us is contained in both light and shadow, and hold compassionate loving-kindness for all aspects of the paradoxical nature of being human. Together we will explore existing strengths, while encouraging growth, and holistic wellness. I work individually, and hold a perspective of each individual's particular context, including the biopsychosocial impacts of the systems in which they exist. I do short term and long term work and cater interventions to the need at hand.

Duration of Counseling Services:
Regular sessions are 60 minutes in length, unless otherwise agreed upon for special circumstances between client and clinician, intake sessions are 90 minutes in length. Duration of treatment will depend on assessment, treatment needs, and the voluntary engagement of the client. The client may choose to leave counseling at any time. Prior to termination of client by counselor, counselor will discuss termination and will provide referrals if client would like to continue counseling with another provider.

Session Fees:

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- **Regular 60-minute sessions: $120 (some sliding fees available)**
- **Fees are due by the end of the session**
- **Agreed upon additional time, will be pro-rated and charged in intervals of 15 minutes.**

Advance payments are not accepted, and refunds are not offered following provided service and payment. If a client feels they have not received appropriate care they may contact the licensing department and/or governing body of the provider's credentials. Clients are not responsible for fees prior to receipt of the counselor disclosure statement

Fee established: $_____

Cancellation Policy:
If you cannot make your scheduled session, please call or email me as soon as possible so that I can reschedule your appointment. If you miss or cancel session with **less than 24 hours notice, you will be charged the full amount for that session.**

To make an appointment or to cancel/reschedule an appointment, please call me at (360) 329 7226**.** I will check my voicemail periodically and try to return your call within 24-48 hours. If I will be unavailable for an extended period of time (1 month or more), we will make arrangements for you to see other therapists when necessary.

Emergencies
You may leave a message at (360) 329 7226. I check regularly for messages during regular business hours. In an emergency, if you are unable to reach me, you can call 911 or the Crisis Clinic of King County at one of the following numbers:

- Crisis Line: 206.461.3222
- Crisis Teen Line: (206) 461-4922
- Crisis Line Toll Free Number: 866.4CRISIS (866.427.4747)

Confidentiality
Per the limits of confidentiality under RCW 18.19.180
All information you share with me is confidential and will not be shared with any other person or agency except, as per Washington State law, under the following circumstances:

1. *There is a medical or psychiatric emergency, emergency personnel may be given necessary information.*
2. *You sign a release of information form specifying the information to be disclosed as well as the person(s) to whom this information can be released (this can be given and revoked at any time).*
3. *I have reason to believe that you may be in danger of harming yourself or others or cannot meet your basic needs.*
4. *I have reason to believe that a child, elderly person, or developmentally disabled person is being abused in any way.*
5. *Parents and legal guardians of non-emancipated minors have the right to request access to client records.*
6. *You are involved in a lawsuit or legal situation and the court subpoenas your records.*
7. *Insurance providers and other third-party payers request information regarding service to clients. Information that may be requested includes: types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.*
8. *If you bring a complaint against me with the Washington State Department of Health, information will be released as necessary to respond to the complaint.*

In order to provide the best possible treatment, I regularly consult with other professionals regarding clients with whom I am working. These consultations are conducted in such a way that confidentiality is maintained.

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Client Rights

Records

I will keep digital records of the meetings that we have and the services I provide to you. None of our telemental health sessions are recorded, but notes will be kept for best practice purposes. I maintain client records in a safe and secure location. Your information is protected per HIPAA guidelines. You have the right to see those records at any time. You have the right to know your diagnosis (if applicable), and I hope that you will participate actively in guiding your own therapy. After termination of therapy records will be saved for seven years before being destroyed. In the event of my death your files will be transferred to Bonnie Walchuck LMFT who will be responsible to destroy your records.

Finding the Right Fit

For the protection of your health and safety, you have the right to choose counselors who best suit your needs and purposes. If we are not the right fit you may request referrals which I will provide.

Licensed counselors are required to meet the standards of professional conduct as outlined by the state of Washington, and per their governing ethics body. For a copy of unprofessional conduct acts please see RCW **18.130.180**. If you feel I have violated any of these professional codes of conduct, and/or you are unable to resolve a dispute with me regarding my services you may contact the department of health:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.236.4700

Supervision and/or Clinical Consultation

As per WAC 246-810-025

As part of ongoing professional development and best care practices, I seek ongoing supervision with qualified professionals in the field. In addition, I seek occasional consultation with other clinicians. These discussions are done under strictly confidential and professional circumstances. I make every effort to hide the identity of clients to protect privacy, and to ensure continued confidentiality. Only as little information as necessary to the consultation will be disclosed, and names will not be used.

Therapist and Client Responsibilities

My responsibility to you includes: confidentiality, communication, safety, professional knowledge, support, experience, and an on-going clinical consultation and professional development/training. I will periodically check in with you to see how you are feeling about the work that is happening. If it becomes clear that I cannot meet your needs in therapy, I will provide you with referrals to other therapists. I believe that counseling is a collaborative process, and that you will get the best care if you are willing to voice your needs and concerns. The more open the communication is, the more

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growth will occur. You are in control of your therapy and your life. If you have any concerns, questions or are dissatisfied with your therapy, I strongly encourage you to discuss this with me. You have the right to request a change in how we are working together, to take a break, or to discontinue therapy at any time.

Consent for Treatment

I, the undersigned, attest that I have read this disclosure statement, have been provided the opportunity to ask clarifying questions, understand the content of this disclosure statement, and have been given a copy for my records. I also understand that my records are protected under federal and state laws (HIPAA) and cannot be released without my written consent, unless otherwise provided for in those regulations. I further understand that I may revoke any consent in writing at any time, but my revocation will not apply to action already taken based on my prior consent.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____