**Cassandra Kotlarchik PLLC**

Cassandra Kotlarchik, MS, LMFT, CEDS

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**THERAPEUTI DISCLOSURE AND POLICY STATEMENT**

*PLEASE READ AND SIGN*

These office policies are provided for your information. Please ask me if you have any questions. This document contains important information about my professional therapeutic services and business policies. Please read it carefully. Bring any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**Licenses and Certifications**

I am a Licensed Marriage and Family Therapist (License # LF60326174) and Approved Supervisor in Washington State. I am also a Certified Eating Disorder Specialist (Certification # 3948) and approved supervisor (#18-307) through The International Association of Eating Disorder Professionals. I have been working in the mental health field since 2009.

**Education**

My education includes a Bachelor of Arts degree in Psychology from the University of Washington and a Master of Science degree in Marriage and Family Therapy from Seattle Pacific University.

**Therapeutic Orientation and Services**

I work from a combination of different theoretical perspectives and will adjust according to your needs. I base my therapeutic work on a systems perspective and will encourage you to explore how family and other systems (social, cultural, religious, etc.) impact your life. I often incorporate Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Interpersonal Therapy, Acceptance and Commitment Therapy and family therapy into my work with clients.

When working with clients who are struggling with food, body and exercise issues, I take a Health at Every Size approach. I strongly believe that focusing on finding health and balance in life, without focus on weight, is the only way to find freedom from food, body and exercise issues. Ultimately, I hope to support my clients toward eventually being intuitive eaters, with the support of a dietitian. For clients struggling with eating disorders, I recommend and require that they also meet with a dietitian and physician. I may recommend meeting with a psychiatrist as well. I am committed to collaborating with these providers to provide the best care for my clients. I will ask clients to sign releases of information for their other providers so I can communicate with them about treatment. I may recommend clients enter a higher level of care if their eating disorder is not managed well in outpatient treatment.

Occasionally, I may ask you to take tests or complete questionnaires in order to provide me with important information about your circumstances. You have the right to decline treatment at any point in time. There are potential emotional risks to engaging in therapy services. Personal issues may be painful and difficult to discuss. Change in your life may also cause discomfort. Sometimes symptoms become worse when you begin to explore underlying emotional struggles. Many clients find the potential benefits of therapy outweigh the potential risks; however, this is a personal decision you will have to make.

Therapy is an experience in which each person contributes. The effectiveness of therapy relies on your contribution. Your contribution and participation within therapy is voluntary and you may stop therapy at any point in time, refuse to participate in an activity, and/or request a referral to another therapist.

My job as your therapist is to provide support and guidance. You as the client are responsible for your own choices and decisions in life and have the responsibility of contributing to the therapeutic process through attendance at sessions and completing any assignments or homework given. For the most successful outcome, issues will need to be worked on at home as well as in the therapy sessions. In the case of children, parents often need to make changes in their own behavior in order to help their child change. To achieve the best possible outcome for a child or adolescent, it is usually necessary for parents to take an active role so that positive changes may occur. This means that at different times therapy sessions may involve the parents alone, the child or adolescent alone, or the entire family together.

**Confidentiality and Records**

This office is compliant with the privacy rules of the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Please see my separate “Notice of Privacy Practices” for detailed information regarding how I will handle health care information collected about you in my practice. For clients who are under 13 years of age who are not emancipated, the law may allow parents to examine their child's mental health records. However, if therapy is to be effective, my client must feel secure that specific confidences will not be revealed to anyone, including parents. By Washington state law, any person who is 13 years or older has the right to consent to outpatient mental health treatment without parental consent. In addition, persons age 13 or older have the right to decide to whom mental health information will be released, including to parents, unless the health care information falls under one of the exceptions to confidentiality (see “Notice of Privacy Practices”). At the outset of treatment, I will clarify limits to confidentiality between a minor and his or her legal guardian.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

Client records will remain confidential unless I have your written permission, receive a court order from a judge or lawyer, or in case of an emergency when I would be unable to contact you or access your records. In the case of an emergency where I am unable to contact you or access your records, the professional that has access to my confidential records is Krystal Davis, MS, LMFT. If you have any questions you may request a copy of your file at any time during the course of therapy. A fee of $0.25 per page will be charged for records you request. If you receive a copy of your file it is your responsibility to keep that information confidential if you so wish. Per Federal Law, records will be retained for a period of seven years.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Please note that the confidentiality of email communication is not guaranteed to be secure, and I try to avoid this mode as much as possible. I use email communication for business activities including but not limited to: scheduling of appointments, communication with collateral contacts, and billing procedures. If you wish to not use email or wish to stop using email as a means of communication please request immediately and in writing to Cassandra Kotlarchik, MS, LMFT, CEDS during a session or at PO Box 1662 Bothell, WA 98041.

If we see each other in public, I will not acknowledge you unless you initiate it. This is not to be rude or because I do not care about you. Your privacy is important and it is your choice whether you wish to interact with me in public. Keep in mind that if we do speak in public, anyone with us will likely ask how we know each other. Please be prepared for this if you choose to approach me in public.

**Exceptions to Confidentiality**

There are some situations when I am permitted or legally required to disclose information without either your consent or authorization:

* If a government agency is requesting the information for health oversight activities.
* If you file a complaint or lawsuit against me, I am permitted to disclose information as relevant for my defense.
* If you file a worker’s compensation claim, and your psychotherapy is relevant to the injury involved in your claim, if properly requested, I must provide a copy of your record to your employer and the Department of Labor and Industries.
* If I have reasonable suspicion that a child has suffered abuse or neglect, the law requires that I file a report with the appropriate government agency.
* If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency.
* If I have reason to believe you or someone else is in imminent danger, I may be required to take protective action, including notifying potential victims, contacting the police, seeking hospitalization for you, or contacting family members or others who can help provide for your protection.
* I am required to report myself or another healthcare provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct. If you have any questions or concerns about this requirement, please talk with me about them.
* If you are using your insurance to pay for therapy services, I may need to share some information with them in order for them to cover your therapy.

**Minors**

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss. If you are 13 or older, you have the right to consent to your own mental health treatment and have your therapy records kept private. I will ask you to sign a release of information for your parents. This is needed to discuss your care with your parents, including payment and scheduling. I will make every effort to respect your privacy, but will need to have some contact with your parents to coordinate your care. You may specify on the release of information what topics you consent to allow me to discuss with your parents. There may be times when I believe something is important to share with your parents. I will discuss this with you openly and encourage you to share it with your parents with my support. I may recommend family therapy; however, you have the right to refuse family therapy.

**Parents of clients under 18**

If you are the parent of a minor who is a client of Cassandra Kotlarchik, MS, LMFT, CEDS, please be mindful that your child is the client. If your child is seen individually for therapy, I will make every effort to preserve your child’s trust and privacy. Therapy can only be effective if your child feels safe working with me. There may be times when I believe something is important for you to know and I will encourage your child to discuss it with you. However, I cannot force your child to do so. If your child is at imminent risk of harming himself/herself or another person, I will disclose this to you and others who need to be informed (including law enforcement or other medical providers). If your child is 13 or older, please be aware that he/she has the right to consent to mental health treatment. Your child must sign a release of information indicating what I can discuss with you upon the onset of therapy. If your child is under 13, you must consent to treatment for your child. While you have the right to his/her therapy records, please be respectful of his/her privacy. Even younger children may feel very betrayed if the therapist shares information with parents that the child wanted to remain private.

Divorced or separated parents often seek therapy for their children to help them deal with the stress and adjustment to the changes they are experiencing. It is my policy, with rare exceptions, that both parentsof the child consent in writing to treatment and payment before the child is seen. I do not perform custody evaluations, and will serve solely as the child’s therapist. I will also ask for a copy of parenting plans for divorced or separated parents so that I am aware of any legal requirements that may relate to therapy.

It is essential that children have the contents of their therapy kept from becoming entangled in the adults’ legal issues. Therefore, you will be asked to sign an agreement to protect your child’s confidentiality on court matters.

**Couples**

If you are seeing me specifically for couple’s therapy, I will meet with you and your partner together. For couple’s therapy, I ask that each partner be open with their partner about communication with me. Secrets are not helpful for relationships and I do not want to keep secrets for one partner from the other. If you are concerned about your safety in your relationship, I will gladly speak to you confidentially and will recommend that you and your partner seek individual counseling before doing couples therapy.

If you are seeing me individually, we may decide to include your partner at certain times. In this case, you remain my client and your partner is participating in your therapy session. In this case, I expect that we will have private conversations about your relationship. However, during couple’s sessions I will do my best to support you and your partner. I will not automatically side with you against your partner, since this would not help improve your relationship.

**Email Communication Agreement**

I understand that Cassandra Kotlarchik, MS, LMFT, CEDS will use reasonable means to protect the security and confidentiality of email sent and received. However, there are known and unknown risks that may affect the privacy of personal health care information when using email to communicate. These risks include, but are not limited to:

* Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by unintended recipients without my knowledge or agreement.
* Email may be sent to the wrong address by any sender or receiver.
* Email is easier to forge than handwritten or signed papers.
* Copies of email may exist even after the sender or the receiver has deleted his or her copy.
* Email service providers have a right to archive and inspect emails sent through their systems.
* Email can be intercepted, altered, forwarded, or used without detection or authorization.
* Email can spread computer viruses.
* Email delivery is not guaranteed.

By Signing below, you agree not to use email for emergencies or to send time sensitive information. It is also agreed that it is your responsibility to follow up with Cassandra Kotlarchik, MS, LMFT, CEDS if you have not received a response to an email within a reasonable time period. By signing below, you give permission for Cassandra Kotlarchik, MS, LMFT, CEDS to send email messages that include patient health care information and you acknowledge that you have read and understand the risks of using email as stated above. If you wish to not use email or wish to stop using email as a means of communication please request immediately and in writing to Cassandra Kotlarchik, MS, LMFT, CEDS in person or at PO box 1662 Bothell, WA 98041.

**Social Media Policy**

It is my policy that I do not interact with current or past clients via social media. If I receive requests from you on social media, I will not accept them. I will not reply to messages received via social media. It is important that we maintain a client/therapist relationship and connecting via social media can blur these boundaries. I will not look at your social media accounts, unless it is something you show me in the context of our therapy sessions.

**Contacting Me/Emergencies**

You may leave a voicemail message for me at 425.405.2837, 24 hours a day. I check my messages regularly and will make every effort to return your call within 48 hours (with the exception of weekends and holidays). If you are difficult to reach, please inform me of some times when you will be available. I do not use text messaging with clients.

If you cannot wait for me to return an urgent call, call the 24 Hour King County Crisis Line at 206.461. 3222, go to the nearest emergency room, or dial 911.If I am gone for an extended period of time, I will inform you ahead of time and discuss whether you would like referrals for other providers.

**Availability**

Currently, I am available for sessions Tuesday, Wednesday and Thursday 9am-5pm. I am a strong proponent of family therapy, especially when working with teenagers. I will often recommend that clients participate in individual and family therapy. Depending on my availability and your schedule, I may be able to provide both individual and family therapy. However, for some clients it is helpful to have a separate individual and family therapist. In this case, I would recommend that you see a second therapist for either individual or family therapy. I am committed to collaborating with other therapists to provide the best care for our clients. I will ask you to sign a release of information for the other therapist so we can communicate about your treatment.

I may take time off for holidays, vacations or illness. I will do my best to give you the most notice possible and discuss how you can receive support between our sessions. I will take off holidays and will remind you of this beforehand.

**Appointments and Cancellations**

Therapy appointments are typically 50 minutes long (53 if using insurance), but we may agree to have shorter or longer sessions, depending on the clinical issue. Your appointment time is set-aside exclusively for you, and I cannot fill that time slot without sufficient notice. To cancel an appointment, please provide at least 24 hours notice, or you will be billed the full hourly fee ($150.00). If you will be arriving late to an appointment, please call me as soon as possible so that I know you are coming and have not forgotten about the appointment. If you arrive late for an appointment, you will be billed the full fee for your session. If you are more than 15 minutes late for a session, you will need to reschedule. If we are able to reschedule during the same week, I will not charge you for the missed session. Please note that insurance companies will not provide reimbursement for cancelled or missed sessions.

I typically see clients once a week unless we have agreed to another arrangement. Your session time is reserved for you each week. If you regularly cancel or miss sessions, I may need to give your session time to another client. If cancellations are common, I will have a conversation with you before giving up your session time.

**Professional Fees**

My current fee for the initial assessment is $225.00 and it typically lasts 90 minutes. This fee includes review of past records and phone calls to your other providers, such as dietitians, physicians and psychiatrists. After the initial session, my fee is $150.00 for a 50 minute session. I have a limited number of sliding scale openings based on financial hardship.

In addition to weekly appointments, I charge $150.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceedings.

If you request records or ask for written reports, a fee of $0.25 per page will be charged for printing costs.

**Billing and Payments**

If you carry accepted insurance, I will bill your insurance company for your sessions. Co-pays will be due at the time of service. You will also be responsible for anything your insurance does not cover (this may include phone calls, charges for late cancellations or certain types of therapy, such as couples counseling). Please contact your insurance company to check your overall policy coverage. It is also your responsibility to contact your insurance company to obtain any pre-authorizations/ authorizations that are required in order for services to be covered by your insurance policy. After submitting claims to your insurance company, I will provide you with invoices for any additional costs that your insurance did not cover (including deductibles and uncovered services). Please make payments for all invoices within 30 days of receiving the invoice.

If I am not a contracted provider with your insurance company, you will be expected to pay all fees at the time of service. You may contact your insurance company to inquire about out-of-network coverage. I am happy to provide you with superbills that you can submit to your insurance company for out-of-network claims.

Payment schedules for other professional services will be agreed to when they are requested. I accept cash, check or credit card.

**Delinquent Accounts**

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client’s treatment is his/her name, the nature of services provided, and the amount due. I will make every effort to fully discuss it with you before taking any action. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, this is grounds for termination of services.

**Complaints**

I hope that we have an open and collaborative relationship. I encourage you to share with me if you are unhappy with any part of our work together. If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your Protected Health Information, you may send a written complaint to the Washington State Department of Health via email, fax or mail. Complaint forms can be found on the Washington State Department of Health website <https://www.doh.wa.gov> and contact information is listed below. I will not in any way limit your care or take any actions against you if you file a complaint.

Mail: Email: [hsqacomplaintintake@doh.wa.gov](mailto:hsqacomplaintintake@doh.wa.gov)

Health Systems Quality Assurance

Complaint Intake Unit Phone: (360)236-4700

PO Box 47857

Olympia, WA 98504-7857 Fax: (360)2362626

**Informed Consent**

Your signature below indicates that you have received a copy of this form, read the information in this document, understand and agree to abide by its terms during our professional relationship.

I have read the above and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself (for individuals age 13 and older).

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): Cassandra Kotlarchik, MS, LMFT, CEDS

I have read the above and have had the opportunity to ask questions. I (parent or legal guardian of minor child under 18 years of age) give permission for evaluation and treatment for my minor child and state that I am the parent or legal guardian for the child.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I am giving consent for communications via:**

Email Cell and/or Phone (circle all that apply)

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_