Counselor Disclosure Statement and Adult Informed Consent to Treatment

Max Tsymbalau, MS, LMHC

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Please read each section carefully, and initial at the bottom of each page.

Education and Credentials
I received my Master of Science degree in Mental Health Counseling from Central Washington University, and I completed my internship at Sound Mental Health in Auburn, WA. I am a Licensed Mental Health Counselor in the state of Washington. My Washington Department of Health license number is LH60711517.

Therapeutic Orientation
I provide psychotherapy and mental health counseling services, and I mainly use Cognitive-Behavioral Therapy, Psychodynamic Therapy, Internal Family Systems Therapy, and Acceptance and Commitment Therapy. I use these modalities in a respectful way, working to stay connected with you in the moment and recognizing that while I am the psychological expert, ultimately you are the foremost authority on what it is like to be you.

Course of Treatment
The length of treatment and frequency of sessions will depend on many factors, including your goals, your level of commitment, and your progress. Generally, I recommend that our sessions take place at least once every 10 days, in order to catalyze the therapeutic process; however we will always decide on the frequency and length of treatment collaboratively.

Appointments and Fees
The fee for a standard 50-55 minute session is $165, unless otherwise arranged. It is due at the time of service and is payable in cash or personal check. I am not contracted with any insurance companies; however, if your insurance covers my services, I can provide you with statements you can submit to your insurance company for reimbursement. *In order to avoid being charged your full session fee for missed appointments, a 48-hour cancellation notice is required.* Insurance does not cover missed appointments.

Client Rights
As my client, you have the right to refuse treatment and the right to choose whether or not to employ me as your counselor. You also have the right to decide which methods or modalities may best suit your needs and goals.

Confidentiality
What you and I talk about during our sessions will be kept confidential. Exceptions to this confidentiality include the following:

1. If I believe you are likely to do harm to yourself (suicide) or to another person (violence and/or homicide), I must take steps to protect you and/or the other person. This may include asking for assistance from other mental health professionals or the police.
2. In the cases of suspected abuse or neglect of a minor child or vulnerable adult, I am required by law to report information to Child or Adult Protective Services.
3. If you are involved in litigation, information can be subpoenaed by a court of law. Although I will request your consent to release information, I can be legally obligated by court order to turn over my records in situations such as this. You may complete a written request for me to maintain minimal records if this is of concern to you.
4. If you are seeing me in couples or family counseling, and you or a family member/partner should happen to see me in an additional individual session, information shared with me in that meeting may be shared by me in the joint session if I feel it to be in the best interest of the work we are doing together.
5. If you have been directly referred to me by someone else, I may as a good business practice, acknowledge to them that you have contacted me and thank them for the referral. I will not discuss your situation with them unless I have your written permission.

Client initials ___

6. For our mutual benefit, I participate in professional consultation; however I will not disclose any identifying information about you.

Risks and Benefits
Most people who come to counseling are experiencing internal distress, relationship challenges, or engage in behavior that worries them and/or others. The purpose of counseling is to help you explore your difficulties and goals in a safe environment, learn new ways of interacting with yourself and others, and thus be better prepared to have the life that you want. At the same time, frequently as we work in therapy you may experience thoughts or feelings that you may find uncomfortable - this is part of the process. As you commit yourself to work through your problem areas and build on your strengths, you will likely see significant improvements in your life.

Appointments and Cancellations
We will schedule our appointments by email, by phone, or in person at the end of our sessions. If you need to cancel or reschedule our appointment, please let me know by email or by phone as soon as you can. If you do not give me at least a 48-hour cancellation notice, you will be charged the full fee for the missed appointment.

Emergency and Other Contacts
Between our appointments, you may email me or call me and, if I do not pick up, leave me a voicemail message. I read emails and listen to messages regularly and will get back to you as soon as I can. If you find yourself in a psychological emergency, please call the National Lifeline at 1-800-273-8255. If you are feeling unsafe, please call 911.

Duration and Termination of Therapeutic Work
Counseling is a highly individual process, and the duration of counseling depends on each person's particular goals and difficulties. As we work together, we will frequently revisit the progress we have made and talk about the potential duration of our upcoming work. You have the freedom to make your own decisions regarding counseling, which includes choosing your counselor or ending therapy with a particular counselor. If you would like to end our work, I would only ask that you discuss your decision with me in person.

Unprofessional Conduct
If you suspect that my conduct has been unprofessional, you can contact the Department of Health:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360-664-9098

The undersigned practitioner has gone over this document with the undersigned client and has answered all questions to the client's satisfaction.

_____ _____
Max Tsymbalau, MS, LMHC **Date**

The undersigned client has been provided with a copy of this disclosure statement, has read the statement, and understands the rights and responsibilities contained herein. The undersigned client authorizes treatment under the conditions of this document.

_____ _____
Client **Date**

Client initials ___