Mark Travis
All Seasons Counseling
345 Knechtel Way NE Suite 111, Bainbridge Island WA 98110
Cell 206-472-0535 Fax 206-451-4317
Email: mark@allseasonscounseling.biz | www.allseasonscounseling.biz

Thank you for choosing to work with me. This packet includes information you will need to begin counseling services.

My ***Disclosure Statement*** describes: (a) how I conduct therapy; (b) my education and training; (c) billing and insurance policies; (d) fees for therapy services; (e) appointment scheduling guidelines; (f) your client rights and responsibilities; (g) my responsibilities as your therapist and a mandated reporter; (h) confidentiality in therapy; and (i) how therapy is initiated and terminated.

The ***Intake Form*** provides me your contact and billing information, and your reasons for seeking therapy. Also included in the ***Intake Form*** packet is my ***Professional Disclosure,*** **Financial Responsibility Policy and Procedures,** ***Washington State Clients Rights Statement,*** and ***Notice of Privacy Practices***. Please read, sign, initial and date all the forms where indicated. Each adult and minors, age 13 years and older involved in therapy, needs to read, sign, initial and date all forms where indicated.

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

- If child(ren) are involved in treatment, and if the parents and/or legal guardians of the child(ren) are separated or divorced, please provide a copy of your parenting plan.

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

Feel free to contact me with any questions, and I look forward to meeting you.

With Kind Regards,

Mark Travis, MA, M.DIV, LMFT

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PROFESSIONAL DISCLOSURE STATEMENT

Philosophy and Approach

As a Licensed Marriage and Family Therapist (License #LF61064085), I view each individual's problems in the context of their life and relationships. My approach to therapy is best described as relationally based, client centered. I am grounded in Adlerian and Structural theories. I also take an integrative approach to therapy, which means as I listen to your story, I begin to discern what form and expression of therapy might be most helpful to you. You are the most important element to healing, transforming and change in therapy.

I provide therapy and counseling services to individuals (12 and older), couples, and families struggling with anxiety, depression, self-harm, family conflict, relational dynamics, gender identity, LGBTQ issues around sexuality. I work in a collaborative fashion with client(s) and any other health professionals who are also providing care. I sometimes assign homework and use assessment tools and questionnaires to gather additional information. The length of treatment varies from client to client and couple to couple, generally ranging from one to twelve months.

Education

1993 M.DIV, Princeton Seminary, Princeton, NJ
2016, MA, Relational and Family Therapy, Seattle University, Seattle, WA

Experience

I have been providing emotional and spiritual care to all people regardless of religious and non-religious beliefs, sexuality, gender identity, political and ideological belief systems since 1994. I have been practicing psychotherapy since the spring of 2016. My education, training and experience have prepared me to counsel individuals and families of all ages, ethnicities, race, religion, and sexual orientation.

Informed Consent

Counseling is understood to be a choice you have made among available options such as (a) other counselors; (b) other therapies; (c) support groups; (d) self-help resources; and (e) 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 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. A copy of the acts of

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unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:
Health Systems Quality Assurance Complaint Intake
PO Box 47857
Olympia, Wa 98504-7857
Phone: 360-236-4700 Email: HSQAComplaintintake@doh.wa.gov

Fees:
My fee for the initial intake session is $130 and $120 per hour for subsequent sessions. Fees are due at the time of service.

Missed Appointments or Late Cancellations: You agree to pay $120 for missed appointments or late concellations (within 24 hours of appointment time). If you arrive late for your appointment, you agree to pay the full session fee. Reminder emails/texts are often sent as a courtesy; note these emails do not absolve your responsibility to attend sessions as scheduled.

Additional Fees: Upon your request, I may communicate with you between sessions and/or consult with other professionals on your behalf. After the initial 10 minutes, I will charge you for my additional time at $120 hour, prorated. Please note that insurance companies do not reimburse for these services.

I do not offer my services for litigation purposes. I will not voluntarily disclose your information in connection with any legal proceeding. If I am requested to provide such information, either verbally or in writing, as part of any legal proceeding on your behalf, you agree to pay me $300 per hour, prorated, including preparation, travel, and waiting time. Insurance will not reimburse you these fees.

In-Network Billing:
Insurance Authorization: you hereby authorize Mark Travis, MA, M.DIV, LMFT and billing services provider, Vicki Splinter of Splinter Billing Service, to release information, including copies of medical records to your insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing claims or as needed for treatment planning and management required by your insurance carrier. The billing services provider will have access to your name(s), dates of service, and diagnosis and treatment codes. You further authorize payment of insurance benefits of services rendered to Mark Travis, MA, M.DIV, LMFT.

Pre-Authorization Responsibilities: Insurance companies commonly require that you obtain a pre-authorization before services can be authorized for reimbursement. You are responsible for obtaining your pre-authorization and for monitoring ongoing authorizations.

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Out of Network Benefits: Upon request, I will provide a super bill for you to submit to your insurance company for out of network benefits if you meet criteria for a DSM-5 mental health diagnosis.

Confidentiality

Your participation in therapy, the content of our sessions, and any information you provide me is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability, I may disclose information to your personal representative.
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpeona from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report or investigation.
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health and safety of any other person;
- If, without prior written, no payment of services has been received in 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

As a licensed Marriage and Family Therapist, 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. In such cases, I will limit the information I disclose to the minimum amount necessary.

Professional Boundaries:

I refrain from entering into multiple 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 therapeutic relationship with you outside of the therapy session. Since Bainbridge is a small community, we may see each other in public. I will not acknowledge that I know you to protect your confidentiality. If you approach me, I will interact with you briefly and refrain from discussing confidential topics outside of the treatment setting.

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Appointment times
Daytime appointments are available between 9am to 5pm Monday through Thursdays. The initial session requires 90 minutes, followed typically with 50 minute sessions once a week or bi-weekly. Please remember to provide at least 24 hours' notice to cancel or reschedule appointments. As mentioned above, fee for missed appointments or late cancellations is $120.

Scheduling Appointments and After Hours Contact.
Please call my private cell phone 206-472-0535 to schedule an appointment or to reach me after hours. I am able to see people in my office at 345 Knechtel Way Suite 111 or provide Telehealth sessions. If you need to reach me between sessions, you can call me cell and leave a message. I check my voicemail regularly during normal business hours and generally return calls within 24 hours. I turn my phone off by 9pm at night and turn it back on at 8am. My days off are Fridays through Sundays. If you are experiencing a mental health or medical emergency call 911 or the Crisis Clinic at 206-461-3222.

I will do my best to keep all communications private, and I utilize an encrypted, HIPPA secure email service. If you are concerned about the content of your email being read by someone other than me, please contact me by phone and leave a voice mail. While I check my email during regular business hours, 9am-5pm, I may not receive your message immediately. Therefore, please do not email urgent information and expect immediate reply. I do not offer therapy by email, nor do I engage in communication via social media with clients or families of clients. I only text clients to confirm sessions. I do not use your name or gender markers when sending you emails or texts. For further information on this topic, please see my Social Media and Electronic Communication policy found on my website www.allseasonscounseling.biz.

Vacations:
I follow the Bainbridge Island School districts vacation schedule. I will generally give you reasonable notice before taking vacation leave. If you are experiencing an emergency during my time away, please call 911 or the Crisis Clinic at 206-461-3222.

Transfer Procedure/Professional Will
If I am suddenly unable to continue to provide therapy services to you due to my illness, injury, or death, Carol Pendleton will contact you and provide you continuing treatment and referrals to other qualified therapists. If Carol is unable or unwilling to perform these duties, Erin LeTellier, will perform them. Carol/Erin may also appoint other licensed mental health professionals to assist in the performance of these duties. If you do not consent to these clinicians accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

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Record Keeping:
I keep brief records for each therapy session using a practice management and electronic software system called "Simple Practice" to facilitate record keeping. Records include: *Date of service, clients name, fee arrangement and record payment, consent and disclosure form (signed by clients and me), presenting problem(s), purpose and clinical diagnosis, notations and results of formal consults, including information obtained from other persons or agencies through release of information. Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy I use*.

If you prefer I keep not treatment records, you must submit a written request to that effect. I will honor your request at my discretion; please note that all disclosures related to safety are documented. I will place your letter in your file. I will still need to write a file with your name, signed disclosure statement, the session date and fee for service.

Please note that I destroy medical records 5 years after last contact, in accordance with Washington state statute. This time will be extended by 1 year after a request for records, release of information, or correction of records. Note that if you are using insurance, they may require I hold onto your records for 6 to 10 years, depending on the companie's policy.

Legal Proceedings:
I do not offer my services for litigation purposes; as stated above in the "fees" section of this document. If you are engaged in couple or family therapy, it is important that you understand that you are likely seeking counseling to clarify the nature of or improve your relationship(s) and that people in counseling relationships, in order to do their best work, must be able to trust that disclosures made in the course of counseling will be kept confidential. However, despite the best efforts and good will of this process, your couple relationship may end, resulting in legally dissolving your marriage or domestic partnership. This may result in legal proceedings to establish or change parenting plan, if children are involved. Please understand I will not voluntarily disclose your information in connection with any legal proceedings on your behalf. If I am compelled to provide such information, either verbally or in writing, as part of any legal proceeding on your behalf, you agree to pay me $300 per hour, prorated, including my travel, waiting, and preparation time. Insurance will not reimburse you for these fees.

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Clients Rights:
As a client in therapy, you have specific rights in addition to the right of confidentiality, including:

- 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 any treatment you do not want and the right to choose a practitioner and treatment modality that best suits your needs;
- The right to discuss your therapeutic progress and goals;
- The right to refuse any testing I recommend;
- 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.

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.
If I have not heard from you for 14 days, I will assume that you wish to terminate your current episode of therapy, and I will close your file at that time. To honor your autonomy and protect your confidentiality, I will not send you a letter notifying you of this termination of care. You may contact me to resume therapy.

Attestation and Consent for Treatment
By signing this document, you are attesting that you have received, read and fully understand and consent to the disclosures, terms and conditions above, that you have received a copy of your HIPPA Notice of Rights and Privacy Practices, you have read and fully understand these rights, and have been given the opportunity to ask questions. You also agree that you have received, read and fully understand the Social Media and Electronic Communications Policy.

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By signing this document, you are attesting to your consent to participation in clinical services provided by Mark Travis, MA, M.DIV, LMFT.

Client Signature: _____ Date:_____

Printed Name: _____ Date:_____

Client Signature: _____ Date:_____

Printed Name: _____ Date:_____

Client Signature: _____ Date:_____

Printed Name: _____ Date:_____

Client Signature: _____ Date:_____

Printed Name: _____ Date:_____

Client Signature: _____ Date:_____

Printed Name: _____ Date:_____

Therapist Signature: _____ Date:_____

Printed Name: _____ Date:_____

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CONSENT TO TREATMENT OF MINORS

This section needs to be completed by the parents and/or legal guardians of a child / childrent 13 years of age and younger who attends sessions. Some custody agreements require the signature of both parents and/or guardians for treatment: therefore, it is my policy to require the signatures of both parents and/or guardians in any divorce/separation situation (I also require it even if the parents and/or guardians are not divorced/separated). In the case of divorce or separation the parents and/or legal guardians must provide a copy of your parenting plane at our initial session.

Confidentiality with Minors:
Minors 13 years of age and older have the same confidentiality rights as adults in the State of Washington. They consent to their own treatment, and if they choose for me to share treatment information with parents, the client must sign a release form granting me permission. Parents have rights to their children's medical records who are 12 years of age and younger.

I am a mandated reporter; this can limit confidentiality if I have reason to believe any child has been or is currently being abused or neglected, and/or if I have reason to believe the child is a danger to self or to another person. In these cases, I may be required or authorized to report this information to the appropriate person or agency to intervene on the child's behalf.

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPPA Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent for your minor child(ren), listed below, to participate in clinical services provided by Mark Travis MA, M.DIV, LMFT.

Name of Child_____ Birthdate_____

Name of Child_____ Birthdate_____

Name of Child_____ Birthdate_____

Name of Child_____ Birthdate_____

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Signatures:
Name of Parent/Guardian: _____Date_____

Signature of Parent/Guardian:_____Date_____

Name of Parent/Guardian_____Date_____

Signature of Parent/Guardian_____Date_____