BRYAN FOSTER: DISCLOSURE STATEMENT AND OFFICE POLICIES STATE OF WASHINGTON REQUIRED

DISCLOSURE STATEMENT

Washington State law requires that I inform you that "Counselors practicing counseling for a fee must be licensed with the Department of Licensing for the protection of the public health and safety. Licensure of an individual does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment."

I am a Licensed Marriage and Family Therapist in the State of Washington. **License #: LF60292053**

EDUCATION

Master of Arts, Psychology, emphasis in Marriage and Family Therapy, Chapman University, 2010
Bachelor of Arts, Human Services, Western Washington University, 2004

THERAPEUTIC APPROACH

I generally work from a cognitive behavioral therapy perspective, which means I hope to help you create healthy thinking and behavior patterns. I also work from a family systems perspective, which means I see people as a part of a variety of systems. I see things as interconnecting and influencing each other. These systems could include the family you grew up in, your work environment, what communities you belong to, and the bigger systems that can include gender, sexuality, and spirituality and I look to help you function better in those systems. I have been in the helping profession for over ten years and have accumulated a variety of techniques that I can access as we go along.

Sessions generally including talking and discussing pertinent issues that are related to symptoms or problems you are interested in working on. Sessions can also include practicing skills that are tailored to helping you increase your abilities related to the symptoms or issues you want to address.

During our initial sessions I will be gathering information as we formulate goals and a plan together. I do both short and long-term therapy. The length of treatment varies depending on the issues and goals you would like to address. All of this can be updated as needed by any of us at any time.

CLIENT RIGHTS

You are entitled to receive appropriate care, respect and confidentiality. It is appropriate for you to raise questions at any point in the therapy process. You have the right to receive treatment that is non-discriminatory, and sensitive to differences of race, culture, language, sex, age, national origin, disability, creed, socio-economic status, marital status, and sexual orientation. It is your right as a client to choose the therapist and therapy modality which best suits you. You have the right to terminate therapy at any time. In order to have a healthy closure, it would be important for us both to participate in the process.

CONFIDENTIAL COMMUNICATIONS

All issues discussed in the course of therapy are strictly confidential. Information regarding your treatment will only be released with your written permission. However, the laws of the state of Washington require certain information to be released in specific situations, such as: suspected abuse or neglect of a child or elder; in the case of possible imminent harm to yourself or others; or in some cases of court subpoena.

Other exceptions to confidentiality occur when you choose to use a cell phone or e-mail to communicate with me or when you "like" or "follow" the Bryan Foster Counseling page on Facebook.

Like other therapists, I seek supervision and consultation from other therapists and consultants to ensure the highest quality of services to you and to facilitate my own professional growth. Identifying information is

protected and confidentiality rules bind these consultations.

RISKS OF TREATMENT
Sometimes problems in relationships develop as an individual engages in therapeutic services and begins to change. In addition, as we talk about emotions and experiences, you may begin to feel discomfort. This is a normal process within therapeutic work.

If we are doing couples therapy, there is no guarantee that therapy will save your relationship. There is a chance that during the course of therapy, one or more partners will decide to terminate the relationship.

DOCUMENTATION
Please be aware that I generally keep as minimal amount of treatment notes as possible to protect your confidentiality. Because you are paying for the service, and not an insurance company, I am able to maintain minimum paperwork. This generally includes an evaluation treatment note and progress notes that reflect the general topics and focus of our sessions.

I encourage you to consider having no treatment notes kept. This ensures your confidentiality. According to Washington Administrative Code (WAC) governing therapy notes you are permitted to request that no treatment notes be kept. If you request this by signing on the next page, here is what will be kept as required per the WAC.

"(2) If a client requests that no treatment records be kept, and the licensed counselor or associate agrees to the request, the request must be in writing and the licensed counselor or associate must retain only the following documentation:

(a) Client name;
(b) Fee arrangement and record of payments;
(c) Dates counseling was received;
(d) Disclosure form, signed by licensed counselor or associate and client;
(e) Written request that no records be kept."

CRISIS INTERVENTION/STABLIZATION
If you believe you are having a crisis or are suicidal contact the Washington State Crisis Line at:
1 866 427 4747 or **Pierce County OptumHealth 1 800 576 7764. You can also text 741741 to access a text-based crisis line.**

If you are in a life-threatening emergency call 911 or go to the nearest emergency room or hospital.
I am generally not available to provide care in the midst of a crisis situation. The above stabilization services are available to you to help you stay safe and begin your recovery. Once you have stabilized, I will be available for follow-up therapeutic sessions.

ADDITIONAL FEES
Clients sometimes request other services from me, mainly dealings with legal or custody issues. These are services that I provide **only** at my discretion when I deem it necessary to improving treatment outcomes or when I am forced to by an enforceable subpoena. The following fee schedule outlines the cost for each service.

Letter writing on behalf of client: $200 per document

Preparation time (including submission of records): $250/hour
Phone calls: $250/hour

Depositions: $350/hour
Time required in giving testimony: $350/hour
Time away from office due to depositions or testimony: $250/hour

All attorney fees and costs incurred by the therapist as a result of the legal action.
Filing a document with the court: $150
The minimum charge for a court appearance: $1250

REFERRAL PROCESS

Sometimes, in the course of therapy, a referral to another clinician may be necessary. This can happen for a variety of reasons including but not limited to; lack of therapeutic progress, scheduling difficulties, conflicts of interest, a therapeutic need that is outside of my professional scope of practice, active domestic violence, active substance abuse. When an issue such as the above arises, a referral to another clinician may be the most beneficial course of action to ensure the best possible experience for the client.

TERMINATION OF SERVICES

Therapeutic services can be terminated by the client at any point for any reason. The client is empowered to have self-efficacy and advocacy. Therapeutic services may be terminated by the clinician if one of the issues outlined in the "**REFERRAL PROCESS"** section compels the clinician to believe the termination of services is in the best interest of the client.

OFFICE AND PAYMENT POLICIES

Appointments are scheduled directly with me. My fees are $140 for the initial diagnostic evaluation and $130 per 53-60 minute psychotherapy session and are payable **during the first evaluation session, generally at the conclusion of the session,** unless we make specific plans to do otherwise. If you arrive late for an appointment, I cannot extend the session into another client's time. Please help me to start on time for you and the next person. (Initial)_____

There is no charge for appointments that are canceled with 24 or more hours notice. Without 24 hours notice, you will be responsible for the payment amount detailed below. (Initial)_____

Phone calls and email communication longer than 15 minutes can be pro-rated at my hourly rate ($130). (Initial)_____

If you plan to seek reimbursement from your health care provider, you need to be aware that I cannot guarantee confidentiality. Many insurance companies require information about diagnoses, treatment goals and progress towards goals. Your insurance company may exercise their right to view your records for auditing purposes. I assume that you will take responsibility for knowing your insurance benefits. Any fees not covered by your insurance company are your responsibility. (Initial)_____

I request that no treatment notes be kept. (Initial)_____

I have received a copy of Bryan Foster's Notice of Privacy Practices. (Initial)_____

I agree to comply the office's weapon's free policy. I will not bring a weapon or firearm onto the premises. (Initial)_____

Your fee will be as follows:

Evaluation session / Follow-up session	Payment Due at time of service	Late Cancel / No-Show Fee
$140/$130	full	$70

I am an independent psychotherapist in private practice and am solely responsible for my personal, professional and financial decisions and actions.

I look forward to working with you.

Statement:
I have read the above material and agree to its terms. I have had the opportunity to ask questions.

_____ _____
Client Signature Date

_____ _____
Bryan Foster, LMFT Date

Bryan Foster Counseling

Personal Data Form - Demographics

Name:	Age:	
Address:		
Occupation/School:		
Phone – Home:	Phone – Mobile:	Phone – Work:
Emergency Contact Name: Emergency Contact Phone:		

Please state the reason for your session / what you would like to accomplish:		
Please list any physical or medical problems you are experiencing:		
Please list any medications you are using, even if occasionally, and the reason you are taking them:		
Please list your primary care provider:		
Have any **relatives** had:		
Depression:	Anxiety:	Bipolar:
Alcoholism:	Drug Dependency:	Schizophrenia:
Other Mental Health conditions:		

Prior mental health treatment you have received:
History of suicide attempts:
History of violent behavior that you have done or has been done to you:

Please circle any of the following if it is a problem or concern:

Physical	**Behavior**	**Emotional/Mood**	**Vocation**	**Relationships**
Nightmares	Irritable	Anxiety	Learning difficulties	Friends
Pain	Impulsivity	Crying	Probation	Siblings
Fatigue	Sexual Dysfunction	Suspiciousness	Dissatisfied with work/school	Parents
Weight problems	Compulsivity	Hallucinations	Problems with coworkers/boss	Spouse
	Opposition	Suicidal/Homicidal Thoughts		Children
		Lack of interest		In-laws
				Significant Other

GAD-7 Anxiety Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems? *(Circle the number to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ____

PHQ-9 Depression Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle the number to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score ____

AUDIT ALCOHOL USE ASSESSMENT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

DRUG USE QUESTIONNAIRE (DAST -10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a question, then choose the response that is mostly right.

These questions refer to the past 12 months only:	Circle Response	
Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
Do you ever feel bad or guilty about your drug use?	Yes	No
Does your spouse (or parent) ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities in order to obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
. Are you always able to stop using drugs when you want to?	No	Yes
DAST-10 score (add circled responses in left column)		

FOR YOUR RECORDS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you, the client, and significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Each time you meet with your psychotherapist, a record is made which may contain your symptoms, diagnoses, treatment, a plan for future treatment, and billing-related information. Usually, less information is recorded if you are not using insurance to pay for treatment. This notice applies to all of the records of your care generated by Bryan Foster, LMFT.

Psychotherapist Responsibilities

Bryan Foster, LMFT is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. We are required to abide by the terms of this notice and notify you if we make changes to this notice, which may be at any time.

How We May Use and Disclose Medical Information About You

Treatment: We may use and disclose medical information about you to provide, coordinate, and manage your treatment or services. We may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your written authorization. For example, if a referral is made to another health care provider we may provide oral information and copies of various reports that should assist her or him in treating you.

Payment: We may use and disclose medical information about you in order to obtain reimbursement for services, to confirm insurance coverage, for billing or collection activities, and for utilization review. An example of this would be sending a bill for your sessions to your insurance company.

Health Care Operations: We may use and disclose, as needed, your health information in order to support our business activities, including quality assessment, licensing, marketing, legal advice, and customer service. For example, we may call you by name in the waiting area when your psychotherapist is ready to see you.

Other Uses and Disclosures

We may use and disclose your health information in an emergency situation to prevent harm to yourself or others. An example would be mandated reporting of abuse to children, the elderly, a disabled person, or when a judge orders the release of information. Only the minimum amount of information relevant to your health care will be disclosed.

We may create and distribute de-identified health information by removing all references to individually identifiable details.

We may contact you to provide appointment reminders, or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the federal government at the address below, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201.
1-877-696-6775
(202) 619-0257

If you have any questions about this notice, please contact:
Bryan Foster
2209 North 30th Street, Suite 1
Tacoma, WA 98403
253 778 6396