Jennifer Palau, MSW, LICSW

INFORMATION ABOUT COUNSELING SERVICES FOR PARENTS OF MINORS AGE 13+:
Treatment, Disclosures, Payment Information, & Privacy Rights

THERAPIST CREDENTIALS

I am a Licensed Independent Clinical Social Worker (LICSW) in Washington state, LW00008221. I am also a Licensed Clinical Social Worker in California (LCSW #20401). I have a Bachelor's degree in Psychology from the State University of New York at Fredonia (1992), and a Masters in Social Work from Arizona State University (1994). I am a member of the National Association of Social Workers (NASW). I am intensively trained in Dialectical Behavior Therapy by Behavioral Tech, LLC in Seattle, WA.

RISKS OF THERAPY

There are few known risks associated with counseling. However, some people report a heightened emotional awareness which can bring on stronger emotions. In some cases, people feel more depressed and have thoughts of suicide. Also, as people grow and learn things about yourself, their relationships with others may change. Counseling is a process of change and will not happen overnight.

CLIENT RIGHTS

Clients over the age of 13 have the right to: 1) be treated with respect and dignity in the therapeutic environment; 2) confidentiality and privacy; 3) refuse or terminate counseling at any time; 4) not be discriminated against; 5) obtain a copy of their records or request to amend a record; 6) to file a formal complaint against the therapist. If your teen desires to terminate the counseling contract, it is helpful when this is discussed in advance, so that proper closure, including referrals when appropriate, can be provided.

CONFIDENTIALITY

I maintain the confidentiality guidelines of the Washington Administrative Code (WAC), the Health Insurance Portability and Accountability Act (HIPPA), and the National Association of Social Workers (NASW). In WA State, clients 13 + have full mental health rights just like an adult. I will not disclose any personal or identifying information to anyone outside the therapist-client relationship without a client's written authorization when they are over the age of 13. I am required to act reasonably to avoid/minimize harm to my client or others in the following areas: 1) evidence suggests physical, sexual, or emotional abuse and neglect of a child, a disabled individual, or the elderly; 2) the client presents with suicidal ideation and refuses to comply with safety commitments; 3) the client reports to plan to harm a specific-named individual; 4) where permitted by or required by law (ie, insurance agreement, legal subpoena with proper notice); 5) consultations with my DBT consult group (client identity is omitted in

consultation). My duty to provide confidentiality will survive the death of a client unless otherwise authorized by the client prior to death. In the event that I see a client around town, I will not initiate conversation or interaction in order to protect their confidentiality.

EMERGENCIES

If you or the client are unable to reach me in an emergency, contact the King County Crisis Line, 206-461-3222, or toll free 1-866-427-4747. If they have a life-threatening emergency, call 911 immediately or go to the nearest hospital emergency room. Please be aware that my email address is not a crisis resource and is not checked regularly.

SOCIAL MEDIA/ELECTRONIC COMMUNICATION

I do not use social media with my clients. I will not accept "friend" requests nor will I communicate with my clients or their family members using social media.
If a client chooses to contact me via cellular phone, text message, email, or fax, she/he understands complete privacy and confidentiality will be at risk due to intercepted calls, technological hackers, or accidentally dialed phone/fax numbers. Clients are responsible for advising me if there is not a safe phone number or address to be contacted, otherwise, I have the right to attempt to contact clients according to the information provided by the client on the Client Info form.

CANCELLATION POLICY

I have a 24-hour cancellation policy. If the client is sick or otherwise unable to make it to the scheduled appointment, the client must contact me at least 24 hours before the appointment. Failure to do so will result in being charged the full session rate. The fee will be due at the beginning of the next session. Insurance companies do not reimburse for missed sessions and you will be responsible for the full fee amount.

FEES AND BILLING PRACTICES

My fee for the initial assessment is $250. My hourly fee for a standard session (50-60 minutes) is $160. At times, I may schedule a longer session (75-90 minutes) at $250. Fees are to be paid at the time of service unless otherwise discussed. I accept cash, check, and credit cards. If you or the client is unable to pay for service, I have the right to terminate therapy and refer the client to a low cost counseling center. There is a $30 fee for returned checks. I am open to phone calls between sessions under 15 minutes. Phone calls over 15 minutes will be pro-rated at my hourly rate. Work such as writing assessments or letters on my client's behalf or talking to other care providers will be pro-rated at my hourly rate. These may not be covered by your insurance and you will be expected to cover these costs.
It is my policy not to become involved in my clients' family legal matters (e.g. divorce, custody, immigration, etc). If subpoenaed to testify in court regarding my work with the client, my base fee will be $375/hour and additional fees may apply. During the course of treatment, my fees may change. You will be informed of fee increases in writing. Any outstanding fees (past 60 days) will incur a 5% fee on the balance owed. Collection

costs and/or attorney fees will be added to the outstanding balance in the event a collection process is necessary.

I am in-network with Premera insurance. I will bill this company directly should you chose to use your insurance for psychotherapy. If you wish to use your insurance company, I am required to provide a diagnosis code to the insurance company which becomes part of your child's medical record. By signing this, you authorize your insurance to make payments to Jennifer Palau, LICSW. If you are out-of-network, I will provide the client or you (with permission from client) with a monthly superbill that you can submit to your insurance for reimbursement. It is your responsibility to determine what is and is not covered by your particular insurance. Payments are due at the time of service. If there is a missed session/payment, payment will be due at the next session.

RECORD KEEPING POLICIES

I will maintain documentation of all consents, authorizations, notices or privacy practices, trainings, and patient requests for records or amendments to records. I will document complaints received and their disposition. Client records will be kept locked in my office or in a locked file cabinet offsite. I will keep client records for seven years from the date of the last treatment session. With respect to the records of a minor, I will keep those records for at least seven years or until the patient is twenty-one years old, whichever is longer. Thereafter, I may destroy client records. When records are destroyed they will be done so in a manner that protects client privacy and confidentiality.

CLIENT AGREEMENT

By signing this form below, I acknowledge I have read and understand the above therapist disclosure, financial responsibilities, and treatment contract. I am aware of the HIPPA privacy practice guidelines from Jennifer Palau, LICSW's website. I understand the above responsibilities for my child, and I will participate in the counseling environment if I have the consent of my teen (over age 13). I understand that if I withhold important critical information from the therapist, I may be interfering with the counseling progress of my teen and I will potentially jeopardize the therapeutic process. I have been given the opportunity to ask questions. I understand this is a legal document and contract. I have been given a copy of this contract. I understand I am signing this not as a client but as an understanding of the services someone in my family is receiving from Jennifer Palau, LICSW.

Parent name_____Signature_____Date_____

Therapist_____Signature_____Date_____