

Paulette de Coriolis, MA, LMHC

Mental Health Counselor

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Counselor Disclosure and Informed Consent

Paulette de Coriolis, MA, LMHC

Washington State License # MHC.LH.61046308

Paulette de Coriolis Counseling, PLLC

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This document is provided to you in accordance with the State of Washington laws and regulations and the Code of Ethics of the American Counseling Association. In this document, “you” refers to the client and “I” and “my” refers to the therapist.

Education, Training, and Credentials

I earned a Master’s degree in Clinical Mental Health Counseling from Antioch University Seattle. I am a Licensed Mental Health Counselor (LMHC). I complete thirty six hours of continuing education each two years including at least six hours of continuing education in law and ethics.

Philosophy and Approach

Therapy is a journey from distress toward authenticity and wholeness. Each person’s journey is their own. As a therapist, I am here to help you find your path. I work from a therapeutic framework of existentialism, which is one of the humanistic therapeutic approaches. Existentialism deals with the ultimate concerns of human life and how each of us deals with those concerns. Although my theoretical frame is existential, I use tools and techniques from other therapy forms, primarily person centered therapy, cognitive behavioral therapy, and gestalt therapy.

I am a specialist in working with transgender clients by training and experience. My practice is LGBTQIA, Poly, & Kink affirming.

Professional Ethics and Scope of Practice

The standards of practice to which I adhere are outlined in the ethical standards of the American Counseling Association and the Washington State Counselors Licensing Law. The law requires me to inform you that Licensed Mental Health Counselors must:

Provide clients at the commencement of any program of treatment with accurate disclosure information concerning the practice, in accordance with rules adopted by the department, including the right of clients to refuse treatment, the responsibility of clients to choose the provider and treatment modality which best suits their needs, and the extent of confidentiality provided by law. The disclosure information must also include the license holder's professional education and training, the therapeutic orientation of the practice, the proposed course of treatment where known, financial requirements, and such other information as required by rule. The disclosure must be acknowledged in writing by the client and license holder.

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Privacy

I only request information from you when it is beneficial to the counseling process. I will not obtain information about you through Internet searches or social media except in an emergency.

Boundaries, Multiple Relationships, and Ethics

In order to provide effective and ethical counseling services, I avoid certain forms of relationships, which are commonly referred to as *dual relationships* or *multiple relationships*. I will not start a counseling relationship with you if we have a prior relationship including a significant friendship, romantic, or sexual relationship, or if I have had such a relationship with one of your family members or romantic partners. If we have had a casual or distant relationship, I may enter into a counseling relationship with you after careful consideration, including consultation with my supervisor or other mental health professionals. Once we have established a counseling relationship, I will not have a social relationship with you outside of my office, whether we have ended our therapy relationship or not.

Once we have established a counseling relationship, I will not at any time have a significant friendship, romantic, or sexual relationship with you, your family members, or your romantic partners. This prohibition applies to current and former clients.

Confidentiality

All information discussed between counselor and client is strictly confidential. By law, information pertaining to our professional relationship can be released only with your prior written consent. Exceptions to confidentiality according to Washington State Law include the following:

- If in my professional opinion, I believe that you pose the risk of an imminent danger to the health or safety of other individuals (for example, violence and/or homicide), I am required to intervene, which may include asking for assistance from other mental health professionals, informing the other individuals at risk, or calling the police;
- If you are potentially at risk for harm to self (suicide), I may legally break confidentiality and call the police, the county crisis team, or other persons. I am not required by Washington State Law to do this and will explore all other options with you before I take this step. If you were unwilling or unable to take steps to guarantee your safety, I will call the police, the county crisis team, or other persons as appropriate;
- In cases of suspected child abuse or neglect, I am required by law to report information to Child Protective Services;
- In cases of suspected abuse of an elderly adult, developmentally disabled person, or other vulnerable adult, I am required by law to report information to Adult Protective Services;
- If you are involuntarily detained under the mental health treatment act and a court finds that my testimony is necessary to protect you or the public;
- In response to a subpoena from the Washington State Secretary of Health. The secretary may subpoena only records related to a complaint or report;
- If you waive this privilege by bringing charges against me.

Additionally, I may not disclose, or be compelled to testify about, any information acquired from our consultations when the information was necessary to enable me to render professional services to those you, except as noted in the paragraph immediately above. If I need

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to breach confidentiality, I will discuss it with you beforehand if possible and appropriate. For our mutual benefit, I participate in professional supervision and consultation with other mental health professionals; however I will not disclose any identifying information about you. Any mental health professionals that I consult with are likewise required to maintain confidentiality.

At the request of my supervisor, I provide her with contact information for my clients. She is also required to maintain confidentiality.

To ensure your confidentiality as a client, if I were to see you in public at any time, I will not initiate any contact with you. If you choose to initiate a visible or audible greeting, I will reciprocate but I will not attempt further communication unless you request it.

Termination and Referral

Although I counsel a wide range of clients, I am not competent in all domains of therapy. If your needs exceed my competence, I will provide you with clinically appropriate referral resources. If you decline the suggested referrals, I will have to discontinue our relationship.

During the course of our work together, when it becomes reasonably apparent that you no longer need my assistance, or are not likely to benefit, or are being harmed by continued counseling, I will have to discontinue our relationship. I will also discontinue our relationship if you do not pay fees as agreed upon. When ever possible, I will provide pre-termination counseling and recommend other service providers.

If you or another person with whom you have a relationship poses a risk of harm to me (for example, if you threaten me with violence), I will discontinue our relationship immediately.

Fees

My fee is \$135 for a 60-minute session. I have available a limited number of sliding scale slots. Will we discuss the fee at our first session; whatever fee we agree to, will be the “usual fee.” Payment is due at the time of service.

I do not bill insurance companies; however, I can provide you with a “super bill” which states the service rendered and diagnosis. Many insurance companies will accept a super bill and reimburse you at their “out of network provider” rate. If we agree to a sliding scale slot, I cannot provide you with a super bill.

Preparation of documentation requested by you is billed at the usual fee per hour. Preparation of documentation requested by an attorney or court is billed at \$270 per hour. Please feel free to discuss financial arrangements with me at any time.

We have discussed the fee and agreed to \$ _____ per hour

_____ Client

_____ Counselor

Appointment Times

Sessions start at the time agreed and end 60 minutes later. If you are late, the session will still end 60 minutes after the agreed start time. If you expect to be late, I would appreciate it if you could call or text me. If you need to cancel or reschedule, please call or text me as soon as

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you know. If you cancel with less than 24-hour notice or “no-show” for an appointment, I may charge you the usual fee.

Communication

I use telephone, fax, and U.S. Postal mail for most of our communication. If you use email, please do not send confidential information, as the security of email cannot be assured. I may not respond to email with email, rather I will call you as needed. Any emails will be stored as part of your record. I return calls and respond to emails as soon as I am able during regular business hours. If you are having an emergency, please call 911. If you are in crisis, you may call the Crisis Line 24 hours a day, every day of the year, at 206-461-3222.

Complaints

If you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously, with care and respect. If you believe that I have been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake, P.O. Box 47857, Olympia, WA 98504-7857, 360-236-4700. You are also free to discuss your complaints about me with anyone you wish, and you do not have any responsibility to maintain confidentiality about what I do that you do not like, since you are the person who has the right to decide what you want kept confidential.

You have been provided a copy of this document and have read and understood the information provided.

Client: _____ Date: _____

Printed name: _____

Counselor _____ Date _____