Dawn Stremel, MA, LMFT
Licensed Marriage and Family Therapist
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Disclosure Statement and Treatment Agreement

Training & Background: I am a licensed Marriage and Family Therapist with the state of Washington and have earned a Masters Degree in Psychology (Child, Couple, & Family Therapy) and a Masters Degree in Education, both from Antioch University Seattle. I have also earned a Bachelor of Arts in Music Education and a Bachelor of Music from the University of Washington, and have completed doctoral work in the area of Adult Learning & Motivation and Adult Development from the Fielding Institute in Santa Barbara, CA. I spent 30 years as a professional musician, having performed with such groups as the Seattle Symphony Orchestra and the Seattle Opera. I have also spent 20 years as a public school educator, earning several state and national outstanding teaching and leadership awards. As a therapist, I have spent approximately 8 years treating children, adults, and families wish such issues as, severe mood disorders, complex trauma & PTSD, chronic pain and medical issues, grief and loss, depression, and anxiety disorders. At present, I am a Clinical Member of the American Association for Marriage and Family Therapy (AAMFT).

Therapeutic Approach: Grounded in Existential and Humanistic traditions, I am trained in Family Systems Therapy, Cognitive Behavioral Therapy, Expressive Modalities (music, art, and poetry therapy), Internal Family Systems (IFS), and Dialectical Behavior Therapy (DBT). I am a versatile clinician, with a willingness and ability to adjust my therapeutical style to meet clients' changing needs. I believe in offering a client centered approach that honors and respects individuals from diverse cultural, social, and family orientations. I believe that Psychotherapy can be an incredibly transformative and healing experience; it is my goal to provide a nurturing, safe, and healing atmosphere for individuals of all ages and backgrounds. With great compassion, humility, empathy, and truth I aim to offer a gentle and affirming therapeutic experience, believing in honoring and celebrating the inherent worth of all human beings.

We take this journey together. You are responsible for setting your goals and working toward change outside of the therapy hour as well as during it. My role is to educate and support you during this period of change. In supporting your perception of reality, present and past, I will not attempt to determine in a legal sense whether the events you describe happened exactly as you remember them. I see you as the one who sets the course for your own life and as the responsible for the decisions and life changes that you make. I may, at various times, make suggestions and give advice, but of course, you are in control of what choices you make and how you implement them.

Course of Treatment: Counseling or therapy can have benefits and risks. You may find that therapy provides immediate relief within a short amount of time, or that the work is difficult, sometimes painful, and ongoing over a significant amount of time. These experiences are normal and it is my intention to provide you with the best opportunity for your individual growth and healing. Our first few sessions may be evaluative in nature and may include contact with referral sources, physicians, other therapists, or family members (only with your written permission). Once my initial evaluation is complete, we will mutually discuss treatment goals, methods, and anticipated length of treatment. You always have the right to request a change in treatment or to refuse treatment. It is important that what we do together meets your needs. Your participation in therapy is fully voluntary. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist.

Rights and Responsibilities: Clients have the right to choose counselors who best suit their needs and purposes, and have the right to terminate therapy whenever you choose. You have the right to be treated with respect, dignity, and courtesy at all times. It is also your responsibility to raise any questions or concerns you may have. Counselors practicing counseling for a fee must be registered with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The purpose of the Counselor and Credentialing Act is to (A) Provide protection for public health and safety; and (B) To empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. If you think that I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you think that this does not resolve the issue, you or I may contact one of my clinical supervisors listed above. If you have any questions or complaints you may contact the Washington State Department of Licensing, P.O. Box 9649, Olympia, WA 98504, 1-800-525-0127.

Confidentiality: All information discussed in the course of therapy is strictly confidential. By law, information regarding treatment or evaluation may only be released with the written consent of the person treated or the person's parent or guardian. In order to provide ethical and professional services, I regularly consult with clinical supervisors and professional colleagues. If I consult with another professional regarding your case, all information will be kept strictly confidential and within the consultation. It is important that all clients know and understand the following ***limits to confidentiality***:

(1) If I believe that you are at imminent risk of harming yourself or another person
(2) If there is evidence or suspicion of physical or sexual abuse or neglect a minor child, developmentally disabled or vulnerable elderly person
(3) If a judge orders certain information disclosed in a legal proceeding

Fees: <u>All fees are due at time of service</u>, including insurance co-pays and co-insurance fees. I accept cash, checks, and credit/debit cards (four major lenders). I typically bill insurance companies $130.00 for an Individual session, however, for private pay clients, I do offer "at time of service" cash discounts for senior citizens, veterans, and full-time college students. **<u>I require 24-hour notice for appointment cancellations and/or rescheduling; late cancellations/rescheduling and "no show" appointments will be charged the full clinical rate</u>**. Any amount past due over thirty days will be promptly sent to collections – it is your responsibility to provide prompt payment of your therapy bill.

I am happy to bill your health insurance company, provided you have mental health coverage. It is your responsibility to manage your health insurance benefit, including any deductibles, etc. I am a preferred provider with most insurance companies and can accept most other insurances as an "out of network provider." Unfortunately, **<u>I do not accept second and third party payments for adults engaging in therapy services; I will provide you with a receipt if you wish to pursue second and third party payments.</u>** If you are an adult and someone else is paying for your therapy, I request that you pay me directly and your family member etc. reimburses you for services. I provide billing receipts on request. It is expected that children (under the age of 18) would have a parent or guardian paying for their services.

A finance charge of 1% per month or $2.00 minimum, whichever is greater, will be assessed on balances outstanding over 30 days, unless we have made other arrangements in advance about your incurring a debt to me. In the event that this matter is turned over to a third-party for collection, <u>you agree to pay all principal</u>. _____ **(Initial Here).**

LETTERS: ***It is important that you know I will not provide letters of fitness or make evaluative statements concerning child custody situations or issues relating to divorce or separation, nor will I provide "expert testimony" in these situations. These services may be obtained from a clinical psychologist; referrals made on request.***

Other Letters: On occasion and at my discretion, requests for mental health/medical disability claims, or letters confirming client enrollment in therapeutic services will be provided and billed at the regular clinical hourly rate, 130.00. This service can also include Harry Benjamin letters for clients seeking hormone therapy and/or referrals.

Contact Information: You may contact me at 360-705-1492 to make an appointment or leave a message. Every effort will be made on my part to return your call within 24 hours during normal business hours. **If you are experiencing a crisis and are in immediate need of a therapist, please call the Thurston County Crisis Line at 360-586-2800 or call 911.**

Since it is impossible to protect your private information or ensure confidentiality through texting, e-mail, or other social networking sites, I do not use those formats to communicate with clients. I prefer to that clients contact me through my office phone and voice mail: 360-705-1492. If you choose to communicate with me through email or texting, you do so at your own risk, and agree to limit information to scheduling appointments.

If you have any questions or concerns which have not been addressed in this Disclosure, please ask me before signing below.

Client Consent to Treatment

I have read and understand this Disclosure Statement and Treatment agreement, or have had satisfactorily explained to me Dawn Stremel's MA Disclosure and Treatment agreement. I have asked any questions that I had about this statement, and about statements regarding fees and payment policies. (For clients under the age of 13, consent must be given and this form signed, by a parent or legal guardian). I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above with Dawn Stremel, MA, and understand that I have the right to terminate counseling at any time I desire. I also understand that Dawn Stremel, MA requests notice of termination at the beginning of a regularly scheduled session so that the reasons for termination may be discussed in terms of my therapeutic issues. I understand that if Dawn Stremel, MA experiences an incapacitating illness or death, she has a legally designated clinician that will handle the security, confidentiality, and reassignment of clients. My signature below indicates that I have received a copy of this agreement.

_____/_____ _____/_____

Client Name (signature) Date Dawn Stremel, MA, LMFT Date

Additional Family Members:

_____/_____ _____/_____

Client Name (signature) Date Client Name (signature) Date

_____/_____ _____/_____

Client Name (signature) Date Client Name (signature) Date