

## **Restoration Counseling Services Informed Consent**

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License # LF00002544  
(360) 779-7921

### **Therapy**

I am a licensed Marriage and Family Therapist who earned my Masters degree from Seattle Pacific University and have been trained to work with individuals, couples, and families. Through the therapy process I apply systemic and relational principles in a caring and professional manner.

Therapy is a different process for every individual and the time necessary for treatment varies depending on the kind and difficulty of the problem to the person. Each person is responsible for his or her own choices in therapy and has the option of stopping therapy at any time.

Aside from counseling with Restoration Counseling Services I have other counseling and coaching obligations in the Bainbridge Island School District that demand my time. In particular during the winter and early spring months my hours may be more limited and flexibility may be necessary in order to continue with therapy.

### **World View**

While I personally hold to Christian values and perspectives, I maintain that all people are valuable and should expect that their beliefs and values will be acknowledged and respected. I believe that therapy is a biological, psychological, social, and also spiritual process. Each of these areas will be explored as appropriate to the degree that the client feels willing and able.

### **Crisis or Emergency**

In case of crisis or emergency and I can not be reached, please call the Care Crisis Line at (800) 843-4793 or dial 911

### **Your Rights Regarding Therapy**

1. You may request a change of therapy, referral to another therapist or to discontinue therapy at any time.
2. You have the right and responsibility to be informed about your treatment.
3. A record is kept regarding your health care service. You may request that I not take or keep notes of sessions. I am required by law to note each session date and diagnosis. You may ask to see a copy of your record. You may also ask to correct your record. Time spent reviewing your record is at the regular charge for therapy.
4. "Counselors practicing counseling for a fee must be registered or certified 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." If you feel that in therapy I have been irresponsible, unprofessional, or unethical, you may contact the Department of Health, Board of Psychology examiners, PO Box 47868, Olympia, WA 98504-2147; 1-360-753-2147, or the Dept. of Health, Marriage and Family Therapy at 1-360-664-4375. Teressa Bentley (lic. # LF00000953) supervises my therapy and you may ask to contact her concerning our work together.

### **Financial Agreement**

Fees for individual, couple, or family therapy are based on a 50 minute session. The fee agreed to pay per session is \$80.00. Some exceptions to this fee can be negotiated based on financial hardship. Generally payment is made each session.

**Continue on back**

**Confidentiality**

In entering into a therapy agreement, I agree to keep all of our interactions under the strictest confidence. Any consultation with other therapists and colleagues will be done in a private and professional manner. If an agreement has been made for therapy, according to ethical and legal standards, no one outside of Restoration Counseling Services has access to information about you without your consent.

There are some exceptions to confidentiality: regarding the report of child abuse, sexual abuse of a minor, abuse of an elderly or disabled person, presenting a clear danger to yourself, or others, the inability to meet one's own needs, or if I receive a court order from a judge to share information. According to the laws of the State of Washington and the AAMFT code of ethics, I am obligated to do whatever is needed to assure your safety and the safety of others.

**Treatment Agreement and Consent for Treatment**

I voluntarily consent to treatment at Restoration Counseling Services. I understand that services may include such types of treatment as individual therapy, group therapy, family and/or couples therapy. I acknowledge that no guarantees have been made to me as to the effect of such treatment procedures and have the option of receiving explanations of treatment and any possible risks involved. I also understand that I may refuse any and all services at any time.

I understand that all clinical information will be kept confidential, except as stipulated by Washington, State statutes. I understand that should I have any complaint or grievance regarding services, I will be assisted in having the grievance procedure explained and having my grievance addressed in a timely fashion.

I understand that I am responsible for my financial obligation to Restoration Counseling Services.

Client(s) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

As the parent/legal guardian of \_\_\_\_\_ ; \_\_\_\_\_ :

\_\_\_\_\_ ; \_\_\_\_\_ I consent to therapy at

Restoration Counseling Services: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist signature: \_\_\_\_\_ Date: \_\_\_\_\_