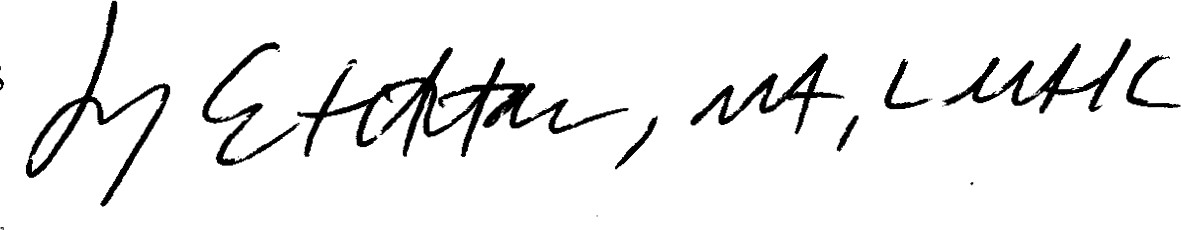
HITZTALER 

COUNSELING, LLC

Dear Client,

Welcome 10 Hitztaler Counseling! I am pleased thatyou have chosen to work with me. I have included]bryou injbrmation about myself my policies, andyour rights as a client. Plems•c me any questions regarding our agreement to work together. I lookJbrward to helping you reachyour goals!

Sincerely,

# Client Information

Date

Name

Date of Birth

Home/ Cell Phone OK to leave a message? Y N

Work Phone ( OK to leave a message? Y N

Address

Name of Spouse/ Parent/ Guardian of client

Emergency Contact Name and Phone

Children/ Siblings/ others in household ( name, sex, age )

Insurance

Medications currently taken

Physician Name and Phone

Prior counseling Experience

General Issues

Strengths

Questions

Whom may I thank for referring you?

By signing this, I acknowledge that I have read and understand the "Notice of Privacy Practices" and I have been given the opportunity to ask questions.



Printed Name Signature Date



Joy E. Hitztaler, MA, LMHC Date

# Disclosure Statement and Information

I am a Licensed Mental Health Counselor for Washington State (LH601030164) and have my Masters Degree in Counseling Psychology from Northwest University in Kirkland, WA. I received my Bachelors Degree in Psychology and a Minor in Pastoral Care from Northwest College, Kirkland, WA. I regularly take continuing education classes with subject matter pertaining to current clients and updates on various diagnosis and treatments.

I have experience counseling children, youth, adults, couples, and families working through many different issues including: phobias, anxiety, depression, adjustment disorders, addiction, Obsessive-compulsive Disorder, sexual abuse, eating disorders, chronic pain, fibromyalgia, families with parents separating and divorced, Oppositional Defiant Disorder, ADHD, Domestic Violence Issues, parenting and discipline, parent-child realtionshihp difficulties, couple and marriage issues, career and life direction, crisis and suicidal ideations, attachment issues, and more. I have worked as a school counselor, child and family therapist, domestic violence group facilitator, inpatient mental health counselor, and social worker. Please let me know if you have any questions. I look forward to working with you and your family!

## Office Policies

Fees: Payment of föes is required at the time of service, the counseling session. Acceptable forms of payment include cash, credit card, or personal check (There will be an additional $25.00 fee for returned checks), You may pay in advance for counseling sessions; if unused prepaid sessions will be fully refundable. Counseling appointments generally last 50 minutes. Fees for therapy are as follows:

* Individual therapy fee: $120.00, the initial session is $140.00
* Couple/ Family therapy fee: $150.00, the initial session is $160.00

Upon request, letters can be written for court, employers, doctors etc. for a fec of $25.0().

Additionally, telephone conversations lasting more than 15 minutes will require fee for a session. Court involvement costs the hourly rate listed above. I am happy to write a letter to your lawyer, doctor etc., compensation for such start at $25.0(), dependant on specifics.

In the event of an emergency you may call the Crisis Clinic at ('206) 447-3'2'22 (King County) or

(253) 759-6700 (Pierce County).



If you are unable to make an appointment, please notify me 24 hours in advance, failure to attend a session will cost you the filli föe. Cancellation notification under 24 hours in advance results in a  If Y'ou arrive late for your sexsion it will still end at the agreed upon time and will still require the full föe. In the event of my absence

(vacation or illness) you will be notified and rescheduled.

# Treatment

Your participation in treatment is voluntary; you may stop at any time. Your counseling therapy with me does not guarantee a certain outcome, variables are involved and we will work together towards your goals. You may at any time choosc to work with another counselor if you see fit. If our therapy goes in a direction I feel better served by another therapist with a specialty in the issues, I may refer you to another therapist. You may ask questions regarding your treatment at any time.

Confidentiality: Information disclosed during treatment is kept confidential. If you pose a danger or threat to yourself or others, I am required by law to report this. If I am made aware of child abuse or neglect, I am also required by law to report it. In the event that I wish to speak to someone regarding your care, you may sign a release form authorizing our communication.

Approach to Treatment: I generally counsel with the modalities of cognitive behavioral, family systems, solution-focused, and psychoeducation, among others as individual needs require. As a Christian I believe the Bible to be true and applicable for issues we experience today. It is up to the client what is included and discussed in treatment regarding spirituality. I am willing and able to counsel persons of varying beliefs.

Course of Treatment: Each counseling session lasts 50 minutes and it is customary to meet once a week. We will continually reassess the counseling goals and determine con tinuing course for counseling, whether it be reduced to every other week or finish regular visits while kccping the option for one time appointments as desired. Again, as treatment is voluntary, you are free to terminate our counseling relationship at any time.

Risks, Benefits, and Outcomes of Treatment: In the course of our work together you may experience pain, anxiety, sadness etc. as a result of drudging through your past, your hurt, your lifö. Changes you may make in your life as a result of our work together may be difficult. Please keep this in mind as you actively work on healing, growing, changing, achieving your goals. Benefits to counseling involve a greater awareness of yourself, greater self-esteem and self-worth, a better understanding of who you are in Christ, closer relationships with others, a change in outlook on life, new motivation, gaining new tools to cope with anxiety, anger, loss, depression etc. Together we will set goals and work towards meeting them.

Consumer Rights/Ethical Protection: As a consumer you have the following rights: the right to receive appropriate care and treatment, employing the least restrictive alternatives available, the right to be treated with respect and dignity, the right to receive treatment that is non-discriminatory and sensitive to difference of race, culture, language, sex, age, national origin, disability, creed, socioeconomic status, sexual orientation, the right to an individualized treatment plan reflecting problems and/or needs identified with you, the right to confidentiality, the right to refuse any proposed treatment, the right to review your case record under specified conditions, the right to be free of any sexual exploitation or harassment, and the right to lodge a grievance if you feel you have been violated. Complaints about the work or ethical behavior of any counselor can be directed to: Washington State Department of Health, Health Professions Quality Assurance, P.O. Box 47865 Olympia, WA 98504-7865 (360)236-4700 "Counselors practicing for a fee must be registered or licensed with the Department of Licensing for the protection of the public health and safety. A registration of an individual with the department does not include a recognition of any practice standards nor necessarily implies the effectiveness of any treatment."

# Consent to Treatment

In signing this document, you agree that you have read and agree to enter counseling relationship with Joy Hitztaler. You agree with and understand the information regarding rights/ ethical protection, disclosure information, confidentiality, appointments, fees/payment policies.

I have read and understood the information provided regarding treatment by Joy E. Hitztaler, MA, LMHC. I am committed to participation in development of and carrying out of treatment goals and plans that best meet my needs. I acknowledge that I am responsible for all fees incurred in counseling and that I am further responsible for all necessary collection, attorney, and legal fees incurred in attempt to collect these fees from me, over and abovc fees charged. I assume all financial responsibility for damage done to property or willlill or accidental injury done to the property or premises and release Joy E. Hitztaler, MA, LMHC from liability for any physical injury sustained in an accident during the commission of vandalism or violence.

( if applicable )

As the parent or guardian of I have read and understood the information provided

regarding treatment. I am committed to participation in the development of the goals and treatment plan for the above mentioned child according to their needs.

x Client and/or Guardian Signature Printed Name Date

x

Joy Hitztaler, MA, LMHC Date