Jen Marino, MA, LMHCA, CCC

License #MC61078168 ; #10007882

jenmarinocounseling@gmail.com | 206-203-7399 | www. jenmarinocounseling.com

Disclosure Statement and Consent for Treatment

Education and Professional Memberships & Qualifications

I am a Licensed Mental Health Counselor Associate in Washington State (#MC61078168) and a Certified Canadian Counselor (#10007882). I received a BS in Neurobiology and Behavior from Cornell University in 2013 and a MA in Counseling Psychology from The Seattle School of Theology and Psychology in 2020. I did my intern training at Seattle Counseling Services. I am currently in a year-long training program with Gabor Mate called Compassionate Inquiry. I am also currently in Supervision with Abby Wong, MA, LMHC (#MHC.LH.60163758), and participate in additional trainings, workshops, conferences, and consultations to enhance my skills and continue my growth as a clinician. I am also an independent practitioner working in association with the Shelterwood Collective. All Shelterwood Collective practitioners are independent provider businesses. All services rendered are representative of each individual practitioner's license, independent business, and practice style. We share values and community in the spirit of providing ethical, professional healing services.

Therapeutic Orientation

I utilize an eclectic, client-led, heart centered approach to therapy. The foundation of my training and practice is a relational psychodynamic approach with influences from narrative theory, attachment theory, object relations, and dialectical behavior therapy. More simply put, I believe that our stories, relationships, and experiences, and how we talk about them, deeply influence our emotional well-being. Therapy with me is largely about learning how to deeply listen to the particularities of your story and the meaning making you engage in the past and present; it is here that story holds its transformative healing power. Together we will also pay attention to how your current and past relationships, and the culture we live in, have influenced the way you now relate to others and yourself. I also take a holistic, somatic approach to healing, meaning that I believe we must incorporate mind, body and emotions in the healing process. My role is to witness and enter into this process with you, a guide into the unknown through embodied exploration, conversation, and play.

I practice with a queer, intersectional feminist, anti-oppression, weight neutral lens. I aim to honor the whole person, to hold each individual's unique, intersectional identities with an understanding that these influence how we engage and are engaged by others. I welcome clients of all races, ages, sexualities, gender identities, religions, backgrounds, and sizes.

Communication and Email

I am open to phone calls between sessions and phone calls that last more than 15 minutes will be charged at my hourly rate, unless otherwise discussed.

Email is not completely secure or confidential, so I prefer not to discuss therapeutic matters over email or text messages and will not write about anything you have disclosed in our session together. It is my preference to use email mainly for scheduling, financial arrangements, and to check in if I have not heard

from you as expected. Please know that emails may become part of your legal file if the court were to request records.

Supervision and Consultations

Per Washington State regulations, I receive regular supervision from Abby Wong, LMHC, a licensed, state credentialed supervisor. Here, I discuss my cases and go over video clips from sessions as a part of my continued training and growth as a counselor. I also seek on-going consultation from other experienced therapists as part of my desire to bring you the best possible care. Thus, at times, I may share pieces of your story with a consultation group. As much as possible, when sharing such information, I will protect your privacy and limit the information I share to the minimum necessary.

Video and Audio Recording Policy

As part of my supervision, I may record all or part of our session. The goal of this practice is to enhance client care and therapist competence. The content recorded is held to the same laws of confidentiality as other material produced during our therapy sessions. Recordings will be destroyed after the supervision session. This acknowledgement will also document that permission has been given by the client(s) for sessions to be recorded (using audio and/or video recording devices). Permission may be revoked by the client at any time.

Your Rights as a Client

1. This is your space. I invite you to bring any and all questions, concerns or frustrations you may have during the course of therapy. If you would like something different in our time together, please bring it forward and I will work with you to create a space in which you feel comfortable and in which your needs and preferences are better met.

2. You have the freedom to make decisions as you please. You have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. I believe doing so is part of the healing process in therapy.

3. You have the right to a relatively comfortable, safe, and professional environment where I consider your best interests my priority. Professional boundaries are essential so that no harm or damage is done. I maintain the following practices regarding professional relationship boundaries:
    a. I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship. This is a professional boundary, not one of not caring. In this same vein, I will not accept social network “friend” requests.
    b. I will not, at any time, have physical or sexual contact with you.
    c. I will not, at any time, accept any gifts from you.
    d. If I were to see you in public at any time, I will not initiate any contact with you, out of respect for your confidentiality. If you initiate, I will respond in kind, but no further than you offer.

4. You have the right to confidentiality. I am bound by professional ethics to protect client rights to confidential communications regarding their involvement in counseling. *All issues discussed in the course of counseling are strictly confidential*. By law, health care information pertaining to you may be released only with your written consent or the consent of a parent or guardian. For this

reason, if you want me to release information about your participation in therapy, I will require a signed "Release of Information" from you. State law (RCW 18.19.180) provides the following exceptions to confidentiality:

a. When there is a reasonable suspicion of child, dependent or elder abuse or neglect
b. When a client presents a danger to self, others or property, or is gravely disabled
c. When a client is involved in legal action and the court requires I provide evidence relating to our sessions
d. When the Department of Health issues a subpoena associated with regulatory complaints
e. When you specifically request in writing to release certain information to a third party (e.g., your primary care physician, teachers, family members, etc.) This permission can be revoked at any time
f. When it is possible, we will discuss any exceptions to confidentiality as they arise.

5. Licensed therapists are required to inform clients of the purpose of the Counseling Credentialing Act (WAC 246-810-031). The purpose of the Counselor Credentialing Act, chapter 18.19 RCW, the law regulating counselors is: (1) To provide protection for public health and safety; and (2) to empower citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. Registration or licensure of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. There are acts that would be considered unprofessional conduct if engaged in by any counselor. You can access a complete list of this conduct at: https://app.leg.wa.gov/RCW/default.aspx?cite=18.130.180. If any of these situations occur during your course of treatment, you are encouraged to contact the Department of Health at the address or phone number listed below to find out how to file a complaint against the offending counselor.

   If you have any concerns about your experience or if you believe that I have acted in an unprofessional or unethical manner, I encourage you to let me know so that we may discuss the situation and I can have the opportunity to address or resolve the problem.

   If you think that discussion has not worked or if you feel uncomfortable bringing this directly to me, for any reason, you are encouraged to contact the following:

   a. Department of Health, Health Professions Quality Assurance
      PO Box 47869, Olympia, Washington, 98504
   b. Email: HSQAComplaintIntake@doh.wa.gov
   c. Phone (360) 236-4700.

Your Responsibilities as a Client

1. *Scheduling*: Consistency in keeping appointments is integral to the counseling process. A standing appointment day/time can be helpful in creating consistency, but we can also schedule each subsequent appointment at the end of our sessions. If you have made an appointment with me and need to cancel it, you must let me know at least 48 hours before the *start* of the session, or you will be charged for that session. Please note that insurance does not cover late cancelled or missed sessions and you are responsible for the full fee ($140).

2. *Session Length*: Therapy sessions are 50 or 75 minutes. If you log on late for a session, you will be seen for the remaining time and will be charged for the full fee. If you are running late, just let me know and I can hold the time for you. If I have not heard from you after 15 minutes, I will assume you are not coming and end the session. You will be charged the full fee.

3. *Attendance*: I see most clients on a weekly basis and prefer to start all new clients on this frequency. If another arrangement is appropriate for you, let's discuss it. I will give you at least two weeks notice of any scheduled vacations.

4. *Completion or Termination of Therapy*: When you would like to end therapy, I encourage you to discuss this in session. I believe that spending time to process an ending can be helpful and healing, as well as uncomfortable and easy to avoid. For this reason, I strongly suggest taking 1-3 sessions to complete your therapy.

   You have the right, at any time in the therapeutic process, to ask for a change of direction or to discontinue. If I don't hear form you for 30 days, I will assume you aren't coming back and will terminate care.

5. *Fees*: The fee for an individual 50-minute session is $140 and $200 for a 75-minute session. I do offer a few sliding scale slots for those who need financial assistance and to meet the needs of the community. Please let me know if this is a need and we can discuss this payment arrangement. Fees are subject to increase, and you will be notified 90 days in advance.

   I am an in-network provider for Lifewise and Premera and bill these companies directly for counseling services. Please let me know if you would like to use your insurance.

   If you must cancel your session, please contact me at least 48 hours in advance, otherwise, you will be responsible for the full session fee. Insurance does not cover these fees and clients will be charged the full $140 for missed or late cancelled sessions.

   Clients are responsible for filing their own out-of-network insurance reimbursement requests. If your insurance provider is covering any or all costs, it is the client's responsibility to make arrangements to be directly reimbursed and filling out the appropriate paperwork. I will provide an itemized receipt as needed.

   If monthly balances are not paid in full by the month's end, a $25 flat monthly late fee will be charged. Please note this late fee is not refundable by your insurance carrier. This fee will be applied following the last day of every month where unpaid balances are applicable. No exceptions will be made.

   If your balance due remains unpaid for over 90 days with no payment arrangements made, the amount owed will be relinquished to a local collection agency, thus, releasing your name and billing information to a third-party. I will attempt to notify you directly prior to contracting with a collection agency should this be applicable. Information specific to your therapeutic work will remain confidential

Emergencies

I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate, or consult.

If you are in immediate crisis, please call 9-1-1 or go to your nearest emergency room. You can also contact your local crisis line:

- Adams; 509-488-5611; Adams County Community Counseling

- Asotin; 888-475-5665; Quality Behavioral Health
- Benton; 800-783-0544; Benton Franklin Counties Dept of Human Services
- Chelan; 800-852-2923; Recovery Interventions
- Clallam; 360-452-4500; Crisis Clinic of the Peninsulas
- Clark; 800-626-8137; Clark County Crisis Services
- Columbia; 866-382-1164; Blue Mountain Counseling of Columbia County
- Cowlitz; 800-803-8833; Lower Columbia Mental Health
- Douglas; 800-852-2923; Recovery Interventions
- Ferry; 866-268-5105; New Alliance Counseling Services
- Franklin; 800-783-0544; Benton Franklin Counties Dept of Human Services
- Garfield; 888-475-5665; Quality Behavioral Health
- Grant; 877-467-4303; Grant Mental Healthcare
- Grays Harbor; 800-685-6556; Grays Harbor Crisis Clinic
- Island; 800-584-3578; Volunteers of America Western Washington
- Jefferson; 800-659-0321; Jefferson Mental Health Services
- King; 866-427-4747; Crisis Clinic
- Kitsap; 800-843-4793; Crisis Clinics of the Peninsulas
- Kittitas; 800-572-8122; Comprehensive Mental Health
- Klickitas; 800-572-8122; Comprehensive Mental Health
- Lewis; 800-559-6696; Cascade Mental Health Care
- Lincoln; 866-268-5105; New Alliance Counseling Services
- Mason; 360-754-1338; Behavioral Health Resources
- Okanogan; 866-826-6191; Okanogan Behavioral Healthcare
- Pacific; 800-884-2298; Willapa Behavioral Health
- Pend Orielle; 866-847-8540; Pend Orielle County Counseling Services
- Pierce; 800-576-7764; Optum Health Pirece County RSN
- San Juan; 800-584-3578; Volunteers of America Western Washington
- Skagit; 800-584-3578; Volunteers of America Western Washington
- Skamania; 509-427-3850; Skamania County Community Health
- Snohomish; 800-584-3578; Volunteers of Americal Western Washington
- Spokane; 877-678-4428; Spokane Mental Health
- Stevens; 866-268-5105; New Alliance Counseling Services
- Thurston; 360-586-2800; The Crisis Clinic of Thurston and Mason Counties
- Wahkiakum; 800-635-5989; Wahkiakum County Health and Human Services
- Walla Walla; 509-524-2999; Walla Walla County Dept of Human Services
- Whatcom; 800-584-3578; Whatcom County Human Services
- Whitman; 866-871-6385; Palouse River Counseling
- Yakima; 800-572-8122; Central WA Comprehensive Mental Health

Consent to Treatment

By signing below, I acknowledge I have read and agree to the terms of the Disclosure Statement and the accompanying information sheets. I acknowledge that I have been given a copy of this document for my records. I acknowledge that I have had the opportunity to clarify the conditions under my consent to treatment. I understand that by signing below I am consenting to treatment with Jen Marino, MA, LMHCA, CCC to the terms described in this document.

_____ _____

Client Signature (or personal representative) Date

_____

Client Name (Printed)

_____ _____

Client Signature (or personal representative) Date

_____

Client Name (Printed)

_____ _____

Therapist Signature Date

_____

Therapist Name (Printed)