Lara McSherry, LMFTA
LM Therapy, PLLC
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Seattle, Washington 98103
Dear Client,

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstances will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

Professional Qualifications

I am currently a Marriage and Family Therapist Associate (MFTA.MG.61479997) working towards full licensure in the state of Washington. I am currently under supervision, supervised by Lori Kimmerly, Licensed Marriage and Family Therapist, LF60172540. I graduated from Seattle University with a Masters in Marriage and Couples and Family Therapy and began working with clients in 2022. I have additional training in telehealth. I am currently pursuing EMDR certification (Eye Movement Desensitization and Reprocessing). I have additional training in ERP (Exposure Response Prevention), Internal Family Systems (IFS), Emotionally Focused Therapy (EFT), and Narrative Therapy.

Therapeutic Orientation:

My training as a Couples and Family therapist emphasized the integration of systems and psychological theories, moral and ethical values, and clinical experience to support healing and empowerment across diverse relationships and individuals. My work is grounded in the belief that every person is intrinsically worthy and capable of living a life they want. I work with adults, couples, and families to build practical tools and internal resources that support relational and individual well-being.

Rooted in family systems theory, I approach client concerns within the broader context of family, social, and cultural systems while maintaining a strength-based perspective. Drawing from Internal Family Systems and Emotionally Focused Therapy, I help clients understand how different parts of themselves and their emotional patterns shape relationships, attachment needs, and responses to stress. I collaborate with clients to develop individualized treatment goals that reflect their unique needs and support meaningful progress.

I am open to integrating spirituality and faith as resources when helpful in addressing client concerns, and I am attentive to issues of diversity related to religion, race, socioeconomic status, sexual orientation, and gender identity.

Client Rights & Responsibilities:

Therapy success is highly dependent on the client's own acceptance, motivation, and drive for change. I will make the commitment to help you identify attainable goals, but it is your effort and participation in therapy that will allow you to achieve them. You have the responsibility to take an active role in the counseling process. Setbacks and impasses may occur periodically, but I am hopeful that personal growth can occur if communication and trust is shared between me and my clients. Overall, I want to work as a team to provide the best therapeutic experience possible.

Your Rights:

You have the right to respectful, ethical care; to refuse treatment; to choose your provider and treatment modality; to informed participation in treatment; to confidentiality under HIPAA and Washington State law; to access to records; and to the ability to file a grievance without retaliation. As an associate provider, my services are delivered under the supervision of a licensed clinician, and clinical information may be reviewed with my supervisor for training and quality of care. Concerns may be addressed directly with me, my supervising clinician, or through the Washington State Department of Health at doh.wa.gov.

State Regulations

These policies and procedures comply with applicable state regulations. LM Therapy, PLLC (DBA Lagom Counseling) is registered in the State of Washington. By engaging with LM Therapy, PLLC you understand that the business and services provided are licensed in the state of Washington unless otherwise noted in the beginning of your session.

You agree to the terms and conditions of the State of Washington and the services provided within this state. You agree and understand that the service you are receiving is within this state. Your provider holds responsibility only to the state in which they reside in and are licensed in and cannot be held accountable for any rules or regulations of other states outside of their licensure and residence.

You understand that you are receiving services at your own risk and hereby release your provider from any legal ramifications should you injure yourself in any way including but not limited to physical, emotional, mental, or psychological distress or injury.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO MY RESPONSIBILITIES AS A CLIENT AND BEGINNING THERAPEUTIC CARE.

_____ _____

Signature Date

Practice Policies

Fees and Payments

My standard fee is $160 for a 53-minute individual/couples/family session. A 30-minute session fee is adjusted to $90 for 30-minutes. A 90-minute session fee is adjusted $270 for 90-minutes.

Payment is due on the date of our session and will be charged automatically via my website's client portal. All payment is collected automatically at 2 AM the following morning after attending the session.

You are required to have a card on file to receive services. If your card declines or fails to make the payment, you will not be able to attend your next session until completing the balance.

Fee Increases

I evaluate and reserve the right to increase my fee annually. Clients will be given a written notice at least 30 days before they are instituted. Fee increases generally reflect standard rates of psychotherapy. I aim to keep

therapy costs accessible and affordable.

Insurance

I do not accept insurance at this time, and you are in agreement to be responsible for the full payment of session fees. If you would like to submit for out-of-network coverage, please know that your therapist cannot guarantee reimbursement as it is fully dependent on your plan and benefits. Superbills are provided each month, upon request.

Record Keeping

I am required by the state of Washington to keep brief notes for every session completed. These notes include a brief statement on what we discussed, what interventions or treatment was provided, and our plan moving forward.

Appointments and Cancellation

Please cancel or reschedule 24 hours in advance, by emailing me at lara@lagomcounseling.com or private messaging me through your simple practice account. You will be responsible for the entire session fee if the cancellation is made less than 24 hours from your appointment's start time. Any accommodations to this policy are made at the therapist's discretion and will be handled on a case by case basis.

There is a 10-minute no show window at the beginning of each session. If you are running late for a session, please let your therapist know within the first 10 minutes of your session at the latest, by emailing me at lara@lagomcounseling.com or private message me through your simple practice account. After 10 minutes, with no communication, your session will be marked as a no-show and you will be charged the full session fee for the missed session. Even after providing notice that you are running late, your session will end at the originally scheduled time. For instance, if you are booked for a session that starts at 10:00 am and ends at 10:53 am, and you arrive at 10:10 am, your session will still end at 10:53 am as originally scheduled.

The standard meeting time for psychotherapy is 53 minutes; however, session times can vary. You and I will determine the length of time of your sessions. Requests to change the 53-minute session needs to be discussed with me prior to scheduling shorter sessions.

Illness

Please do not attend in-person if you are sick. There is no penalty to shift to telehealth services at the same time of your session for illness related reasons limiting in-person attendance. If transitioning to telehealth occurs more than half of your monthly sessions for two consecutive months, your therapist may be unable to reserve an in-person slot and may need to find a new time.

Due to scheduling limitations, your therapist may not be able to guarantee in-person sessions for rescheduling.

Arrival

When you arrive, please wait in the waiting room until your therapist comes to you. Please arrive no more than 10 minutes early for your appointment, as the waiting area may be in use. While reasonable efforts are made to protect privacy (such as soundproofing and staggered scheduling), confidentiality in shared spaces cannot be fully guaranteed. Please be mindful and respectful of others coming and going from the office space.

Initial Consultations

All consultations and initial sessions are held via telehealth, no exceptions.

Accessibility

If you need to contact me between sessions, please email me at lara@lagomcounseling.com. I am often not immediately available; however, I will attempt to return your email within one to two business days. If a true emergency situation arises, please call 911 or any local emergency room.

Throughout the year, there are times where I will be out of office and not conducting session. Except in emergency situations, I will make every effort to provide at least two weeks' notice for any planned time out of the office.

Social Media and Telecommunication

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Privacy & Confidentiality

If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it is not appropriate to engage in any lengthy discussions in public or outside of the therapy office.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Electronic Communication

Email, text messaging, and electronic portals are used for administrative purposes only (e.g., scheduling, cancellations, billing). These methods should not be used for therapeutic content or emergencies, and confidentiality cannot be guaranteed. Responses are not immediate. In an emergency, call 911 or 988.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Substance Use and Session Environment

You may not attend sessions while under the influence of alcohol, non-prescribed substances, or any substances that impair judgment or participation. It is your responsibility to arrive at sessions in a mindset and physical location that are conducive to therapy. Sessions must be conducted in a private, safe space where confidentiality can be maintained. You may not attend sessions while driving or engaging in activities that interfere with your ability to fully participate. If you arrive for a session while under the influence of any substance that impairs your judgement or participation, or log into a virtual session while driving or while otherwise engaged in activities that affect your ability to participate, I will terminate the session immediately. You will still be billed for the cost of the scheduled session.

Couples and Family Therapy

When providing therapy to couples or families, the treatment unit is the relationship, not the individual. Information shared individually may be discussed in conjoint sessions unless otherwise agreed upon in writing. I cannot withhold information from one member of the family or couples unit.

To avoid conflicts of interest, I cannot serve as both your individual therapist and your couples or family therapist. If I am working with you in one role, I cannot provide therapy to you in the other.

Scope of Practice & Limitations of Services

My practice is designed to provide outpatient psychotherapy to individuals, couples, and/or families whose needs are appropriate for private practice care. I work within the scope of my training, licensure, and areas of clinical competence. In order to provide ethical and effective treatment, there are certain populations, concerns, or levels of care that I do not provide.

Private practice psychotherapy may not be appropriate for individuals who require intensive, specialized, or higher-level services, including but not limited to: active psychosis, unmanaged substance dependence, acute suicidal or homicidal risk, eating disorders requiring medical monitoring, court-ordered treatment, or situations requiring frequent crisis intervention or multidisciplinary care.

If at any time your needs fall outside the scope of services I provide, I will discuss this with you, and I will offer appropriate referrals to more suitable providers or programs, to support your safety, quality of care, and ethical practice.

No Custody Recommendations

Therapy is not intended to be used for legal purposes, including but not limited to custody disputes, litigation, or court proceedings. I do not voluntarily participate in legal proceedings, provide forensic evaluations, write letters or reports for legal matters, or communicate with attorneys or courts on a client's behalf.

You acknowledge and understand that LM Therapy, PLLC does not make custody recommendations nor legal or court recommendations nor determine an individual's fitness to be a parent. You acknowledge and understand that I can only provide verification that you are attending counseling and participating in the process. You acknowledge and understand that your records are confidential unless I receive a signed release of information or a court order that allows the release of the records. You acknowledge and understand that there are additional state laws and ethical issues that govern the release of information to you or to certain parties. You acknowledge and understand that I will explain the impact of any relevant laws or issues along with the process for challenging these laws or issues.

Termination

You may discontinue therapy at any time. I may also initiate termination of services with appropriate notice, discussion, and referrals when clinically indicated, when therapy is no longer beneficial, or for administrative reasons such as nonpayment.

Ending a therapeutic relationship can be challenging; therefore, I encourage you to participate in my termination process whenever possible to support closure. The length and nature of the termination process will depend on the duration and intensity of treatment.

I will not terminate our therapeutic relationship without first discussing the reasons and purpose of termination with you, except in situations where immediate termination is clinically or ethically required. If

therapy is terminated for any reason, or if you request a referral to another provider, I will offer a list of qualified psychotherapists. You may also choose a provider independently or through another referral source.

If we have not met for a session in the past 30 days AND you do not have a future session scheduled, I will begin the process of closing your file for legal and ethical reasons. I will contact you by email to discuss the plan. Closing your file means that you are no longer listed as an active client and will lose access to the client portal via Simple Practice. You can reach out at any time to request services, subject to availability.

Emergencies:

Due to the limitations of Private Practice, I cannot provide emergency services in the event of a mental health crisis or emergency. If you experience an emergency, call one of the following numbers or go to your designated hospital emergency room.

- General emergencies: 911 or 988

- National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- Text Crisis Line: 741741

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS ABOVE.

_____ _____

Signature Date

Privacy Policy

This notice describes how your medical information may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and, as applicable, RCW Chapter 70.02 entitled “Medical Records - Health Care Access and Disclosure.” Please review it carefully.

I respect your privacy. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. The law protects the privacy of the health information I create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations.

Per Washington Law, I am required to maintain records of our sessions for 5 years after our last visit unless otherwise requested by you. All session records are stored in a safe location. The law mandates that you may request and access to your treatment records at any time. Prior to record release, I may request a meeting to discuss the benefits and risks of record access and release.

Your Right to Access Your Records.

“Access to your Records” is defined under HIPAA as the right to access to your protected health information (PHI) in one or more "designated record sets" we maintain. This includes your right to inspect or obtain a copy, or both, of the PHI, as well as the right to direct me to transmit a copy to a designated person or entity of your choice. You have a right to access your PHI for as long as I maintain your PHI, regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether it originated with me, another provider, or you.).

A "Designated Record Set" is defined under HIPAA as a group of records we maintain that comprises your:

• Medical records and billing records about you that we maintain;

• Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

• Other records that are used, in whole or in part, by me to make decisions about you.

The term "record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by me. Thus, you have a right to a broad array of health information about yourself maintained by me, including:

• medical records; billing and payment records;

• insurance information;

• clinical laboratory test results; medical images, such as X-rays; wellness and disease management program files; and

• clinical case notes; among other information used to make decisions about you.

In responding to a request for access, I am not, however, required to create new information, such as explanatory materials or analyses, that does not already exist in the designated record set.

Information Excluded from the Right of Access:

You do not have a right to access PHI that is not part of a designated record set because the information is not used to make decisions about you. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions more generally, rather than to make decisions about you. For example, a hospital's peer review files or practitioner or provider performance evaluations, or a health plan's quality control records that are used to improve customer service or formulary development records, may be generated from and include an individual's PHI but might not be in the covered entity's designated record set and subject to access by you .In addition, two categories of information are expressly excluded from the right of access:

My personal notes documenting or analyzing the contents of a therapy session, that I maintain separate from the rest of your medical record.

Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

However, the underlying PHI from your medical or payment records or other records used to generate the above types of excluded records or information remains part of the designated record set and subject to

access by you.

Form and Format and Manner of Access.

HIPAA requires me to provide you with access to your PHI in the form and format requested, if readily producible in that form and format, or if not, in a readable hard copy form or other form and format as agreed to by the covered entity and individual.

If you request electronic access to PHI that I maintain electronically, I must provide you with access to the information in the requested electronic form and format, if it is readily producible in that form and format, or if not, in an agreed-upon alternative, readable electronic format.

The terms "form and format" refer to how your PHI is conveyed to you (e.g., on paper or electronically, type of file, etc.) Thus, when you request a paper copy of PHI maintained by me either electronically or on paper, it is expected that I will be able to provide you with the paper copy requested.

Where you request an electronic copy of PHI that I maintain only on paper, I am required to provide you with an electronic copy if it is readily producible electronically (e.g., I can readily scan the paper record into an electronic format) and in the electronic format requested if readily producible in that format, or if not, in a readable alternative electronic format or hard copy format that you and I agree to.

Where you request an electronic copy of PHI that I maintain electronically, I must provide you with access to the information in the requested electronic form and format, if it is readily producible in that form and format. When your PHI is not readily producible in the electronic form and format requested, then I must provide access to an agreed-upon alternative readable electronic format. This means that, while I am not required to purchase new software or equipment in order to accommodate every possible individual request I must have the capability to provide some form of electronic copy of PHI maintained electronically; it is only if you decline to accept any of the electronic formats readily producible by me that I may satisfy your request for access by providing you with a readable hard copy of the PHI.

I also may provide you with a summary of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided in addition to that PHI, so long as you, in advance: (1) choose to receive the summary or explanation (including in the electronic or paper form being offered by me); and (2) agree to any fees (as explained below in the Section describing permissible Fees for Copies) that I may charge for the summary or explanation.

I also must provide access in the manner you request, which includes arranging with you for a convenient time and place to pick up a copy of your PHI or to inspect your PHI (if that is the manner of access requested by you), or to have a copy of your PHI mailed or e-mailed, or otherwise transferred or transmitted to you to the extent the copy would be readily producible in such a manner. Whether a particular mode of transmission or transfer is readily producible will be based on my capabilities and the level of security risk that the mode of transmission or transfer may introduce to your PHI on my systems (as opposed to security risks to your PHI once it has left the systems). I am not expected to tolerate unacceptable levels of risk to the security of your PHI on my systems in responding to requests for access; whether your requested mode of transfer or transmission presents such an unacceptable level of risk will depend on my Security Rule risk analysis. However, mail and e-mail are generally considered readily producible. It is expected that I have the capability to transmit PHI by mail or e-mail (except in the limited case where e-mail cannot accommodate the file size of requested images), and transmitting PHI in such a manner does not present unacceptable security risks to my systems, even though there may be security risks to your PHI while in transit (such as where you have requested to receive your PHI by, and accepted the risks associated with, unencrypted e-mail). Thus, I may not require that you travel to my physical location to pick up a copy of your PHI if you request that the copy be mailed or e-mailed.

Fees for Copies. HIPAA permits me to impose a reasonable, cost-based fee if you request a copy of your PHI (or agree to receive a summary or explanation of the information). The fee may include only the cost of: (1)

labor for copying the PHI you requested, whether in paper or electronic form; (2) supplies for creating the paper copy or electronic media (e.g., CD or USB drive) if you request that the electronic copy be provided on portable media; (3) postage, when you request that the copy, or the summary or explanation, be mailed; and (4) preparation of an explanation or summary of your PHI, if agreed to by you. The fee may not include costs associated with verification; documentation; searching for and retrieving your PHI; maintaining systems; recouping capital for data access, storage, or infrastructure; or other costs not listed above even if such costs are authorized by State law.

Washington State Law provides that:

- Upon receipt of a written request from you to examine or copy all or part of your recorded health care information, as promptly as required under the circumstances, but no later than fifteen working days after receiving the request, I will:

a) Make the information available for examination during regular business hours and provide a copy, if requested, to you:

b) Inform you if the information does not exist or cannot be found;

c) If I do not maintain a record of the information, inform you and provide the name and address, if known, of the health care provider who maintains the information;

d) If the information is in use or unusual circumstances have delayed handling the request, inform you and specify in writing the reasons for the delay and the earliest date, not later than twenty-one working days after receiving the request, when the information will be available for examination or copying or when the request will be otherwise disposed of; or

e) Deny the request, in whole or in part, under RCW 70.02.090 and inform you of the denial.

- Upon request, I shall provide an explanation of any code or abbreviation used in the health care information. If a record of the particular health care information requested is not maintained by me in the requested form, I am not required to create a new record or reformulate an existing record to make the health care information available in the requested form. Except as provided in RCW 70.02.030, I may charge a reasonable fee for providing the health care information and I am not required to permit examination or copying until the fee is paid.

RCW 70.02.090 states that

(1) Subject to any conflicting requirement in the public records act, chapter 42.56 RCW, I may deny your request if I reasonably conclude that:

a. Knowledge of the health care information would be injurious to your health;

b. Knowledge of the health care information could reasonably be expected to lead to your identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate;

c. Knowledge of the health care information could reasonably be expected to cause danger to the life or safety of any individual;

d. The health care information was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes; or

e. Access to health care information is otherwise prohibited by law.

(2) If I deny a request for examination and copying under this section, I, to the extent possible, shall segregate health care information for which access has been denied under subsection (1) of this section from information for which access cannot be denied and permit you to examine or copy the disclosable information.

(3) If I deny your request for examination and copying, in whole or in part, under subsection (1) a. or (1) c. of this section, I shall permit examination and copying of the record by another health care provider, selected by you, who is licensed, certified, registered, or otherwise authorized under the laws of this state to treat you for the same condition as I have treated you. I shall inform you of your right to select another health care provider under this subsection. You shall be responsible for arranging for compensation of the other health care provider so selected.

Confidentiality: The session content and all relevant materials to your treatment will be held confidential unless you request in writing to have all or portions of such content released to a specifically named person/persons.

Exceptions to Confidentiality: I am required to disclose health care information, including individually identifiable health information in the following situations:

- If you threaten, or attempt to commit, suicide or otherwise conduct yourself in a manner in which there is a substantial risk of incurring serious bodily harm;

- If you threaten grave bodily harm or death to another person;
- If I have a reasonable cause to believe that abuse or neglect of a child has occurred or that a clear and present danger to a child's health, welfare, or safety exists;
- If I have a reasonable cause to believe that abandonment, abuse, neglect, or financial exploitation of a vulnerable adult has occurred;
- If a court of law issues a legitimate subpoena for information;
- To federal, state, or local public health authorities, to the extent I am required by law to report health care information.

I am permitted to disclose health care information, including individually identifiable health information in the following situations:

- If I have reasonable cause to believe that that use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;

- To a person whom I reasonably believe is providing health care to you;
- To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services, provided they follow certain guidelines and requirements;
- For payment, including information necessary for you to make a claim, or for a claim to be made on your behalf for aid, insurance, or medical assistance to which you may be entitled.

Additional details can be found at: 45 CFR § 164.512(j), RCW 26.44.030, 70.02.050, 70.02.200, 70.02.210, and 74.34.035

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS OF THE PRIVACY POLICY.

_____ _____

Signature Date

Telehealth Consent Form

By booking an appointment with me and signing this consent, you are providing informed consent to the terms and conditions stated here:

You acknowledge that you understand the nature of online counseling services as well as the duties, qualifications, and limitations of your provider, and you have been provided with this information prior to providing you with any professional services. Also known as Telepractice, Telemedicine, Distance Counseling, Cyberpsychology, Text-Based Therapy, Behavioral Telehealth, and Online Therapy, Telehealth is defined in Washington State as “providing a psychotherapy service that is not "in person" and is facilitated through the use of synchronous or asynchronous telecommunication technology by a practitioner to provide health care to a patient at a different physical location than the practitioner. Such technology may include, but is not limited to, telephone, telefax, email, internet, or videoconference.

"Telehealth" does not include the use, in isolation, of email, instant messaging, text messaging, or fax.

Washington State permits a practitioner-patient relationship to be established through Telehealth.

Washington State prohibits establishment of a practitioner-patient relationship through email, instant messaging, text messaging, or fax.

Washington State law requires that you are physically located in the State of Washington to receive telehealth services from me. Washington State makes no exceptions for temporary relocation outside of Washington State.

Disadvantages to Telehealth include cultural differences, language barriers, and strength of internet connection, which may impact the delivery of services. Telehealth may also limit my ability to observe certain nonverbal or physical cues.

You may provide off-line contact information in case of a technology breakdown, or if reconnection is not possible.

If you have any history of major psychiatric episodes, suicidal or homicidal attempts or thoughts, hospitalizations, hallucinations, drug/alcohol dependence or disordered eating, you must disclose this information and understand that you may be referred out to a higher level of care per my discretion.

The telehealth service used by LM Therapy, PLLC uses Simple Practice unless otherwise noted, which is the safest and easiest client/provider network. All data is encrypted, your sessions are anonymous, and none of your information is stored. The service adheres to HIPAA, PIPEDA, and GDPR data privacy requirements.

Client’s Rights When Receiving Telehealth Services:

(1) You have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of your medical information for in-person psychotherapy. Any information disclosed by you during the course of my therapy, therefore, is generally confidential.

(2) There are, by law, exceptions to confidentiality, including mandatory reporting of child, and vulnerable adult abuse and any threats of violence you may make towards a reasonably identifiable person. You also

understand that if you are in such a mental or emotional condition to be a danger to yourself or others, I have the right to break confidentiality to prevent the threatened danger.

(3) You understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, you understand that while you may benefit from Telehealth, results cannot be guaranteed or assured. You further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by me to others regarding your treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

(4) In addition, you understand that Telehealth treatment is different from in-person therapy and the benefits of teletherapy may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

Consent to Telehealth Services:

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth services by providing notice to LM Therapy, PLLC.

I hereby consent to engage in Telehealth with LM Therapy, PLLC as a venue for my treatment. I understand that this includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THE TELEHEALTH INFORMED CONSENT.

_____ _____

Signature Date

Video & Audio Recording Release

As an additional support for your counseling process, I may occasionally use the video footage or audio recording of your session(s) to consult with other health care professionals. This may occur during time of treatment or after treatment for purposes of peer review, education and quality assurance.

During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission, and it will be deleted when it is no longer needed for these purposes.

Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems always to ensure maximum confidentiality.

In addition to video and audio recordings made for consultation, I may also opt to use a digital Note Taker using audio recordings to create an accurate and timely record of your care. Instead of writing notes by hand, the session will be recorded which allows me to give you my undivided attention during your time with me. This means better care and more meaningful conversations between us.

Washington has a two-party consent for audio recordings, so it's important for you to know that your voice and conversation with me are recorded to document your sessions. As soon as the audio is transcribed (usually a few seconds after the appointment ends), the audio recording is permanently deleted. This recording process complies with the Health Insurance Portability and Accountability Act (HIPAA).

I hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts. A refusal to grant consent for this video or audio recording will in no way affect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect. By signing below, I agree to let my clinician record our appointment audio to document my care.

_____ _____

Signature Date

Good Faith Estimate

Your Rights:

Pursuant to the Federal No Surprises Act, you are entitled to receive this Good Faith Estimate of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services I recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from me, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. Your initiation of a patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

My Fees:

The fee for a 53-minute psychotherapy visit (in-person or via telehealth) is $160. For a 30-minute session,

the fee is $90. For a 90-minute session, the fee is $240. For a 120-minute session, the fee is $320.

Number of Visits:

Most clients will attend one visit per week, but the frequency of visits that are appropriate to you may be more or less than once per week, depending upon your needs. Based upon a fee of $160 per visit, if you attend one visit per week, your estimated charge would be $640 for four visits provided over the course of one month. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment. Please see attached Fee Sheet for additional fees and details. All of our billing is upfront; you will not be charged any additional fees after service.

This Good Faith Estimate is not a Treatment Recommendation:

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with me at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate January 1st, 2026.

Credit Card Authorization

By your electronic signature of this form, you authorize charges to your credit card through Stripe via Simple Practice for services rendered. These charges will appear on your bank/credit card statement as . You have the right to request a paper copy of this document.

I authorize LM Therapy, PLLC to charge my credit card on file through Stripe. I understand and agree that my card may be charged for any session that is not cancelled at least 24 hours prior to the scheduled appointment or for any missed appointment. I acknowledge that I am responsible for the full session fee, regardless of insurance reimbursement or coverage.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify LM THERAPY, PLLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

BY SIGNING BELOW I AM CONFIRMING THAT I HAVE RECEIVED A GOOD FAITH ESTIMATE AND AGREE TO THE ITEMS OF THE CREDIT CARD AUTHORIZATION.

_____ _____

Signature Date

Intake Questionnaire

Full Legal Name: _____

Date of Birth: ____ /____ /_____

Phone Number: _____ - _____- _____

Address:

Emergency Contact Information (optional)
Name:

Relationship:

Phone Number:

Are you currently having thoughts, a plan, or intention to hurt yourself?

- ☐ Yes, I am currently thinking about harming myself.
- ☐ No, I am safe and have no thoughts of harming myself.
- ☐ Not presently, but I have in the past month.
- ☐ I'm not sure how to answer this.

Do you currently use any substances?

Are you currently taking any medications?

Are you feeling safe at home?

What is your occupation? Do you like your job?

Anything else you would like for me to know?