Carrie Heron, LSWAIC
Unstruck, LLC
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Informed Consent and Disclosure Agreement

Welcome: Before starting your therapy journey, it is important for you to understand what to expect, as well as your rights and responsibilities. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign the document or at any time in the future.

My credentials: I have a Master's degree in Social Work from the University of Washington and am certified in Phoenix Rising Yoga Therapy. I am a Licensed Social Work Associate - Independent Clinical (LSWAIC), credentialed by the State of Washington (License #SC60941532), which means that I am licensed to practice clinical social work (therapy) while meeting regularly with my clinical supervisor toward independent licensure.

About my practice: The scope of my practice is holistic: holding space for heart, mind, body, and spirit, I support people to tap into their own wisdom and capacity for growth. I draw on my training in social work, yoga therapy, ACT (Acceptance and Commitment Therapy), and meditation to create a space in which clients feel safe, while at the same time finding their growing edge to make changes within themselves and their lives. I have experience working with a diverse range of people of different ages, abilities, gender identities and expressions, racial/ethnic backgrounds, socio-economic backgrounds and sexual orientations and I believe that it is critical to honor the context in which we live and how our social identities impact our experiences and healing processes.

The scope of my services: I am qualified to work with a wide variety of clients and challenges, but sometimes might not have the training needed to address a particular concern. If this is the case, I will discuss it with you and make sure that you receive a referral to another professional who is better able to serve you. It is your right and responsibility to choose the provider and

treatment modality which best suits your needs, and you have the right to refuse treatment or request a referral to another provider at any time.

What to expect: In our first session, we will send time getting to know each other. I will ask you to share more about your hopes and intentions for our work together and I will explain more about what the process might entail and we will review the consent forms and make sure all your questions are answered.

Our first few sessions will focus on assessment and information-gathering so that we can co-create concrete treatment goals, and will also include some skill-building. This assessment period might be more or less lengthy depending on you and your unique goals and needs.

Therapy has both benefits and risks. Risks may include heightened awareness of uncomfortable feelings, such as sadness, guilt, anxiety, frustration, fear, loneliness, helplessness, and anger, because the therapy process often involves exploring challenging aspects of your life experience. However, therapy has been shown to have benefits for individuals who engage in the process. Therapy often leads to increased skills for managing challenging feelings and experiences, greater personal awareness, and increased effectiveness in interpersonal relationships. But there are no guarantees about what will happen and the process requires your active engagement, including practicing skills outside of our sessions.

Fees: Individual therapy is billed at rate of $100 per hour session. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment can be made by check, Venmo (@unstruck), or credit card (online through scheduling system).

Cancellations: There will be no charge for cancellations made at least 24 hours prior to scheduled appointment. Any cancellations within less than 24 hours of the appointment will result in full payment for the missed session (unless due to emergency).

Sliding scale: Please ask about the sliding scale option if you are unable to make the full payment due to any circumstances.

Insurance: I do not accept payment through health insurance plans and I do not bill insurance companies. Upon request, I am happy to provide you with a receipt that you can use if filing an out-of-network claim with your insurance company. Please note that out-of-network

reimbursement might be contingent upon specific diagnoses. I cannot guarantee that your insurance company will reimburse any of your expenses. Please contact your insurance provider directly.

Professional Records: I am required to keep appropriate records of the services that I provide. Your records are maintained in a secure location in my office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis (if applicable), topics we discussed, your medical, social, and treatment history, and (if applicable) records I might receive from other providers and copies of records I send to others.

Confidentiality: The information you share with me during our sessions is considered confidential information and is protected by state law. As a therapist, I cannot reveal to third parties whether or not you are a past or current client of mine and cannot disclose any of the information you discuss during our sessions without first obtaining your written consent to do so.

In the following instances, however, I may be mandated or allowed to share information without your written consent:

- If you are involved in a civil or criminal lawsuit, a judge can order your file be turned over to the court
- If you make statements that a child, elderly, or disabled person has been abused or neglected, law requires me to report that information to the appropriate authorities
- If you make statements that indicate you intend to harm yourself or others, I may report that information to the appropriate authorities

Please see Notice of Privacy Practices (HIPAA) document for more information.

Email notifications: When appointments are scheduled, automatic email reminders for your appointment will be sent to the email you used when scheduling your first appointment. By signing this consent form, you agree to receive these notification, and verify that you understand that email is not a confidential medium for transmitting health information.

Contacting Me: I am often not immediately available by telephone. You may leave a message and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you do not hear from me or I am unable to reach you, and you feel you cannot wait

for a return call or if you feel unable to keep yourself safe: 1) contact Crisis Connections (call 866-427-4747) or Crisis Text Line (text 741741); 2) go to your Local Hospital Emergency Room; or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and contact information of the mental health professional covering my practice.

Some clients prefer to use text messages and emails primarily for schedule changes. I can assure you that voicemails and what we say in person or over the phone is confidential, but I cannot guarantee this with other forms of communication.

I am aware of the risks of text messaging and email, and I want to use these forms of communication with my therapist. _____ (initial)

I confirm that I have been given the Notice of Privacy Practices (HIPAA) document _____ *(initial)*

I have read the above disclosure agreement and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

Print name _____

Signature _____ **Date:** _____

Carrie Heron, LSWAIC
Unstruck, LLC
575.224.2273
carrie@unstruckllc.com
www.unstruckllc.com

Liability Waiver

The following is a release and liability waiver. Please read carefully before signing and ask for clarification on any portion that you do not understand. Please initial after each statement indicating that you understand and agree to the statement:

1. I understand that holistic therapy may incorporate both cognitive and physical approaches, and that there is always an inherent risk when participating in physical activities. I agree to let the therapist know of any physical limitations I might have or any physical activities I do not wish to participate in. _____(initial)

2. I hereby release the therapist, Carrie Heron, and the owners of the building in which the therapy takes place from responsibility for any injuries that I may sustain as a result of participation in this therapy _____ (initial)

I have read the above liability waiver and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

Print name _____

Signature _____ Date _____

Carrie Heron, LSWAIC
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carrie@unstruckllc.com
www.unstruckllc.com

Virtual Sessions

I offer virtual therapy sessions through DoxyMe.com, a HIPAA-compliant videoconferencing service. Because of some essential differences between in-person and virtual interactions, it is important that you understand the unique risks associated with virtual (also know as tele-therapy) sessions. By signing this form, you agree to participate in tele-therapy with a mental health provider at Unstruck, LLC. This means that you agree with the following statements:

- I understand that I will be informed of the identities of all people who are present during the tele-therapy session and informed of their purpose for attending the session.
- My therapist has explained how the tele-therapy system works and how it will be used for my treatment.
- My therapist has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.
- I understand that my therapist will not be physically present during my tele-therapy session. Instead, we will see each other electronically.
- Potential risks include the following: (a) at times the video image may be unclear or inadequate; (b) a disruption in the connection may occur; and (c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I understand that tele-therapy is a new form of treatment that is not yet validated by research. As such, there may be potential risks that may not yet be recognized.
- I understand that at any time, I may decide to discontinue tele-therapy sessions with my provider. My therapist will refer me to a local mental health provider who can provide face-to-face services.
- My therapist has explained the risks and benefits of receiving tele-therapy. I understand that I still may need to see a specialist in person.
- I understand that information from my tele-therapy sessions will be protected by HIPAA privacy laws. I may request a copy of my electronic record in writing.

I voluntarily consent to participate in tele-therapy using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Print name _____

Signature _____ **Date** _____

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