A B C

Allie Bulliman Counseling

34004 9th Avenue South, Suite A-11, Federal Way, WA 98003

TREATMENT PROGRAM STATEMENT AND COUNSELING AGREEMENT

THE PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGEMENT OF ITS RECEIPT ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. WE WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR OUR TREATMENT AND EDUCATIONAL PROGRAMS.

YOUR RIGHTS AS A CLIENT:

As a client of a registered and/or licensed counselor, you have privileged communication under the laws of the State of Washington. You may give written permission for your counselor to disclose that information. If you are being seen in family or couples treatment, information shared in any individual meeting may be shared by your counselor in a joint session if it is deemed to be in the best interest of the work you are doing with the counselor. The informational brochure from the State of Washington lists additional exceptions to your right to confidentiality.

You always have the right to request a change in treatment or to refuse treatment. You also have the right to view, copy or request a change in your records. The Counselor Credentialing Act provides protection for public health and safety and empowers Washington State citizens by providing a complaint process against those counselors who would commit acts of unprofessional conduct. The informational brochure printed by the State of Washington Department of Health lists conduct, acts, or conditions that constitute unprofessional conduct.

It is very important that your work here meets your needs. If you believe you are not being helped, it is important that you discuss it with your counselor so that the difficulty can be resolved. If the situation cannot be resolved, your counselor will assist you in finding appropriate, alternative treatment.

APPOINTMENTS AND FEES:

Appointments are scheduled with a frequency believed to be most beneficial. The time scheduled for your session is set-aside specifically for you. Please understand that payment of your bill is part of your treatment. If you miss a session without canceling, or if you cancel with less than 24 hours notice, you will be charged in full for the missed time. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate. Full payment is due at the time of service and must be in the form of either cash or check. Extended payment plans and sliding scale fees for hardship situations are handled on an individual basis only.

Any work done related to a legal issue on your behalf will be charged on an hourly basis for the time spent on your case. This includes meeting with your attorney, writing reports, travel and preparation time.

The parent(s) or guardian(s) of a minor are responsible for full payment.

INFORMED CONSENT AND REQUEST FOR SERVICES:
It has been explained to me that counseling is not an exact science, and that I have the right to have a clear description of the nature and character of the proposed counseling. I also realize that I have treatment options outside of Allie Bulliman Counseling including no counseling at all and that no guarantee or assurance has been made to me as to the results that may be obtained from treatment by ABC.

My signature below verifies that:

1. I have freely elected the counseling/treatment program offered by ABC in good faith and without duress.

2. I give permission for Allie Bulliman to release psychological reports to referring physician(s), mental health practitioner(s), or agencies.

3. I understand that any therapy, diagnostic work, testing, video and/or audio taping (conducted by my consent) may be reviewed by a supervising or consulting psychologist designated by ABC.

4. I am aware that treatment through ABC is not an emergency service and I have been informed of phone numbers to call in the event of an emergency during evening and weekend hours.

5. I have received a copy of the Washington State Department of Health brochure on Counseling and Hypnotherapy Clients and have been informed about the purpose of the Counselor Credentialing Act.

6. I have received a copy of the published fees for services provided by AB Counseling and have made a financial agreement for services rendered to me.

7. I have received a written disclosure that includes the registration, certification, and/or license number of Allison Bulliman, LMHCA, R-DMT at ABC. This disclosure also includes information regarding her treatment philosophy, education, and experience.

8. I agree to defend, indemnify and hold ABC, its principals, agents, and employees harmless from and against any and all liability, loss or damage that I, as a client may suffer as result of claims, demands, cost, or judgments arising out of, in connection with, or incident to ABC's performance of services.

9. I have read this Treatment Program Statement and Client Agreement and I understand it. I have asked any questions that I desired in regard to this agreement, fees, and payment policy.

Client Signature _____ Date _____

Counselor Signature _____ Date _____