

Noelle Mestres, MSW LICSW

611 Main Street, Suite B-2
Edmonds, WA 98020
425-771-7036

WA State License #: LW00006356

CLINICIAN DISCLOSURE STATEMENT

Welcome to my practice. Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy, methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to facilitate our work together, here is some basic information about me and my practice.

I have been practicing since 1991, post-graduate since 1992. I have a Masters Degree in Social Work from the School of Social Service at Saint Louis University in St. Louis, Missouri and am licensed in the state of Washington. I use techniques from a variety of theoretical orientations including family systems, cognitive-behavioral, and psychodynamic therapy. I have advanced training in the Gottman Method for couples therapy. I borrow from this method as well as others, primarily Emotion Focused Couples Therapy, in work with couples. My experience includes work with children, adolescents and adults in individual, group and couples therapy. Currently, I work with adults, couples and adult groups only.

It is important that you understand that counseling has both benefits and risks. You may experience uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Your therapy may also involve recalling unpleasant aspects of your history. Psychotherapy has been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships and resolution of specific problems. However, I can make no guarantees about how the therapy process will be for you specifically.

If you have concerns or complaints about any aspect of your treatment, please attempt to discuss them with me first. If you feel that I have been unethical or unprofessional, you may contact the Counselor Program at the Department of Health's Health Professions Quality Assurance Division.

Counselors practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. The purpose of the law regulating counselors is to provide protection for public health and safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct [WAC 246-810-031].

If you are seeing me for couples therapy there are issues of confidentiality, which are unique to it. It is not therapeutically advisable for the therapist and one partner to hold confidential information from the other partner. This does not mean that information will be automatically shared. However, clients will be strongly encouraged to share pertinent information as necessary to augment the therapy process. A culture of "secrecy" disrupts the effectiveness of couples therapy. Thus if you choose to have a partner participate in therapy, either individually or conjointly, do not tell me anything you wish kept secret from you partner. These are all things I will discuss with you in our work together.

(cont'd)

You will be provided with my Notice of Privacy Practices. Please note: I am part of two clinical consultation teams and hire outside individual consultation. Identifying information about you will not be used. When I am away, I may provide identifying information (PHI) about you to my back up therapist in order to provide you with the best continuity of care should you need help when I am away. Please talk with me if you have concerns about this or would prefer that this not occur.

While the attached written summary [see 'Notice of Privacy Practices'] of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. The laws governing these issues are quite complex. While I am happy to discuss these issues with you, should you need specific advice, a legal consultation may be advisable. If you request it, I will provide you with relevant portions or summaries of the applicable state laws governing these issues.

I return phone calls as quickly as possible during my work week days; those are Tuesday through Friday. In case of an emergency, during the work week day, in the evening or on the days I am not in the office, please call the Snohomish County Care Crisis Clinic at 245-258-4357, the King County Crisis Clinic at 206-461-3222, 911 or go to your nearest emergency room. You will hear the crisis clinic phone numbers in the outgoing message on my voicemail. If you are a current active client and need to reach me urgently, please let me know this in your message. I will call as soon as I can but please use the above instructions and numbers if it is not soon enough to meet your need.

Your appointment is held exclusively for you. If you are unable to keep your appointment, please give at least 24 hours advance notice to cancel.

FEE AGREEMENT

Fee for 60 minute Intake Session: \$150.00

Fee for 60 minute (53 + minutes) Individual Session: \$125.00

Fee for 45 minute (38-52 minutes) Individual Session: \$125.00

Fee for 30 minute (16-37 minutes) Individual Session: \$62.50

Fee for 90 minute private paying couples session: \$187.50

*a select number of low fee spaces are available for qualifying clients (please discuss with me to see if spaces are available if needed)

By signing this disclosure you are confirming that you understand and agree to the fee amount above and that payment is due at the time of service. You acknowledge that you understand that having insurance does not guarantee payment of benefits and that you are responsible for the unpaid portion of the fee. Some plans specify co-insurance or co-pay amounts as determined in a contract signed by Noelle Mestres, MSW LICSW. You understand that Noelle Mestres, MSW LICSW will abide by such contractual arrangements should they apply and that you can ask about this at any time. You agree to provide insurance information and to inform Noelle Mestres, MSW LICSW if you plan to use your insurance.

Telephone sessions are not covered by insurance. Appointments that are not cancelled with a 24 hour notice will be subject to the full fee rate. Insurance does not cover missed appointments.

(cont'd)

You agree to pay all fees for which you are responsible and understand that failure to do so may result in a break in service. If you decide to utilize your insurance plan: you hereby authorize your insurance benefits be paid directly to Noelle E. Mestres, MSW LICSW and to forward any insurance payments you might receive directly to Noelle E. Mestres. You authorize Noelle E. Mestres, MSW LICSW to release any information required to process this claim or to obtain authorization for services. You understand that a diagnosis will be provided to your insurance company and you agree to this disclosure. This consent, with respect to the conditions noted above, shall be effective only so long as is reasonably necessary to obtain reimbursement.

Regarding electronic communication; please understand that e-mail nor texting is guaranteed to be secure. Please also understand that any such correspondence may be part of your clinical record. Please do not contact me via e-mail or text for clinical matters or emergencies. Please call me in those circumstances. On occasion, e-mail or text can be a convenient way to schedule and send non-sensitive information. If you choose to do this, again, please remember the above. **Please note: I do not always check e-mail on a daily basis. I am often not able to respond to e-mail until the next day or longer if I am away.**

Your signature below indicates that you have read and understand this Disclosure Statement in it's entirety and that you agree to all terms herein, have received a copy of this Disclosure, and wish to enter treatment on these conditions. In addition fee arrangements and terms of confidentiality have been clearly made.

Client: _____ **Date:** _____

Client: _____ **Date:** _____

Therapist: _____ **Date:** _____

