

Letter of Agreement

A Canelli, MA/LMHC
Canelli Counseling and Consultation PLLC
1812 E. Madison Ste 206
Seattle, WA. 98122

I. DISCLOSURE TO CLIENT

- A. **Credentials:** I am a Licensed Mental Health Counselor in Washington State (LH 00011134) and a Washington Administrative Code Approved Supervisor.
- B. **Education, Training, and experience:** I received a Bachelor of Science from Bastyr University in Health Psychology with a minor in Research. I received a Masters of Arts, Education in Counseling from Seattle University. I completed my internship hours at Seattle Counseling Service. I continued at SCS to work as a mental health provider specializing in Transgender/Gender Variant and Queer populations. I have worked for many years in the LGBTQ community as a therapist and advocate. During my time at SCS I received my LMHC and started to work as an adjunct teaching assistant for Seattle University. I am also a supervisor at the Seattle Crisis Clinic.
- C. **Professional Memberships:** I am a member the National Board of Certified Counselors and the Washington Mental Health Counselor Association.
- D. **Services Provided:** I provide psychotherapy for individuals, groups, and couples. I offer multi-body sessions for families, chosen or biological. If it is in the best interest of the client, I coordinate care with other service providers-based on the client informed consent.

II. WORKING RELATIONSHIP

A. **Confidentiality:** The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State law set limits on confidentiality. Please review these limits to confidentiality and my privacy practices in my Notice of Privacy Practices.

B. **Health care coordination:** It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, you should get a physical examination from a physician as soon as possible, and it would be best to tell your medical provider that you will be working with me so we might begin to coordinate your health care. With your written authorization, I may obtain your medical records so I have a better understanding of your overall health.

C. **Appointments:** We will schedule our appointments either via phone , email, or in person at the end of a session. I don't use text messaging to communicate with clients. Please notify me via phone, at (206) 898-0231, as soon as possible if you have any schedule conflicts or emergencies, which would require you to cancel our appointment. Likewise, I will notify you via phone if I should need to cancel our appointment. I will have to charge you the full session fee if you do not give me 24 hours notice of any cancellations, and you will not be charged if I cancel our appointment. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment, otherwise you will receive a bill for this fee. When you arrive for an appointment, please wait in the Suite 206 waiting room and I will promptly meet you. Our sessions will be for 50-minutes, and we will need to end on time. I cannot accommodate making up for lost session time

unless it is due to my error or tardiness. I charge the full session fee for any shortened sessions due to your late arrival or early departure. If you are late and have not notified me by phone, I will remain in the office for 30-minutes past our appointment time.

D. Fee for services: My fee for counseling is \$140.00 per session. This is the same fee charged for any missed or late canceled appointments. Additional fees might include: preparation of requested documents (e.g. letters to lawyers, government agencies, etc.) and copying and sending records. I will discuss these fees with you at the time of a request. I am an out of network provider, so I do not accept insurance. I can provide you with a billing statement that you can submit to your insurance company for reimbursement.

E. Payment for services: I accept cash or personal check payments made payable to **A. Canelli**. Payments are due directly to me at the time of service (at the end of each session). If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. Please inform me of any changes in your financial situation that impacts your ability to pay for services.

F. Record keeping: If requested I will give you a copy of your statement at the end of each month, which will serve as proof of service fees, payments, and outstanding balances. If you have an outstanding balance, I will notify you and payment is due promptly.

G. Insurance: I am an out-of-network provider; therefore, I will not make submissions for reimbursement to your health insurance provider.

H. Emergency, urgent, or other contacts: I am not able to provide crisis or emergency services. If you have a physically or psychologically life-threatening emergency, please immediately call 911 or Seattle Crisis Clinic at (206) 461-3222. They have 24-hour availability to offer crisis counseling, community resources, and emergency assistance. You may call me anytime and leave a message on my confidential voice mail. You may also email me with your message, aside from canceling an appointment in less than 48 hours of the scheduled time when I need to be contacted via phone. Please remember that anything you send over email is not confidential. I retrieve my messages periodically, and I will return your call or email at my earliest convenience.

I. Therapy relationship and professional boundaries: I value maintaining a warm, safe, and professional environment where I consider your best-interest. With the utmost respect for you and our relationship, I believe that professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

- 1) I will not, at any time, have a social relationship with you outside of my office, whether we have ended our therapy relationship or not. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.
- 2) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting.
- 3) I will not, at any time, accept any gifts or foods from you. I may accept a card or note from you.
- 4) To ensure your confidentiality as a client, if I were to see you in public at any time, I will not initiate any contact or familiarity with you. If you choose to initiate a visible or audible greeting, I will reciprocate but I will not attempt further communication unless you request it.

5) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referral services, as well as the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also includes any business and financial relationships. Also, I will not provide any services beyond my expertise, including legal or medical advisement.

6) I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, and other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.

7) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter, neither your death nor mine terminates your confidentiality rights.

J. Therapeutic work and duration: You have the freedom to make decisions as you please. You may engage in therapy as long as you would like. You may also withdraw from therapy at any time. I respect and promote your right to make your own decisions. This is consistent through the process of collaborating with you to formulate goals for therapy and to determine evaluation of goals. 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. If you would like to end therapy, I would only ask that we first discuss this in person.

K. Risks and benefits: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your relationships and life, you might experience greater difficulty throughout our work. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

L. Complaints: If you have a complaint or inquiry about my professional services, please contact the Washington State Department of Health. Please ask me if you have questions on how to submit a complaint or inquiry.

Letter of Agreement for Counseling

A Canelli, MA/LMHC NCC
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- I have read the Letter of Agreement for Counseling with A. Canelli, MA/LMHC NCC and understand it.
- I have had the opportunity to ask A. Canelli, MA/LMHC NCC questions and to be provided further explanation pertaining to the Letter of Agreement.
- I agree to follow the terms in the Letter of Agreement.
- I will receive a copy of the Letter of Agreement following my signature.
- It is understood that my relationship with A. Canelli, MA/LMHC NCC may be discontinued whenever the terms in the Agreement are not fulfilled by either of us.

Name (printed)

Signature

Date

A. Canelli MA, LMHC

Date