

**Sara Muckler, MA LCPC, LMHC  
Db a Sara Muckler, MA PLLC**

1644 Plaza Way PMB410, Walla Walla, WA 9936

206-605-6329

**DISCLOSURE STATEMENT, CLIENT RIGHTS AND INFORMED CONSENT FORM**

I am a Licensed Mental Health Counselor (LMHC) in the state of Washington – LH 60558817, a Licensed Clinical Professional Counselor (LCPC) in the state of Idaho – LCPC 6687, and a Licensed Professional Counselor (LPC) in the state of Oregon - C9807.

I received a Bachelor of Science in Communications from the University of Idaho and a Master of Arts in Psychology, Systems Counseling from LIOS Graduate College of Saybrook University. As part of my graduate studies I completed an internship at Child and Family Counseling of Catholic Community Services in Kent, Washington.

In the state of Washington, the practice of counselors is regulated by the Washington State Department of Health. Any questions or complaints may be addressed to: WASHINGTON STATE DEPARTMENT OF HEALTH Adjudicative Service Office, P.O. Box 47879, Olympia, WA 98504-7879.

In the state of Idaho, the practice of counselors is regulated by the Idaho Bureau of Occupational Licenses. Any questions or complaints may be addressed to: STATE OF IDAHO BUREAU OF OCCUPATIONAL LICENSES Owyhee Plaza 1109 Main St., Suite 220 Boise, ID 83702-5642.

In the state of Oregon, the practice of counselors is regulated by the Oregon Board of Licensed Professional Counselors and Therapists. Any questions or complaints may be addressed to: OBLPCT, 3218 Pringle Road SE, Ste. 120, Salem, OR 97302.

HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices. The Notice, included in this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. We will give you a copy of this Agreement, including the Notice.

**CONFIDENTIALITY**

The contents of material disclosed in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide and I abide by ethical and legal requirements of confidentiality and privacy of records. The information you provide during counseling is confidential, EXCEPT during the following cases:

- When your counselor has reasonable cause to suspect that a child (anyone under the age of 18 years), an elder, or a developmentally disabled, or physically impaired person under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect.
- When your counselor has reasonable cause to suspect a threat of injury to another, homicide, or suicide she may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm.
- When your case is reviewed for supervisory reasons. In these cases, your real name will not be disclosed.

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- Information may be released to parents of minor children who have the legal right to access their children's medical information, unless there is a court order prohibiting one of the parents from access.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the therapist-client (or social work-client) privilege law. I cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders me to disclose information, I am required to provide it. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- Worker's Compensation: If you file a worker's compensation claim, your counselor may be required to give your mental health information to relevant parties and officials.
- If a client files a complaint or lawsuit against me, or my business entity, Sara Muckler, MA PLLC, I may disclose relevant information regarding that patient in order to defend myself.
- Your health insurance plan has the right to review your Clinical Records for any services you have asked them to pay for. Unless your treatment is being paid for by a Workers Compensation plan, a health insurance company is not entitled to see Counseling Notes, which are detailed notes your counselor may make concerning what you have talked about in therapy. However, they are entitled to see protected health information in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

**DUAL RELATIONSHIPS OR MULTIPLE RELATIONSHIPS**

- Counselors need to be neutral, objective, and professional.
- Dual relationships or Multiple Relationships in psychotherapy refers to any situation where multiple roles exist between a therapist and a client. Examples of dual relationships are when the client is also a student, friend, family member, employee or business associate of the therapist.
- Counselors make every effort to avoid dual relationships with clients that could impair their judgment or increase the risk of harm to the client.
- When dual relationships cannot be avoided a counselor takes appropriate steps to ensure that judgment is not impaired and that no exploitation occurs.
- Sex between counselor and client is never appropriate.
- A counselor cannot be your friend on Facebook or other social media.

**USES AND DISCLOSURES REQUIRING AUTHORIZATION**

I may use or disclose Protected Health Information for purposes outside of treatment, payment, and health care operations when authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. Individuals will be notified if there is a breach of unsecured Protected Health

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Information. Clients have a right to restrict certain information to health plans where they pay out-of-pocket, unless the disclosure is required by law.

**CLIENT RECORDS**

As your counselor, I will maintain a Clinical Medical Record file on your case, which is the property of Sara Muckler, MA PLLC. You may examine and/or receive a copy of your file if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials.

Please note: If you are being seen in couples, group, or family therapy, some state laws concerning confidentiality are not clear. I will not release information to other parties without your written permission of all individuals involved in the therapy session, except when allowed or required to do so by State or Federal law, unless a court order requires me to release information about your case.

**COURT APPEARANCES**

At times, a client may ask a counselor to appear in court on their behalf or the behalf of their children. Counseling is primarily a therapeutic relationship with the goals focused on personal growth and healing, with all information shared in session being confidential. Therefore, it is my policy to refuse all requests to appear in court on behalf of any client. In the case that I may be subpoenaed to testify in court, an hourly fee of \$90 an hour will be assessed, with four hours of services to be paid prior to the court appearance. This hourly fee includes my time traveling to and from a court appearance, as well as my time waiting to testify.

**MINORS/GUARDIANSHIP**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. The age of consent in the states of Washington and Oregon is 13. Therefore, any client aged 13 or older in the state of Washington or Oregon has the right to refuse to release information in their record to anyone, including their parents, absent a court order to the contrary. The age of consent in the state of Idaho is 18. Therefore, any client aged 18 or older in the state of Idaho has the right to refuse to release information in their record to anyone, including their parents, absent a court order to the contrary.

**IN THE EVENT OF A CLIENT'S DEATH**

In the event of a client's death, the right of privileged information remains with the deceased. If family members or legal representatives request a copy of the client's record, a court order duly signed by the judge or court clerk must be presented and authenticated prior to release of any information.

**FEES**

All fees are due at the time of service. If you are utilizing your insurance benefits, I will bill your insurance company. Please take the time to inform yourself of what services your individual insurance plan provides and what your individual copay, co-insurance, or deductible is. Please note that in the event that your insurance provider does not pay for services, you are responsible for all fees.

Appointments are billed at the following rates:

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\$250 for initial intake (90 minutes)  
\$175 for a 50-minute session  
\$225 for an 80-minute session

I have a limited number of appointments available for those in need of a sliding scale payment. Please feel free to contact me to discuss this further.

All payments must be received at the beginning of each session. Cash, personal checks, Visa or Mastercard are acceptable forms of payment. A \$20 fee will be assessed for returned checks. Payment for the fee and unpaid balance must be made in cash, money order or by credit card before an additional session can be scheduled. For your convenience, I can keep a credit card number on file. I store this information in a password-protected file on a password-protected laptop.

In addition to scheduled appointments, I charge \$175/hour for other professional services you may need, though I will break down the hourly cost into 15 minute increments if I work for less than an hour. Other services include report or letter writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request.

When payment for services are the responsibility of the client, or a person who has agreed to provide payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (ie., diagnosis, treatment plan, progress notes) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the provider or collection source.

Please note that I use an outside medical biller for billing purposes. In order for them to bill your insurance, I will be providing them with your name, date of birth, mental health diagnosis and date and length of session. They and myself use every precaution to protect your personal information.

**CANCELLATION POLICY:**

If you need to cancel or reschedule your appointment, please call me as soon as possible so that I can adjust my schedule and allow other clients the opportunity to take your spot. **If you cancel less than 24 hours before the start time of your session OR you do not show to your session, you will be responsible for paying a \$40 fee for the missed session.** Missed sessions are not billable to insurance.

**GENERAL INFORMATION**

I am not always immediately available by phone, but I check phone messages each working day and will try to return your call within 24 hours or the next working day. **If you are experiencing an emergency and can't wait for a return call, you can go the emergency room, call 911, or call the National Suicide Prevention Hotline at 988.** I am available by email or text for administrative or scheduling purposes only. Please do not email or text me content related to your therapy sessions, as this email is not encrypted and, therefore, not completely secure or confidential. If you choose to communicate via email or text, be aware that all emails are

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retained in the logs of your and my internet service providers. If you contact me via email or text, I will assume that you approve of my replying to you and that you accept these risks. I do not accept friend or contact requests from current or former clients on social networking sites such as Facebook or Instagram.

\_\_\_\_\_  
Client's name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Signed by: \_\_\_\_client \_\_\_\_guardian \_\_\_\_personal representative

**CLIENT RIGHTS**

As a client you have the right to:

- Have your records be confidential. The Health Information Privacy Protection Act (HIPPA) states that you have the right keep your records confidential. The Confidentiality statement identifies circumstances in which mental health professional have a responsibility to report information to appropriate persons with or without the consent of the client.
- If attending an in-person session, you may leave the premises at any time. You will not be detained against your wishes, unless you are an imminent danger to yourself or others. If attending a telehealth session, you may leave the session at any time. However, if you are an imminent danger to yourself or others, I may contact your emergency contact, law enforcement, or social services for your safety and the safety of others. You may refuse any service that you do not want.
- You have the right to discontinue services at any time. If discontinuation of services is done against professional advice, this will be documented in your medical records. For those who are mandated by court order or to fulfill requirements of probation/parole the terms set in place by the court or probation/parole may supersede the right to discontinue services at will.
- You can expect to receive treatment that is beneficial to you and respects your values.
- You can expect treatment to be free from emotional, sexual, and or physical abuse.
- Sexual intimacy between a counselor and client is never appropriate and should be reported to the state licensing board.
- Socializing outside of the office is not an option.
- You may report immoral or unethical activities to the Washington State Department of Health, the Idaho Bureau of Occupational Licenses or the Oregon Board of Licensed Professional Counselors and Therapists. You have the right to file a complaint without retaliation.
- To have access to the medical records in your case file at any time (requests for copies, or releases to other entity fall under above stated guidelines).
- You have the right to disagree with the medical records in your files. You may request that the information be changed. Although, we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.
- You are entitled to receive information about my counseling methods and techniques, the length of counseling and the cost. There is no agency or person able to guarantee the outcome of therapy. While there are benefits to therapy, there are potential risks. The risks most likely to occur are: 1) experiencing unpleasant emotions during the therapy process and 2) experiencing a change (not always desired) in relationships as a result of personal therapeutic growth.
- You have the right to decline or question any treatment procedure or approach. You have the right to a second opinion from another mental health practitioner. A referral to another provider will be given upon request.

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

\_\_\_\_\_  
Client's name (please print)

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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Signature

Date

Signed by: \_\_\_client \_\_\_guardian \_\_\_personal representative