

Nicole T. Shiraev, MSW, LICSW, PLLC

<http://www.shiraev-pllc.com>

Office Address: 150 Nickerson Street, Suite 105, Seattle, WA 98109

Office Phone: (206) 496-2426

Fax: (206) 327-9169

## INTRODUCTION

This Disclosure Notice is required by state law to provide you with information about me, my policies, and the way I conduct treatment. It is intended to allow you to make decisions about your treatment and the work we are doing together, and to assure that you understand the purpose and process of that work. Clients always have the right and are encouraged to ask questions related to this information as they arise throughout the treatment process.

As a client you have the right to appropriate care, respect, and confidentiality. You have the right to treatment that is non-discriminatory and sensitive to differences of race, culture, language, sex, age, national origin, disability, creed, socio-economic status, marital status, and sexual orientation. As a client, you have the right to work with me in choosing the therapy modality that best suits you. You have the right to terminate your therapy at any time although in order to have a healthy closure for you, it could be important for us to both participate in the process of terminating treatment.

My goal is your personal recovery, so that you can complete treatment. I cannot predict how many sessions we will ultimately need, but I do anticipate that there will be an end to the treatment.

I want to be fully open with clients about the costs associated with services and for that reason explicitly describe my fees and payment requirements here and below. Clients must pay all fees due to me the provider in full at the beginning of each session or as otherwise agreed upon between client/client's guarantor and provider. Payment may be made by personal check made out to Nicole T Shiraev, LICSW, PLLC or by credit card (VISA, MasterCard, American Express, and Discover accepted). For clients using their out-of-network insurance benefit I will provide you an invoice at the end of each session that you may need if you seek reimbursement from an insurer. For clients wishing to use insurance to cover services, I am contracted with the following insurers: Premera Blue Cross, Regence, Bridgespan, Kaiser, First Choice Health Network PPO, First Choice Health EAP, Group Health, Compsych EAP, and LifeWise Health Plan of Washington. Fees reimbursed to me, the provider, from your insurance company are based on contracts with those companies and may vary from plan to plan. Clients are responsible for paying co-pays and deductibles in full at the beginning of each session. I cannot advise you as to what any insurer may or may not cover and to be aware if prior authorization for services is needed. I also want to be clear at the outset that beyond one missed appointment/late cancellation per year I must charge in full for any appointments that you miss or cancel, regardless of reason for missed appointment/late cancellation, less than 2 business days (business days for my practice are M-W, however for purposes of notifying me of

scheduling changes, Thursday and Friday will be considered a business day) before the scheduled appointment time. Services may be suspended for clients with outstanding balance, with services resuming promptly after all balances are paid in full. Clients receiving services through EAP programs with Compsych cannot be charged a late cancellation/no-show fee per my contract with Compsych EAP. First Choice Health EAP clients should be aware that failure to show/cancel less than 24 hours for an appointment will result in forfeit of one EAP session for which First Choice Health EAP will reimburse me for. Please do not hesitate to ask for any clarification you need. (\_\_\_\_\_ client initials/date).

## **RISKS OF TREATMENT**

As with any health treatment, there are potential risks and side-effects to mental health therapy. The inherent nature of the therapy process often requires discussing emotional material. So clients do not always leave a session feeling good and will sometimes have to tolerate difficult emotions between sessions. My goal is always to minimize such difficulty for a client. Should you experience any difficulty please let me know so, together, we can address it appropriately. (\_\_\_\_\_ client initials/date).

## **STATE-REQUIRED DISCLOSURE**

Washington State law requires I inform you: "Counselors practicing counseling for a fee must be licensed with the Department of Licensing for the protection of the public health and safety. Licensure of an individual does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment." (\_\_\_\_\_ client initials/date)

## **MY EXPERIENCE, LICENSES, & EDUCATION**

I have 10 years years of professional clinical experience as a Licensed Independent Clinical Social Worker providing individual, family, and group therapy for a wide-array of clients of all age groups experiencing a very broad range of problems.

I am a Licensed Independent Clinical Social Worker in the State of Washington (License No. LW60091324) and also maintain an active clinical social work license in Virginia (License No. 09040065606).

My Master's in Social Work (MSW) degree was conferred in May 2004 by Radford University, Radford, VA. My Bachelor's of Science Degree in Psychology was conferred in May 2002 by Virginia Tech, Blacksburg, VA.

## **FIRST SESSION**

As with all sessions, payment is due in full at the beginning of the session. The first session (fee \$135.00) will be a 45-60 minute intake/assessment session (\_\_\_\_\_ client initials/date). We will discuss what brings you to me and your treatment needs and goals. I will

provide you my initial assessment of how we should proceed in our next session and address whatever questions or concerns you might have about my assessment . We will also go over practical issues of how many future sessions will likely be needed, when to schedule the next sessions, costs of services, etc.

### **FOLLOW-UP SESSIONS**

These will be 45-60 minutes each (fee per session \$125.00) (\_\_\_\_\_ client initials/date). We will work to develop a positive therapeutic rapport so that I can better understand your needs and concerns and work with you to help you learn coping skills for navigating the life situations challenging you and for aiding your overall health and well-being. We will seek to achieve treatment goals as quickly as possible; I want you to feel better as soon as possible--not to just keep you coming back for ever-more sessions.

### **FINAL SESSION**

Once you have met your treatment goals and are experiencing symptom reduction, I recommend a final 45-60 minute session (\$125.00) (\_\_\_\_\_ client initials/date) to discuss the progress you have made, how you can maintain that progress going forward, and signs you should watch for that indicate the need for a “booster session” or further ongoing therapy.

### **OTHER SESSIONS AND SERVICES**

There may be times when it would be more convenient for you for us to have a session via telehealth services (audio-video conferencing through Google Meet) or through brief phone contacts. If you would like to do that please let me know so we can reach agreement on whether I am satisfied that such options will be clinically appropriate and then agree on scheduling, length of session, and payment. Telehealth services are treated and billed as equal to a face-to-face session and many insurers now offer such services as a covered benefit. As plans may vary I encourage you to check with your insurer about your individual plan. A separate telehealth consent form is needed by those patients wishing to use that service and must be provided to me in advance of such services.

Telephone sessions are not a covered benefit and standard self-pay rates apply. Brief phone contact can be a covered benefit and when phone contact meets that standard I will bill you/your insurer accordingly. Telephone contact lasting 15 minutes or less will be complimentary to all patients. Self-pay rates for phone contact is based on my hourly rate (\$125/hour) and pro-rated accordingly. (\_\_\_\_\_ client initials/date)

### **OTHER SERVICES**

I will provide additional assistance related to your treatment as we agree upon such as coordinating with other members of your care team, paperwork completion (e.g., FMLA paperwork), etc. I will charge you for the time I spend providing this assistance at an hourly-rate of \$125.00 (so, for example, if I spend 30 minutes on such tasks I will charge \$62.50). I will require payment in advance (\_\_\_\_\_ client initials/date).

I reserve the right to recommend to you that as a supplement to my treatment you seek additional professional care from other appropriate providers (e.g., appointment with primary care physician, psychiatrist, etc.) and to end my treatment if you refuse. I also reserve the right to refuse requests for any services or referrals that I believe are not clinically indicated.

I do not provide court-ordered treatment. I am unable to provide “on-call” or other such after hours/emergency mental health services. For such services please review the emergency and after hours resources below and on my website at: [www.shiraev-pll.com](http://www.shiraev-pll.com) . (\_\_\_\_\_ client initials/date)

## **AFTER HOURS AND EMERGENCY MENTAL HEALTH CONCERNS**

Crisis Line-King County, WA (206) 461-3222 or 1-800-244-5767

National Suicide Prevention Hotline: 1-800-273-TALK (8255) or use the online chat program to speak with a trained professional at <http://www.suicidepreventionlifeline.org>

Teen Hotline-King County, WA 1-866-833-6546 (1-866-TEENLINK) (6 PM-10 PM) or <http://866teenlink.org>

Dial 911 or go to nearest emergency room or urgent walk-in facility.

Finally, many insurance companies offer nursing advice by phone 24/7. If you have insurance offering such service keep that number at hand.

## **CONFIDENTIALITY**

I maintain the privacy of my clients in accordance with current standards as outlined in the Federal guidelines as stated in the Health Information Portability Accountability Act (HIPAA). Put simply, this generally means for my clients that what is said in session stays in session except in the narrow circumstances described below.

I will provide information about your treatment to another person (such as another care provider) if you give me your written request/permission.

Also, I am required to comply with any lawful court order for information.

I also am legally required to notify the relevant agency if I have concerns about the imminent safety of my client or the public and to report any suspected or known abuse or neglect of a minor or person I suspect is gravely disabled and unable to meet their needs. Relevant agencies include Child Protective Services (CPS), Adult Protective Services (APS) and, in rare cases, local law enforcement or the community mental health provider(CDMHP). Whenever possible, I will discuss with the client any such concerns, but I reserve the right to not discuss those concerns with the client if I believe that would put anyone's safety at risk. This policy is in accordance with standard mandatory reporting laws within the State of Washington.

## **OTHER INFORMATION RELEVANT TO CONFIDENTIALITY**

If and when we communicate via phone or internet such communication will be vulnerable to the same confidentiality risks, if any, incurred by any communication via those technologies.

Like other therapists, I sometimes consult with other therapists or other care providers to help me provide the best care for my clients, but client identifying information is protected and confidentiality rules protecting your privacy bind anyone with whom I consult.

Finally, like many other therapists, I utilize an electronic medical records system through *Practice Fusion* (<http://www.practicefusion.com/>). Information contained in the electronic medical record as managed by Practice Fusion is maintained in compliance with all current HIPAA guidelines. Any information disclosed during a session and relevant to a client's treatment may be entered at my clinical discretion and for purposes of maintaining accurate mental health records of clients with whom I work. You may request to view or obtain a copy of your mental health record (copying/printing fees may apply) and may request addendums to the record be created should you wish to dispute or correct information within your mental health record that I maintain through Practice Fusion. Speak with me directly for support in such matters.

If you would like to obtain a list or copy of the acts of unprofessional conduct listed under RCW 18.130.180 you may contact the Department of Health at the following address and phone numbers: HSQA Complaint Intake, PO Box 47857, Olympia, WA 98504-7857; Phone: (360) 236-4700; E-mail: [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

**CLIENT CONSENT & AGREEMENT**

By signing below I am consenting to treatment with Nicole T. Shiraev, MSW, LICSW, PLLC. I agree to maintain my account in good financial standing and agree to pay all fees for which I am responsible based upon the policies stated above. I am aware of my rights as a client and of the confidentiality and privacy policies as described above and which are in accordance with the laws of the State of Washington and the U.S. Government.

\_\_\_\_\_  
Patient's Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Legal Guardian's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Minor Patient (required for minors between ages 13-17 receiving care)

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date