Soul Care Psychotherapy *~an affiliate of Pacific Pastoral Counseling Service*

Joanna Robinson, M.Div.,M.Ed

Receipt of Disclosure Statement and Office Policies

(*Please initial each section; for couples, both should initial.*)

_____I have read, understood, & agreed to Pastor Joanna Robinson's Welcome Letter/Disclosure Statement and Office Policies statement. These documents informed me of her counseling ministry's orientation and her approach to counseling, her education and training, her professional certification, and my rights as a client. They also acquainted me with policies regarding fees, cancellation and rescheduling, and how to contact her. I understand I may request copies of these documents, if desired.

_____I understand that, as an ordained minister Pastor Robinson views all information and communication regarding my counseling as private, confidential, and confessional in nature. I understand that it will not be disclosed to anyone outside of Pastor Robinson's office, with very limited exceptions (see Disclosure Statement). Any other disclosures must be jointly agreed upon by me and Pastor Robinson, and any such exceptions will always be made in a way that protects and preserves the confessional and confidential nature of my therapy process.

_____I understand that the regular fee for a 50-55-minute counseling session is $160.

For Clients Receiving Fee Adjustments:

_____I understand that sometimes fee adjustments may be available, depending on various factors, chiefly my family income. We have discussed my financial situation, and I agree to pay $____per session, with the remaining $_____being written off as an adjustment to my account. ***I also understand that I am responsible to pay my regular fee for any missed sessions, or for sessions cancelled with less than a full 24 hours' notice***

For Clients Planning to Seek Reimbursement from Insurance:

_____I understand that Joanna Robinson is not contracted with any insurance companies. I understand that I will need to pay for my therapy at each session, and that my insurance *may* pay for part of the cost, if I choose to seek reimbursement. I understand that I will need to check with my insurance to see if I have out-of-network benefits, and to determine the process for submitting claims for reimbursement to my insurance company myself. ***I also understand that insurance companies do not pay for missed sessions, or for late cancellations.***

_____***I understand that Pastor Joanna Robinson, M.Div., M.Ed. will never disclose the fact that she sees me, or the content of our therapeutic work, to any court of law or attorney, unless her professional conduct is at issue, or unless required by law. I understand that if my need for therapy includes having a therapist who will share information in court, or with an attorney, I should seek another therapist.***

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(Continued on Page 2)

_____ **I understand Joanna Robinson's Cancellation Policy: If I am unable to keep an appointment, I realize a minimum of a full 24 hours notice by telephone/voicemail is required, or I will be responsible to pay the full session fee** (for example, if my appointment is at 1 pm Wednesday, I will need to cancel **before** 1pm Tuesday). I understand that, unlike a medical office, she does not over-book her daily schedule, and that my appointment time has been reserved exclusively for me.

_____ **Length of Appointments:** I understand that counseling appointments last 50-55 minutes starting from the scheduled time of the appointment, unless other arrangements have been made, and that because each hour is reserved for one particular client, appointments cannot be extended if I am late.

_____ **Electronic Communication:** I understand the following regarding the privacy and security of email and any other electronic communication with my therapist:

- While standard security and privacy practices have been implemented, Joanna Robinson and Soul Care Psychotherapy are unable to provide a 100% guarantee of the security and confidentiality of email communication.
- I understand that Joanna Robinson's policy is to use email with clients only 1)to communicate basic information that is non-urgent or non-emergent; and 2)to communicate with clients in a manner that is minimally personal and minimally identifiable. I understand that if I choose to use email for scheduling or for any other purposes, I am agreeing to accept these limitations on security and privacy.
- **I understand that Joanna Robinson and Soul Care Psychotherapy provide the option of using an encrypted email system, which I may access with a password received from my therapist. Encrypted email provides greater security, and if I'm interested I will ask my therapist for instructions and the password.**

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Guardian Signature if Client is a Minor Date

_____ _____
Pastoral Counselor's Signature Date

Request for Minimal Records: By signing below I am requesting that my psychotherapy records be kept to the minimum administrative records necessary for my work in therapy, in order to most fully protect my privacy. I understand that the only records kept would be an intake sheet, therapist's calendar, records of my account, and very limited notation regarding the administration of my work.

Signed: _____ Date: _____

Guardian (If under 18): _____ Date: _____