Eric G. Huffman, MSW, LICSW

Licensed Independent Clinical Social Worker
State of Washington LW00007638
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425.361.2511

Personal Disclosure Statement and Informed Consent for Treatment

Washington State Law requires that I provide a written disclosure statement to each client prior to starting a program of treatment. This document provides important information about my professional services, business policies, education, psychotherapy approach as well as policies with regard to confidentiality, privacy, scheduling, fees and cancellations. Please read it carefully and write down any questions you may have so that we can discuss them at our next meeting. When you sign this document it will represent an agreement between us.

Education and Experience

I received a B.A in History and a B.A in Classical Studies from the University of Washington. In 1997 I received my Master of Social Work (MSW) and have been licensed as a Licensed Independent Clinical Social Worker (LICSW) since 2003. I am also an approved supervisor for therapists seeking licensure in Washington State. I have received specialized training in Time Effective Therapies and Clinical Theory and Practice, and am currently in the Adult Psychoanalytic Psychotherapy Program at the Seattle Psychoanalytic Society and Institute. I have extensive experience providing therapy in the prison system as well as in residential treatment, inpatient and outpatient facilities. I developed and taught a course on Addictions and Mental Illness in Corrections for the University of Washington Tacoma Campus-Department of Social Work. I have also authored two book chapters and a peer reviewed journal article on providing psychotherapy in a prison setting.

My treatment philosophy

I believe we have a healthy core that wants us to be able to play, work and love. It is this healthy core that lets us know something is wrong, that we are not happy or that there must be more to life. Our healthy core is full of hope. I believe that therapeutic change occurs through a supportive, trusting relationship in which the clients' strengths are drawn out and highlighted. Within this relationship, I work to empower clients to develop awareness of themselves, their ways of relating, and their unique coping skills in the face of stress and change. My training is primarily psychodynamic. Increasing awareness of thoughts and feelings that occur within and

outside our conscious awareness is the focus of psychodynamic therapy. However, I also draw heavily on cognitive behavioral, developmental and problem solving approaches. I help people learn to listen to and understand themselves in the way that I try to listen to and understand them. My focus is on the relationship people have with themselves, as well as the relationships they have with others. I find that discovering and sharing humor in therapy is an important element of growth. My goal is to help you find the life you want and to support you in the transition.

FEE INFORMATION AND PAYMENT POLICIES

I provide a free fifteen minute phone consultation to decide if we should meet and what scheduling issues may be involved.
Sessions last for 45-60 minutes depending on possible insurance coverage restrictions.
My fee is $135 per session. I am sometimes able to offer a sliding scale.
I prefer cash or checks but also accept Visa, MasterCard, American Express and Debit cards.
Payment by private pay clients or for out of network clients is due at the end of the session. For out of network clients, I will provide documentation you can submit to your insurance company for reimbursement; please confirm your insurance company's reimbursement policy with the company.
To begin treatment, we will meet for an assessment period, which typically extends over three sessions. During the assessment I will gather information on your situation and the help you are seeking. At the conclusion of the assessment I will make a recommendation for services. If I am not able to offer you the most appropriate service, I will refer you to another service provider.
Many insurance policies will reimburse you for some portion of my services as an out of network provider. The insurance companies are often changing policies and eligibility and I may not currently be a Preferred Provider for your insurance; it is always helpful to check with me. My decision to remain out of network with some companies is a further assurance of your privacy.

APPOINTMENTS

We will agree on specific appointment times, reserved exclusively for our sessions together. Our mutual protection of this time is important in order to preserve the integrity of our ongoing work. I will give you notice well in advance of my vacation time whenever possible, usually at least 4 weeks. Please provide me a minimum of 2 weeks notice about your vacations so that you will not be charged for missed appointments. I do not charge for occasional missed appointments when I am given at least **48 hours notice**. If you are too sick to come, this policy may be waived. <u>You are responsible for the full cost of the full session cancelled before 48 hours</u>. I do charge for my time in all other instances where you miss your appointment. If

appointments are missed for any reason with such frequency that it interferes with the integrity of our work this policy will be reexamined.

CONFIDENTIALITY

I am bound by my professional ethics to protect client rights to confidential communications in regard to their involvement in psychotherapy. For this reason, if you wish me to release information about your participation in therapy to anyone, I will require a signed "Release of Information" from you. This confidentiality has the following exceptions as provided by law:

1. In the event of a medical emergency, emergency personnel or service providers may be given necessary information.
2. In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made.
3. In the event of suspected child, elder or vulnerable adult abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.

A fuller description of privacy and confidentiality practices will be provided to you when we meet and is available on my website.

Revised 3/1/2016

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Receipt of Personal Disclosure Statement and Informed Consent for Treatment

I have received a copy of the Personal Disclosure Statement and Informed Consent for Treatment. I have had the opportunity to read and review it, and I understand the contents. By signing below I acknowledge receipt of the Personal Disclosure Statement and Informed Consent for Treatment.

Signature of client:_____Date:_____

Printed Name of client:_____