

**Leslie Johannes, MEd, LMFT, Jungian Psychotherapist**  
**Personal and Relationship Therapy**

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425-452-9767

**CLIENT-THERAPIST AGREEMENT**

**Client Rights and Responsibilities**

Psychotherapy provides a safe environment in which a person may clarify issues, identify feelings and increase awareness and understanding of self. You have the right to choose a therapist who best suits your needs and purposes. You have the right to be treated with respect. You have the right to privacy. You have the right, as well as the responsibility, to ask questions about your therapy and to participate in developing the goals of your therapy. It is important that any preferences, concerns or issues that arise regarding your therapy be brought into the therapeutic conversation to optimize the benefit to you. Your personal growth and the rate at which you make the desired changes in your life are your responsibility. It is important to understand that participation in therapy is not an assurance that desired outcomes will be realized.

**Therapist Responsibilities**

It is my responsibility to provide a safe and confidential setting for you to explore and expand your understandings of your life and relationships. It is also my responsibility to provide you with service that is professional and respectful of you, including your values, beliefs, life experiences and relationships. You will find that as a part of the therapeutic process your beliefs, perceptions and behaviors may be challenged as a matter of course.

**Confidentiality**

Therapeutic conversations are confidential and will be disclosed only with your written consent, except for confidential consultation with other clinicians. **Disclosures required or permitted by law** include, but are not limited to: **1) court ordered** information, records or testimony; **2) mandatory reporting** of suspected **abuse, neglect or exploitation; 3) threat of serious bodily injury or threat to any person's life.** **Other exceptions to confidentiality** occur when you choose to **1) use a cell phone or email** to communicate with your therapist or **2) use** reimbursement systems provided by your **insurance** company. Since insurance companies routinely require disclosure of a diagnosis, dates and types of service for reimbursement and may conduct an audit of a client's record, complete confidentiality cannot be assured when you choose to use insurance benefits.

**Records**

I keep written records of our sessions. You may make a request in writing that information about your therapy be shared with another professional. I will not disclose your record to others unless you direct me to do so or the law authorizes or compels me to do so.

**NOTE:** If you are planning to participate in family or couples therapy, it is important to note that **any participant in the therapy or legal guardian of a child engaged in therapy may request records or have records subpoenaed for court actions. Such legal scrutiny runs counter to the therapeutic process and is seriously advised against by this therapist.**

**Appointments**

Therapy services are by appointment only. You may schedule a 50 minute or 75 minute session. The fee for the initial meeting includes time beyond the session for assessment and will be charged at the 75 minute rate. It is important to conclude sessions in a timely manner, even when material remains to be addressed. You may leave messages for me anytime day or night. I pick up messages regularly and your call will be returned at the earliest opportunity. In the event of an emergency, you are advised to call either 911 or the Crisis Line at 206-461-3222 for immediate assistance.

In the case of **couples therapy**, it is important that sessions include both partners, unless an alternate plan has been jointly agreed upon or established by the therapist. I reserve the right to cancel the session if either partner does not attend as planned, in which case the full fee will be charged.

**Fee Agreement**

- I understand that my fee for therapy is \$125 for a 50 minute session, \$185 for a 75 minute or initial session. I agree to pay the fee or designated co-payment in full at each session. If fee increases are instituted, they will take effect in January.
- I agree to give 24 hours notice when canceling an appointment and I understand that in the absence of providing this notice, the full fee will be charged.
- I understand that brief telephone calls, up to 10 minutes, are not billed; however, telephone conversations or email exchanges taking longer than 10 minutes will be billed at the hourly rate.
- I understand that I am responsible for the full fee, even if I have insurance that I am relying on to cover the cost of the therapy. I agree to pay in a timely manner any amounts not paid by my insurance company.
- I understand that I may request an itemized bill to submit for insurance benefits in the event that my therapist is an out-of-network provider with my insurance company.
- I understand that any unpaid balances that are 60 days past due will be assessed with interest for each month thereafter.

**My signature indicates:** 1) my agreement to these terms and 2) that I have received a copy of the Therapist’s Disclosure Statement, this Client-Therapist Agreement, the brochure, “Counseling or Hypnotherapy Clients” as well as “RCW 18.130.180 Unprofessional Conduct”, including the addresses and phone numbers for the Department of Health Counselors Program, where I may direct questions or concerns.

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Client Signature Date

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent Signature (parent with medical decision-making rights) Date

\_\_\_\_\_  
Leslie Johannes, MEd, LMFT Date