Inner Refuge Counseling

Lyn-Maria Boxill, M.A.C.P., LMHCA
Inner Refuge Counseling
1700 7th Ave.
Suite 2100
Seattle, WA 98101

Therapist-Client Service Agreement

About Me

I am a licensed mental health counselor associate (MC 60987850) in Seattle, Washington. I am a graduate of the Master of Counseling Psychology program at Northwest University in Kenmore, Washington with experience in trauma informed counseling in both a residential facility and a government orphanage located in Botswana. I utilize a flexible narrative approach that incorporates elements of CBT, Lifespan Integration, Person-Centered, Strengths-Based, and various forms of Art and Play therapies. My focus is on establishing a safe environment in which individual adults and adolescents can feel safe and secure as they approach and address various life challenges and trauma. I also work with adult individual and adolescents on understanding, confronting, and working through various social justice concerns.

The First Few Meetings

The first few meetings are an opportunity for us to get to know each other and explore how we might journey together. During this time, I will want to evaluate your needs in order to get a better sense of how I may be of help. As we talk, I will also be able to offer you some first impressions of what our work might include. You should consider this information along with your own impressions to decide if you want to continue our journey together. Therapy involves a commitment of time, energy, and money so it is important for you to choose a counselor with whom you feel comfortable. You have the right to refuse treatment and a responsibility to choose the provider and treatment modality which best fits you and or your adolescent's needs. If at any point you have any questions about me or about a modality used, please let me know so that we can discuss them together. If your doubt persists, we can review alternatives with myself and my supervisor to identify a treatment model or setting that best accommodates your need (this may include referral).

Consultation

I will need to consult with my licensed supervisor, D.J. Burr, MA, LMHC, S-PSB on a bi-weekly basis to be in compliance with the WA-State Department of Health requirements for LMHCAs. I may also need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Please know, information about you may be shared in this context without using your name.

Appointments and Cancellation Policy

My initial consultations are 90 mins; regular visits are 50 minutes. This can vary if needed, however, please plan to be in session for the full time unless otherwise arranged. You are responsible for arriving on time for your appointment. If you are running late for a session, please

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notify me immediately. Note, your appointment will only be held for 15 minutes. After the 15 minutes, you will be required to reschedule your appointment, and will be charged the full fee for late cancellation/no-show. If you need to cancel an appointment for any reason, you are required to provide a minimum of 48 hours advance notice. You will be responsible for the entire fee if cancellation is less than 48 hrs. A scheduled appointment means that time is reserved for you. If an appointment is canceled with more than 48 hours notice, it can be rescheduled within the same week, pending schedule availability . If that is not possible, or for any other missed appointments, I will charge the full $150 fee.

Fees and Insurance

You are responsible for paying for your session at the beginning of each session. My fee for an initial consultation is $200 for new clients. My fee for each subsequent 50 minute appointment is $150.

Acceptable forms of payment are debit or credit card (Master/Visa) only.

Contacting me

I can be reached by phone at (206) 503-2107. I may not be immediately available to receive calls however; I do check voicemail frequently and will try to return your call within 24-48 hours. Please know, I do not answer calls after 8 p.m. In the event of an emergency please contact 911, any local emergency room, Seattle Crisis Hotline at 844-549-4266, or the Nation Suicide Prevention Lifeline at 800-273-8255. You may also contact me by email at mboxill@innerrefuge.com.

Social Media and Telecommunication

Confidentiality of you the client and of that which is present within the realms of our therapeutic alliance is of the utmost importance. In attempt to minimize dual relationships and uphold my commitment to confidentiality, I do not accept friend or contact request from current or former clients on any social networking sit (Facebook, Instagram, LinkedIn, etc). It is my belief that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. Similarly, if we cross paths in public, I will not acknowledge you. Please know, if you do choose to approach me, this is acceptable, however, it is my expectation that there be no mention of discussions had in the therapeutic setting. Crossing the above boundaries have a great potential to blur the safety established within the therapeutic relationship. If you have any questions regarding this or any part of the policy, please bring them up when we meet and we can talk more about it.

Electronic Communication

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. Although I will make every effort to respond to messages in timely manner, I cannot guarantee immediate response and request that you do not use these methods of

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communication to discuss therapeutic content and/or request assistance for emergencies.

Communication in Public

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you do choose to acknowledge me first, I will be more than happy to speak briefly with you. Please know, I will not engage in any conversation about topics discussed in the therapeutic setting and will prefer not to engage in lengthy discussions that potentially reveal the parameters of our therapeutic alliance.

Limits of Confidentiality

The law protects the privacy of all communications between a client and a counselor. In most situation, I can only release information about you and/or your adolescent's treatment to others if you sign a written authorization form. However, in certain situations, I am legally obligated to take actions in order to protect you and/or your child or other from harm.

- If I have reasonable cause to believe a child under the age of 18 has suffered abuse or neglect, I am legally mandated to make a report to the proper law enforcement agency or to the state department of social and health services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult is being abandoned, abused, financially exploited or neglected, I am legally mandated to make a report to the proper law enforcement agency or to the state department of social and health services. Once such a report is filed, I may be required to provide additional information.
- If I believe that you present a clear, imminent risk of serious harm to yourself, I may be required to disclose information in order to take protective actions. These actions may include contacting family members or others (pre-determined and documented by you) who can assist in protecting you / or seeking your hospitalization.
- If you have made a specific threat of violence against another or if I believe that you present a clear, imminent risk of serious physical harm to another, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking your hospitalization.

Further, the law allows the release of confidential information without your authorization in the following situations: a) to a person who I believe is providing healthcare to my identified client, b) to any healthcare provider who I believe has previously provided my identified client healthcare to the extent necessary for me to provide healthcare to you and/or your child, unless you instruct me in writing not to make such disclosure, and finally c) to an immediate family member or any other individual with whom you have a close personal relationship if the disclosure is appropriate within good professional practice, unless you instruct me in writing not to make the disclosure. If you are under the age of 13, I may have to share information with your legal guardian about what we discuss in therapy or during an evaluation. I will act in your best interest when disclosing

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information to your legal guardian. If any of these situations arise, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary. If you have any questions that I haven't addressed either in this document or with you personally, please feel free to ask me for clarification at any time. I look forward to working with you.

Termination

Ending relationships can be very difficult. Therefore, it is extremely important to have a termination process in place as we work together to achieve some closure. Length of termination depends on the length and intensity of treatment. I may terminate treatment after appropriate discussion with you if I determine that therapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of the termination. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists for continued treatment. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless advance arrangements have been made, for legal and ethical reasons, I must consider the professional relationship discontinued. Any outstanding payments need to be settled at this time.

Agreement for Counseling Services

Client's Name: _____ Date of Birth: _____

The Health Insurance Portability and Accountability Act (HIPAA), requires that you sign this "Agreement for Counseling Services" and that I have provided you with a copy of my "Notice of Information Practices." This policy further explains HIPAA and the protection of your personal health information. Your signature represents an agreement between us. You can revoke this Agreement in writing at any time.

I hereby acknowledge that I have received and have been given an opportunity to read copies of

1. Lyn-Maria Boxill, M.A.C.P., LMHCA's Notice of Information Practices
2. The Therapist-Client Services Agreement

I understand that if I have any questions regarding these policies or my privacy rights, I can address them with LMHCA Boxill.

I, _____ , authorize and request that my therapist, LMHCA, Lyn-Maria Boxill, provide counseling services including mental health assessment, interventions and/or

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diagnostic procedures that now or during the course of my care are advisable. The frequency and type of assessment will be decided between the client and the therapist.

Client Signature: _____ Date: _____

LMHCA, Lyn-Maria Boxill: _____ Date: _____