LESLIE TAYLOR
Graduate Student
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Dear Client,
I am deeply honored to have the opportunity to work with you on your journey of mental health wellbeing. I see my role as a guide for you on this journey, helping to cultivate the space for you to do the necessary work to access the inner resources and deeper wisdom that will lead you to health & happiness. Please read carefully and sign the consent form acknowledging you have read and understand the content. If, for any reason, you are not comfortable reading this document or are unable to, I would be happy to walk through it with you, even reading it aloud, if you prefer.

Professional Qualifications:
I received my Bachelor of Science in psychology from Washington State University and Master of Education from the University of Washington. I am currently a third-year graduate student at Wake Forest University working towards obtaining a Master of Clinical Mental Health Counseling. I have additional training in telehealth.

Therapeutic Orientation:
The Clinical Mental Health Counseling program at Wake Forest University emphasizes integrating systems and psychological theories, moral and ethical values, and clinical experience to heal and empower diverse relationships and individuals in all cultural locations. My experience is grounded in a belief that every individual is intrinsically worthy. I work with individuals to develop positive tools and resources to help improve their relational and individual wellbeing. With training rooted in family systems theory, I aim to address the needs of individuals in the context of family, social and cultural systems while working from a strength-based perspective. I empower clients to develop customized treatment goals that fit their needs and move them towards their goals. I am sensitive to issues of diversity related to religion, race, socio-economic status, sexual orientation, and gender identity.

Informed Consent for Therapy

Client Responsibilities:
Therapy success is highly dependent on the client's own acceptance, motivation, and drive for change. I will make the commitment to help you identify attainable goals, but it is your effort and participation in therapy that will allow you to achieve them. You have the responsibility to take an active role in the counseling process. Setbacks and impasses may occur periodically, but I am hopeful that personal growth can occur if communication and trust is shared between me and my clients. Overall, I want to work as a team to provide the best therapeutic experience possible.

State Regulations:
Equilibrium has contracted No Stress No Stigma aka nsns.systems. Both are registered in the State of Washington. By engaging with Equilibrium /NSNS you understand that the business and services provided are licensed in the state of Washington unless otherwise noted in the beginning of your session. Our policies and procedures comply with applicable state regulations.

Equilibrium via NSNS and your provider hold responsibility only to the state in which they reside in and are licensed in and cannot be held accountable for any rules or regulations of other states outside of their licensure and residence. By engaging with Leslie Taylor, you understand that the services provided are licensed in the state of Washington unless otherwise noted in the beginning of your session.

You agree to the terms and conditions of the State of Washington and the services provided within this state. You agree and understand that the service you are receiving is licensed therapy within this state. **If you reside outside of Washington State, you understand that it is not licensed services, but rather a confidential consultation or life coaching session.**

Equilibrium via NSNS holds responsibility only to the state in which they reside and is licensed in and cannot be held accountable for any rules or regulations of other states outside of their licensure and residence.

I understand that I am receiving services at my own risk and hereby release my provider and Equilibrium via NSNS from any legal ramifications should I injure myself in any way including but not limited to physical, emotional, mental, or psychological distress or injury.

Confidentiality:
The privacy of your personal information is very important to me. I will not break confidentiality unless you request this of me, or the law requires me to do so. If you have questions regarding any of the following information, I would be happy to discuss these with you in session.
Examples of possible disclosures include:

1. When there is reason to suspect the abuse of a child, disabled person, or vulnerable adult.
2. When a person appears to be in imminent danger to him or herself.
3. When a person has threatened to harm another person.

In these instances, I am required to make a report to the appropriate authorities. In addition, the courts may subpoena treatment records in certain circumstances. Any type of release of confidential information will be discussed with you beforehand. I am compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights regarding personal health care information. In accordance with RCW 71.34.530: Any minor **thirteen years or older** may request and receive confidential outpatient mental health treatment without the consent of the minor's parent, based on my discretion.

Your therapist may make a diagnosis that documents the medical necessity of your treatment. Your therapist may also make periodic treatment plans which document that treatment is being provided according to medical necessity. This information may be requested by other health professionals or insurance companies. This information is confidential unless you give written permission to allow me to release this information.

I consult with various experts in specific fields of mental health so that I can better serve my clients. I also participate in regular group supervision and consultation who may observe cases or sessions. If I consult on my work with you, I will not use your name or any information that can identify you. If there is any reason to believe you might know one of these professionals, I will tell you their name, so you have the option to request I do not consult with them regarding your care. You also have the option to request that pre licensed individuals/student interns are not included in your session or case discussion at any time.

“No Secrets” policy in Couples Counseling:
When I agree to work with a couple, I consider that couple to be the client. During our work, I may see one of you for individual sessions. These sessions should be seen by you as part of the work that I am doing with the couple, unless otherwise indicated. If I am to be effective, I may need to share information learned in an individual session with the couple. I will use my best judgment as to whether, when, and to what extent I will make such disclosures to the couple and will also give the individual the opportunity to make the disclosure first. Leslie Taylor will not be held to the limits of confidentiality within the couple/family unit parameter and will not serve or be expected to serve as a secret keeper.

Record Keeping:
Brief notes of our sessions are included in the therapy process. The law mandates that you have access to your treatment records. Under the provision of the Health Care Act of 1992, you may request your file be made available to another health care provider. I will not disclose your records to others unless directed by you, or unless the law authorizes or compels me to do so. I am also required to keep records of our sessions for seven years, unless otherwise requested by you. I maintain all session records in a secure location.

Problems:
Therapy is the Greek word meaning *to heal*. Often growth cannot occur until past issues are discussed and confronted, sometimes causing distressing feelings such as sadness and anxiety. It is important for you to discuss any questions or concerns you may have with me as they arise in session.

Termination of Therapy:
Your voluntary involvement allows you to discontinue therapy at any time. If I feel you are no longer benefiting from therapy or feel there is a conflict in values, I may discuss possible termination. I ask that you discuss your intent to terminate in advance. You can be assured that I will respect your decision to proceed as you determine what is best for you. In most cases, goals will be identified, progress monitored, and therapy jointly terminated when your objectives are met. You are free to consult with me or resume therapy later.

Supervision/Consultation
My internship is supervised primarily by Cory Wilson of Equilibrium, LLC & Amanda Rausch, LMFT at Amanda Rausch LMFT, LLC. They are both licensed marriage and family therapists in the state of Washington. I consult with both Cory and Amanda and other professionals in group supervision regarding the therapeutic services I provide clients. These consultations are obtained in such a way that confidentiality is maintained. If you have any concerns or questions people, contact Cory Wilson at (206) 351-0079 corymwilson@gmail.com or Amanda Rausch at (206) 462-5830 or amandarauschmft@gmail.com.

Fees:
Payment is based on what you can afford per 50-minute session. These services are for individuals who do not have adequate mental health coverage or no insurance at all.

Appointments and Cancellations:
Appointments are made by emailing me. Once an appointment time is agreed upon, that time will be held exclusively for you. Please call to cancel or reschedule **at least 24 hours** in advance, or you may be charged for the missed appointment or late cancellation. After ten minutes of a no show, your entire appointment will be used and must be rescheduled. You will be responsible for the cost of that session. It is important to end sessions with a plan. If I do not hear from you within 3 days of a canceled session, a close out email will be sent to you with a date that your file is deemed inactive.

Emergencies:
If you experience an emergency and cannot reach me, call one of the following numbers or go to your designated hospital emergency room.
General emergencies: 911 or 988
National Suicide Prevention Lifeline 1-800-273-TALK (8255)
Text Crisis Line: 741741

Creating a Safe Environment for Sessions
For safety reasons, I am not permitted to continue with a session if clients are actively driving their vehicle at the time of session. Clients will need to have their vehicle parked in a safe location or forfeit their session and be asked to schedule another time. Clients will be charged the full cost of the forfeited session.

Similarly, we cannot see clients who are under the influence of non-prescribed medications, drugs and/or alcohol. Session will be canceled immediately if your therapist observes or suspects any substance use, including alcohol. Canceled sessions will be charged the full session rate.

Additional:
I/We understand that my provider does not make custody recommendations nor legal or court recommendations nor determine an individual's fitness to be a parent. I/We understand that my provider can only provide verification that I/We are attending counseling and participating in the process. I/We understand the records are confidential unless a signed release of information or a court order allows the release of the records. I/We understand that there are additional state laws and ethical issues that govern the release of information to you or to certain parties. I/We understand that any relevant laws or issues will be explained along with the process for challenging these laws or issues.

Informed Consent Agreement

My signature below indicates that I have been provided a copy of the Informed Consent for Therapy Agreement. I have read and understand the information presented in this form. I agree to the stated terms and consent to therapy and/or consultation with Leslie Taylor and Equilibrium via NSNS.

Client Name (Please print): _____

Client Signature (Please sign): _____

Date:

Parent Guardian Name if Child is under 13: _____
**Please note ages 13-17 must consent for own treatment*

Childs Name (please print): _____

Signature of Parent/Guardian: _____

Date:

Telehealth Consent Form

SPECIFICS FOR ONLINE COUNSELING: By booking an appointment with Leslie Taylor and signing this consent, you are providing informed consent to the terms and conditions stated here:
You acknowledge that you understand the nature of online counseling services as well as the duties, qualifications, and limitations of Leslie Taylor and that Leslie Taylor has provided you with this information prior to providing you with any professional services. Also known as Telepractice, Cyberpsychology, Text-Based Therapy, Telehealth, Behavioral Telehealth, and Online Therapy. Distance counseling is providing a psychotherapy service that is not "in person" and is facilitated through the use of technology. Such technology may include, but is not limited to, telephone, telefax, email, internet, or videoconference. Disadvantages include varying time zones, cultural differences, language barriers, and strength of internet connection, which may impact the delivery of services. Clients may provide off-line contact information in case of a technology breakdown, or if reconnection is not possible.

If you have any history of major psychiatric episodes, suicidal attempts or thoughts, hospitalizations, hallucinations or drug/alcohol dependence or have been diagnosed as any of the following disorders that include but are not limited to –Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type 1, Mentally Ill/Chemically Addicted (MICA), and/or Schizophrenia - you must disclose this information and understand that you will not be able to work with Leslie Taylor and you will be referred out to in person treatment.
Leslie Taylor reserves the right to terminate membership to any user found ineligible for services and may refuse all current or future use at any time.

I hereby consent to engage in teletherapy (e.g., internet or telephone-based therapy) with Leslie Taylor as a venue for my psychotherapy treatment. I understand that this includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.
The telehealth services Leslie Taylor uses are “VSee” and “Zoom Professional,” which are the safest and easiest client/provider networks. All data is encrypted, your sessions are anonymous, and none of your information is stored. The service adheres to HIPAA, PIPEDA, and GDPR data privacy requirements.
I understand I have the following rights under this agreement:

(1) I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.
(2) There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
(3) Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
(4) I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
(5) In addition, I understand that Telehealth treatment is different from in-person therapy and the benefits of

teletherapy may include but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing notice to my provider.

Signature: _____

Date: _____

VIDEO AND AUDIO RECORDING RELEASE

As an additional support for your counseling process, I occasionally may use the video footage or audio recording to receive consultation from other health care professionals that I consult with. This may occur during time of treatment or thereafter for purposes of peer review, education, and quality assurance. During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission, and it will be deleted when it is no longer needed for these purposes.

Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems always to ensure maximum confidentiality.

I hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.

In no way will the refusal to grant consent for this video or audio recording effect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect.

Client's Name: _____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature*: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

** Required for clients aged 12 and under.*

HIPAA COMPLIANCE

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical Records - Health Care Access and Disclosure." Please review it carefully. We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

- *Protected health information* means individually identifiable health information:
  Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- In Washington State, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose (RCW 70.02.030(6)). Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

Client Name:_____

Signature:_____Date:_____

Resources

- In an emergency call **911**
- National Suicide Prevention Lifeline- **1-800-273-8255**
    - Open 24/7
    - All calls are confidential
- Text the Crisis Text Line **"HELLO" to 741741**
- Snohomish Country Crisis Line- 1-800-584-3578
    - Crisis Services and Commitment Services are available 24/7 to anyone in the North Sound Region.
- Washington Recovery Hotline- **866-789-1511**
    - 24-hour help for substance abuse, problem gambling and mental health
- The Trevor Project- **1-866-488-7386**.
    - An LGBT crisis intervention and suicide prevention hotline
    - Open 24/7
- Trans Lifeline- **877-565-8860**
    - Crisis and Suicide prevention for the Transgender community
    - Open 24/7
- National Teen Dating Abuse Helpline- **1-866-331-9474**
    - If you're under 21, you can call Teen Link and ask to talk to a peer. The phone line is open 6 p.m.– 10 p.m. and chat is available 6 p.m. – 9:30 p.m. daily.
- SAMHSA Treatment Referral Hotline (Substance Abuse)- **1-800-662-HELP (4357)**
- RAINN National Sexual Assault Hotline- **1-800-656-HOPE (4673)**
- To speak to a crisis counselor in Spanish, call **1-888-628-9454**.

Also visit your:

- Primary care provider
- Local psychiatric hospital
- Local walk-in clinic
- Local emergency department
- Local urgent care center

Apps

Suicide Prevention Apps – There are several Apps available on a smart telephone device. They will help you recognize warning signs, build a safety plan, and give practical advise on how to intervene with an at-risk person. The apps provide you with resources on suicide prevention information, breathing exercises and grounding techniques, and some helpful dos and don'ts when reaching out to a potentially suicidal love one.

Other apps to improve self-care:

- Calm Harm provides tasks to help you resist or manage the urge to self-harm, including cutting. If you want to you can set a password so that it's completely private.
- Stop, Breathe & Think - Meditation & mindfulness to help you build the emotional strength and confidence to handle life's ups and downs. It has a unique approach that allows you to check in with your emotions, and then recommends short, guided meditations, yoga, and acupressure videos, tuned to how you feel.
- Headspace offers guided meditations, animations, articles, and videos.

NO STRESS NO STIGMA GOOD FAITH ESTIMATE

Provider Name: Leslie Taylor	Supervised by License/#: Cory Wilson, LMFT #60682772 Amanda Rausch, LMFT PLLC #60461063
Provider Address: 3614B California Ave SW, Seattle, WA 98116	
Provider Tax ID# (if applicable): N/A	Provider NPI # (if applicable): N/A

Patient Name:	Patient Date of Birth:
Patient Address:	
Services Requested:	Date of Initial Session (if applicable):

In pursuant to the No Surprises Act, you are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $80. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of $80 per visit, if you attend one psychotherapy visit per week, your estimated charge would be $299 for four visits provided over the course of one month. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment. Please see attached Fee Sheet for additional fees and details. All billing is upfront, you will not be charged any additional fees after service.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate January 1st, 2024

Client Information Sheet

Name: _____ Birthday _____

Age: _____ Pronouns_____

Address: _____

City: _____ State:_____ Country:_____ Zip:
Must be a physical residence, not P.O. Box

Email Address: _____

Phone: Home: _____ Cell: _____

Emergency Contact: _____ Phone: _____

How Did You Hear About These Services?

_____

_____

Religion/Spirituality: _____ Race/Ethnicity: _____

Gender: _____

Sexual Orientation: _____

Relationship Status:_____

Where do you currently work? How long have you been working for your current employer?

If you are living with someone, who are you living with? How long have you lived at your current residence?

What are the main problems that are causing you to seek treatment at this time?

What kinds of symptoms are you having?

On a scale of 0-10, 1 is the best and 10 is the worst, rate the severity of your problem:

When did your problems begin? Date or life event (ex: divorce, loss of a loved one).

What is the approximate number of caffeinated beverages that you consume each day?

What is the approximate number of alcoholic drinks that you consume each week?

Do you use any other drugs such as tobacco? *If yes*, please indicate what drugs and how frequently. *If no*, please write N/A or No.

Have you ever been hospitalized for any emotional or psychiatric reason?
If yes, please include dates of hospitalization, reason for hospitalization:

If yes, was the hospitalization helpful?

Have you ever received therapy before? Yes No

If yes, please include dates of treatment, the name of the primary clinician, reason for the treatment, and reason for termination.

Are you aware of any current diagnoses? If so, please list in the space provided.

Are you taking any psychiatric medication (ex: anti-depressants)? Yes No

If yes, please fill in the table below:

Medication #1:	Dosage:	Frequency:	Name of Prescriber:
Medication #2:	Dosage:	Frequency:	Name of Prescriber:
Medication #3:	Dosage:	Frequency:	Name of Prescriber:

Have you ever made a suicide attempt? Yes No

If yes, please indicate the following:

-How many times you have made a suicide attempt?

-What is the approximate date of your last attempt?

-What did you do to hurt yourself?

-Were you hospitalized as a result of your suicide attempts? Yes No N/A

-Do you have any current thoughts of harm to self or to others? Yes No

Is there anything else you want me to know before we begin therapy?

Fee Policy Disclosure and Consent Form

1. *Session Prices:* Prices per session can be found on our website. Please note that pricing per session is at the discretion of each therapist.
2. *Superbill and Release of Record Requests:* $28 (Subject to additional copy fees of no more than $1.24 per page for the first 30 pages and no more than $1.94 per page for all other pages. If the provider personally edits confidential information from the record, as required by the statute, the provider can charge the usual fee for a basic office visit.)
3. *Submission of claims for client via 3rd party platform:* $28 per month plus no more than a 5% transaction fee.
4. *Letter from Mental Health Professional:* $160
5. *Requests for Clinician to Complete Specific Paperwork:* $28 per page or the provider may charge the usual fee for a basic office visit.
6. *Professional Consult with Other Care Provider:* The provider can charge the usual fee for a basic office visit.

By signing your name below, you confirm that you understand the above policies regarding fees.

Signature:_____ Date:_____