Shane Patrick
COUNSELING

Dr. Shane Patrick, D.Min, Th.M, MA, LMHC
Professional Counseling for Individuals and Couples
≫ 10116 Main St., Suite 204, Bothell, WA 98011
≫ 16000 Bothell Everett Highway Ste. 200, Mill Creek, WA 98012
Phone & Text | 425-951-0422

Disclosure & Informed Consent Packet

(*Couples Client Packet - V6*)

To New Clients:

This packet contains important information about my practice and forms you must complete before our first session. Please review this packet in its entirety and sign the various sections where prompted, prior to our initial appointment. Doing so allows us to spend as much time as possible on you and your counseling goals, and as little time as possible on administrative matters. If you are unable to complete the paperwork in advance, I will have copies available in my office, and we will use session time to complete it together.

CHECKLIST FOR COMPLETING THIS PAPERWORK

- **Print your name** in the space provided here, on page 1.
- **Disclosure Statement** (pages 2–5) — Covers your counselor's training and orientation, fees and financial policies, cancellation policies, confidentiality and its limits, and your rights as a client. Sign and date on page 6.
- **HIPAA Notice of Privacy Practices** (pages 7–11) — Explains how your health information is used, protected, and disclosed, and outlines your privacy rights. Sign and date the Client Acknowledgment on page 11.
- **Financial Agreement** (page 12) — Confirms your agreement to the payment terms and financial policies described in this packet. Sign and date on page 12.
- **Online Therapy Informed Consent** (pages 13–14) — Covers your rights, responsibilities, and the potential risks and benefits of telemedicine sessions. Sign and date on page 14.
- **Technology & Communication Policy** (pages 15–16) — Outlines between-session contact guidelines, emergency procedures, weather closures, social media policy, continuity of care, and your consent to session audio recording. Sign and date on page 16.
- **Consent to Treatment — Risks and Benefits** (page 17) — Describes the benefits and potential risks of counseling and your informed consent to begin treatment. Sign and date on page 17.
- **Credit Card Payment Authorization** (page 18) — Authorizes card-on-file billing for sessions. Complete all fields and sign.
- **Good Faith Estimate** (pages 19–20) — Provides an estimate of expected costs as required under the No Surprises Act. Sign and date on page 20 to acknowledge receipt.

Client Name: _____ (please print)

Client Name: _____ (please print)

DISCLOSURE STATEMENT

Counselor Training, Counseling Orientation, and General Information

Training and Degrees: I hold a Master of Arts degree in Clinical Mental Health Counseling from Northwest University; a Doctor of Ministry in Worldview & Cultural Engagement from Southwestern Baptist Theological Seminary; a Master of Theology in Systematic Theology & Academic Ministries from Dallas Theological Seminary; a Master of Science in Management (Organizations & Strategy) from the University of Texas at Dallas; and a Bachelor of Science in Business (Management Information Systems) from Auburn University. In addition to my formal degrees, I pursue ongoing continuing education in evidence-based counseling approaches (WAC 246-809-610, RCW 43.70.495) and have received specialized clinical training in Gottman Method Couples Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and Lifespan Integration. I also bring more than two decades of experience in pastoral and ministry leadership roles to my counseling work.

Counseling Orientation: My theoretical orientation is rooted in a biblically informed Christian worldview and the wisdom of Scripture concerning human flourishing. I am convinced that good orthodoxy (right belief) leads to good orthopraxy (right action) and to growth in wellness, resilience, contentment, healing, and joy. I am equally convinced that all truth is God's truth. Therefore, wherever general alignment with Scripture allows, I also draw on a wide range of evidence-based counseling modalities (e.g., Gottman Method Therapy, Psychodynamic Therapy, and a variety of approaches drawn from Cognitive Behavioral Therapy (CBT), among others). These tools, together with the guidance of the Holy Spirit, will be central to the counseling goals we pursue together. Clients who prefer a purely secular therapeutic framework are welcome to discuss this with me; I can also assist in locating appropriate referral options.

Practice & Administrative Arrangement: My private practice, Shane Patrick Counseling, operates in partnership with Seattle Christian Counseling / WA Christian Management, LLC, which provides office space and other administrative services. Client fees are collected and processed through Seattle Christian Counseling / WA Christian Management, LLC. Shane Patrick Counseling is solely responsible for all clinical care.

Scope of Practice: I provide counseling services to individuals and couples. I practice as a Licensed Mental Health Counselor in Washington State (License No. LH61643814) under Chapter 18.225 RCW and WAC 246-809, and in accordance with the ethical standards of the American Counseling Association. This practice serves adult clients only (18 years of age and older). If you are under 18, or if you are seeking services for a minor, please contact me to discuss an appropriate referral.

I am unable to provide:

- Psychological testing or formal psychological evaluations.
- Forensic evaluations or child custody assessments.
- Medication management or psychiatric services.
- Crisis stabilization or inpatient/residential services.

If your needs fall outside my scope, I can assist you in locating appropriate referrals.

Counseling Rates & Fees: The following outlines my fees and financial policies. Please review these carefully before our first session.

- **Per Session Fee:** The current fee for individual and couples' sessions is $240 per 53-minute clinical appointment.
- **Annual Rate Review/Adjustment:** Fees are reviewed each December against current industry standards, regional cost of living, and other inflationary factors. Any related adjustments take effect January 1. Rate adjustments will not exceed 10% per year.

DISCLOSURE STATEMENT (Cont.)

- **Payment:** Payment by cash or check (made out to *Seattle Christian Counseling*) is due at the close of each session. Payments by credit card will be processed before the close of the business week in which the appointment occurred using the card you place on file with us (i.e., via completion of the *Credit Card Payment Authorization Form* included in this packet).
- **Credit Card Processing:** A processing fee of 2.5%–4% will be added to credit card transactions to offset fees charged by the card network.
- **Returned Checks:** A $40 fee will be charged for any returned check.
- **Unpaid Balances:** Balances unpaid after 30 days incur a finance charge of 1% per month (12% annually, the maximum permitted under RCW 19.52.020). Outstanding balances may be sent to a collection agency.

Payment Model | Private Pay with Superbill Option

This practice operates on a private pay basis (cash, check, or credit card), meaning I do not bill insurance for counseling services or accept insurance as direct payment for counseling.

However, many clients are still able to take advantage of their plan's *out-of-network mental health benefits*. Upon request (typically monthly or every other month), I will provide a Superbill — a detailed receipt containing the information your insurance company needs to process a reimbursement request. You then submit this directly to your insurer according to their procedures.

While many clients receive regular reimbursements using this process, reimbursement decisions are made entirely by your insurance company, and I have no influence over them. Reimbursements you receive, if any, depend on your plan's specific benefit details, any plan deductible you might have to pay before receiving benefits, and other policy details that vary widely from plan to plan.

IMPORTANT: Regardless of how — or whether — your insurance company responds to a reimbursement request, you are personally and fully responsible for all counseling fees. Our financial agreement is between you and me and is not contingent on what your insurer decides.

Cancellation & Appointment Policies: Please understand that I must hold firmly to a 48-hour cancellation policy. To help offset the costs associated with late cancellations and no-shows, the full session fee will be charged when adequate advance notice is not provided.

- ≫ Cancellation Fee Exception: If you are able to reschedule your missed appointment within the same Monday–Saturday calendar week, the late cancellation fee will be waived. This option is subject to availability and is not guaranteed — please contact me as soon as possible to check for openings.
- ≫ Late Arrivals: If you arrive late, I will still end at our scheduled time and the full fee applies.
- ≫ Missed Appointments: Late cancellations and no-shows will be billed as late cancellations rather than clinical sessions. Typically, this eliminates the possibility for superbill submission/reimbursement, as insurers seldom reimburse for missed client appointments.

Termination of Treatment: Life circumstances can sometimes lead clients to step away from counseling unexpectedly for a period of time. At other times, for any variety of reasons, a client may choose to discontinue counseling on a more long-term basis. You may end treatment at any time without moral, legal, or financial obligation beyond fees for services already rendered.

However, providing at least one week's notice—paired with a final appointment, ideally—allows us to bring our work together to a thoughtful and more considered close. Alternatively, if I have not heard from you and we have had no scheduled appointment or contact for 60 days following our last appointment, I will generally consider the therapeutic relationship inactive and close your file administratively. Before doing so, I will make a reasonable attempt to reach out to you. If you end up needing help with a referral to other qualified providers, just let me know and I would be happy to assist you.

DISCLOSURE STATEMENT (Cont.)

Testifying in Court: I am a treating clinician, not a forensic evaluator. If you become involved in legal proceedings requiring my participation, you will be responsible for all of my professional time, including preparation, transportation, and wait time. My rate for legal involvement is **$450 per hour**. I am not a certified child custody evaluator and cannot serve in that capacity.

Record Preparation for Legal Purposes: If you, your attorney, or a court requests clinical records, formal notes preparation, or other documentation requires preparation time outside of the scope of a typical appointment, you will be responsible for the time required to prepare these. This work is billed at my standard clinical rate or as otherwise agreed upon in advance. I will notify you before undertaking preparations that are likely to result in a charge, and I will provide a written estimate if requested.

Confidentiality and Limits of Confidentiality

Your communications with me are confidential and protected under Washington law (RCW 70.02, RCW 18.225.105) and federal law (HIPAA, 45 CFR § 164). However, there are specific legal exceptions to confidentiality you should be aware of:

- **Mandatory Child Abuse Reporting:** I am required by law to report reasonable suspicion of abuse or neglect of any child under age 18 to the Department of Children, Youth, and Families (DCYF) or law enforcement (RCW 26.44.030).
- **Mandatory Vulnerable Adult Reporting:** I am required to report suspected abuse, neglect, or exploitation of a vulnerable adult to Adult Protective Services (RCW 74.34).
- **Duty to Protect:** If I determine that a client presents a serious risk of physical harm to an identifiable or foreseeable third party, I may be required to take reasonable protective steps, including notifying law enforcement and/or warning the potential victim (RCW 71.05.120; Volk v. DeMeerleer, 386 P.3d 254 (Wash. 2016)).
- **Imminent Risk of Self-Harm:** I may disclose information if necessary to prevent a serious and imminent threat to your health or safety (RCW 70.02.050).
- **Court Order or Subpoena:** I may be required to disclose records pursuant to a valid court order or subpoena, subject to applicable Washington State procedural protections.
- **Professional Consultations:** I regularly consult with other licensed professionals about client cases. Consultations are conducted on a confidential, de-identified basis whenever possible.
- **Other Legal Requirements:** Disclosure may be required in other circumstances specified by law, including involuntary treatment proceedings (RCW 71.05.217) and health oversight investigations (RCW 18.130.050).

Your privacy is one of my highest priorities in our work together. In every case, I will disclose only the minimum information necessary to satisfy legal requirements.

Choosing a Counselor

Research concludes that the therapeutic relationship between counselor and client is the primary determining factor in whether or not counseling will be successful. The work we do in the counseling setting is also deeply personal. For these reasons, finding the right fit between client and counselor matters a great deal.

At all times, your rights include: choosing the counselor who best meets your needs, seeking a second opinion from any licensed mental health provider you wish, or discontinuing therapy altogether. If you ever feel our work together is not serving you well, I encourage you to tell me so I can adjust my approach accordingly, or so I can help you find a better fit with another counselor if that's what you'd prefer — I would much rather help you find the right support with another counselor than see you discontinue counseling altogether. (cf. *WAC 246-809*)

DISCLOSURE STATEMENT (Cont.)

State Registration

Washington State requires therapists who practice psychotherapy for a fee to be licensed with the Department of Health for the protection of public health and safety.

I am licensed as a Mental Health Counselor under **Chapter 18.225 RCW** (Mental Health Counselors, Marriage and Family Therapists, and Social Workers) and **WAC 246-809**. My license number is **LH61643814**.

Licensure does not constitute recognition of any particular practice standard, nor does it imply the effectiveness of any treatment.

Unprofessional Conduct

If you believe my conduct has been unprofessional in any way, you have the right to file a complaint with the Washington State Department of Health. A comprehensive list of acts constituting unprofessional conduct appears in RCW 18.130.180.

To file a complaint, contact:

Washington State Department of Health — Health Systems Quality Assurance

PO Box 47869, Olympia, WA 98504-7869 | (360) 236-4700

Website: https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/mental-health-counselor

Contacting Me

You may send me a text message or leave a voice message at **425-951-0422**. You may also email me at shanep@seattlechristiancounseling.com. I check messages when my schedule allows during business hours, and will respond to client inquiries within 48 hours. Please limit messages and inquiries to scheduling and non-crisis matters.

Weather / Emergencies

Weather-Related Appointment Cancellation Policy: Shane Patrick Counseling (SPC) follows the Northshore School District's weather-related schedule. If Northshore School District delays or cancels school on a given day, SPC will observe the same opening, delay, or closure schedule. The district posts these closures on the following website: https://www.nsd.org/resources/reference/closures-delays. Weather-related cancellations on will not be subject to the standard late cancellation fee.

Emergency Care: I am unable to offer acute care or respond to mental health emergencies. If you experience a mental health emergency or crisis:

- **Call 911** for any immediate emergency.
- **Call or text 988** (Suicide & Crisis Lifeline — free, 24 hours).
- **Crisis Clinic:** (800) 244-5767 | (206) 461-3222.

DISCLOSURE STATEMENT (Cont.)

Client Acknowledgment

By signing below, I acknowledge that I have read and understood the Disclosure Statement (pages 2–5), including information about my counselor's training and orientation, cancellation and appointment policies, confidentiality and its limits, and my right to choose a counselor or file a complaint.

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you may access this information. It covers Protected Health Information (PHI) as defined under HIPAA (45 CFR Parts 160 and 164) and, as applicable, RCW Chapter 70.02 (Uniform Health Care Information Act). Please review it carefully.

Our Privacy Commitment

We will not disclose your personal health information to others unless you authorize us to do so, or unless the law requires or permits it. The law protects the privacy of health information we create and obtain in providing care to you — including your symptoms, diagnoses, treatments, test results, information from other providers, and billing information.

What Is Protected Health Information (PHI)?

PHI is individually identifiable health information that is transmitted or maintained in any form or medium — electronic, paper, or oral.

How We May Use and Disclose Your PHI

For Treatment

- Information obtained by your care team will be recorded in your medical record and used to determine and provide your care.
- We may share information with other providers involved in your care to keep them informed about your treatment.

For Payment

Washington State law (RCW 70.02.030(6)) requires your **written authorization** before we may disclose your PHI for payment purposes — for example, if you request a Superbill to submit to your insurer for out-of-network reimbursement. This is more protective than federal HIPAA, which permits certain payment disclosures without authorization. Your signature on the Financial Agreement in this packet serves as that authorization for Superbill requests.

For Health Care Operations

- We use medical records to assess quality and improve services.
- We may use records to review provider qualifications and performance, and to train staff.
- We may contact you to remind you of appointments or provide information about treatment alternatives or related health benefits.
- We may disclose information for accounting, legal, risk management, insurance, and audit functions, including fraud detection and compliance.

Your Health Information Rights

The health and billing records we create are the property of the health care provider; the PHI contained in them belongs to you. You have the right to:

- Receive, read, and ask questions about this Notice.
- Request restrictions on certain uses or disclosures (we must comply with requests we agree to, though we are not required to grant all requests).
- Request and receive a paper copy of this Notice.

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES (Cont.)

- Examine and obtain a copy of your health care information (we will respond within 15 working days per RCW 70.02.080).
- Request amendment or correction of your health information (submit in writing; if denied, you may file a statement of disagreement).
- Receive an accounting of disclosures of your health information made in the preceding six years (one free request per 12-month period).
- Request that your information be delivered by alternative means or to an alternative location.
- Revoke a prior authorization in writing (revocation does not affect information already released).
- File a complaint with us or with the U.S. Secretary of Health and Human Services without retaliation.

Washington law (RCW 70.02.170) also provides you with a **private right of action** if your health care information is improperly disclosed, including the right to seek actual damages and reasonable attorney's fees. This exceeds federal HIPAA, which does not grant clients a direct legal cause of action.

For help with any of these rights during normal business hours, contact our Privacy Officer:

Dr. Shane Patrick, D.Min, Th.M, MA, LMHC — Privacy Officer
10116 Main St., Suite 204, Bothell, WA 98011
16000 Bothell Everett Highway Suite 200, Mill Creek, WA 98012
425-951-0422

Therapy Notes and Records

I keep two distinct types of notes, each with different legal status and protections. Understanding the difference can help you know what to expect if you ever need to request your records or if your records are sought by a third party.

Psychotherapy Notes

Psychotherapy notes are my private clinical working documents — kept separately from your official health record — in which I record my personal impressions, observations, and clinical reflections from our sessions. These are notes I write for myself as part of my clinical thinking process, not as part of your formal care record.

These notes receive the highest level of privacy protection under both federal and Washington State law (HIPAA; RCW 70.02.230). Your written authorization is required before I may release them to any third party — insurer, attorney, other provider, or anyone else. Washington law is more protective than federal HIPAA in this area and does not permit release in most circumstances, even where HIPAA might otherwise allow it.

Limited exceptions where no authorization is required:

- Use by me in providing your own treatment.
- To prevent or reduce a serious and imminent threat to your health or safety or that of another person (RCW 70.02.050).
- In training supervised students or interns in mental health.
- To defend against a legal action or proceeding you initiate against me.
- When required by a coroner, medical examiner, or health oversight authority.
- When otherwise required by law.

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES (Cont.)

While you may authorize the release of psychotherapy notes to a third party of your choosing, I retain the right to decline direct requests for these notes consistent with HIPAA (45 CFR § 164.524(a)(1)(i)). In such cases, this is not a punitive measure. These notes are written in the moment as raw clinical impressions — preliminary draft-level thinking that happens before a clear clinical picture has formed.

Reading them without professional clinical context, and without the context of our ongoing work together, risks miscommunication, could cause unnecessary misunderstanding or distress, and may harm the therapeutic relationship. If you have questions about what is in your record, please ask me directly.

Clinical Progress Notes

Clinical progress notes — sometimes called SOAP notes — are part of your official health record. They document the practical and clinical elements of your care: session dates and times, service codes, diagnoses, treatment plans, your symptoms and progress, and clinical test results. These are the notes insurers, courts, and other providers typically request.

You have the right to request and receive a copy of your clinical progress notes in writing. I will respond within 15 working days per RCW 70.02.080. These records may also be subject to subpoena or court order, subject to the 14-day advance notice requirement under RCW 70.02.060.

Disclosures Without Your Authorization Permitted by Law

In addition to the exceptions noted in the Confidentiality section of the Disclosure Statement, we may use or disclose your PHI without your authorization in the following circumstances:

- **Workers' Compensation:** If you make a workers' compensation claim.
- **Public Health and Safety:** To prevent or reduce serious threats to health or safety; to report to public health or legal authorities; to prevent or control disease, injury, or disability; to report vital statistics.
- **Abuse or Neglect Reporting:** To public authorities as required by law (see Disclosure Statement for specifics).
- **Correctional Institutions:** If you are incarcerated, as necessary for health and safety.
- **Law Enforcement:** When we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **Health and Safety Oversight Activities:** For example, information shared with the Department of Health for oversight purposes.
- **Disaster Relief:** To assist in notifying your family about your condition during a declared disaster.
- **Work-Related Health Conditions:** For example, if an employer requests assessment of health risks at a worksite.
- **Military Authorities:** As required by law related to military missions.
- **Judicial/Administrative Proceedings:** At your request or as directed by a subpoena or court order. Note: Washington law (RCW 70.02.060) requires 14 days' written notice to both you and me before records may be released pursuant to a subpoena.
- **National Security / Government Functions:** As required by law.
- **Coroners, Medical Examiners, Funeral Directors:** As authorized by law.
- **Organ and Tissue Donation:** To organizations facilitating donation if you are a registered donor.
- **Incidental Disclosures:** Disclosures incidental to permitted uses, provided we have taken reasonable safeguards.
- **Limited Data Sets:** PHI with identifying information removed, for research or public health purposes, subject to a data use agreement.
- **Approved Medical Research:** If the research has been approved and has policies to protect your privacy.

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES (Cont.)

Family and Others

Unless you object, we may release relevant health information to a family member or friend who is involved in your care, or to assist in disaster relief notification. You have the right to object to this use at any time.

Our Responsibilities

- Keep your PHI private.
- Provide you with this Notice.
- Follow the terms of this Notice.
- Notify you in the event of a breach of unsecured PHI.

We may update our privacy practices. If we do, we will revise this Notice. You may always request the most current version from our office.

Questions or Complaints

If you have questions about your privacy rights or wish to report a concern, contact our Privacy Officer (see page 5) or file a complaint with:

- Washington State Department of Health — Counselor Programs, PO Box 47869, Olympia WA 98504-7869 | (360) 236-4700
- U.S. Secretary of Health and Human Services (HHS Office for Civil Rights: hhs.gov/ocr)
- We will not retaliate against you for filing a complaint.

Special Authorizations

Certain federal and state laws provide heightened protections for specific categories of health information. When your PHI falls into one of these categories, we will contact you to obtain the required written authorization before any use or disclosure. These categories include:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse Treatment Records (RCW 70.96A.150)
- Mental Health Services for Minors (RCW 71.05.390–690)
- Communicable and Certain Other Diseases — Confidentiality (WAC 246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

For any other use or disclosure not described in this packet, we will seek your written authorization before proceeding. If you sign an authorization and later wish to revoke it, you may do so in writing at any time; revocation does not affect information already released.

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES (Cont.)

Client Acknowledgment

By signing below, I acknowledge receipt of the HIPAA Notice of Privacy Practices as outlined on pages 7–11 (Pursuant to HIPAA, 45 CFR Parts 160 and 164, and RCW 70.02.120) and voluntarily consent to receive counseling services from Dr. Shane Patrick.

I understand that I have the right to ask questions, accept or decline any recommended treatment approach, and that Dr. Shane Patrick provides counseling services only and is not responsible for the acts or recommendations of any other provider or referral I may receive.

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date

FINANCIAL AGREEMENT

The financial terms and policies governing our work together — including session fees, payment procedures, and cancellation policies — are described in the Disclosure Statement (pages 2–3). This Financial Agreement page serves as your formal acknowledgment of, and agreement to, these financial policies and terms.

Client Acknowledgment

By signing below, I confirm that I have read and understood the financial terms and policies described in this packet — including the Counseling Rates & Fees, Payment Model, and Cancellation & Appointment Policies — and I agree to be bound by those terms.

Effective Date: _____, 20_____

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date

ONLINE THERAPY INFORMED CONSENT

I hereby consent to engaging in telemedicine (also referred to as online therapy or telehealth) with Dr. Shane Patrick, D.Min, Th.M, MA, LMHC, for psychotherapy services. I understand that "telemedicine" includes health care delivery, diagnosis, consultation, treatment, and education using interactive audio, video, or data communications under Chapter 18.134 RCW (Washington Uniform Telehealth Act).

Rights with Respect to Telemedicine

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or program benefits.
- All laws that protect the confidentiality of my health information apply equally to telemedicine services.
- Information I disclose in therapy is generally confidential, subject to the exceptions described in the Disclosure Statement (page 3).
- I understand that telemedicine does not provide emergency services. If I am in a crisis, I will call 911 or go to the nearest emergency room.
- If I experience suicidal thoughts or urges, I will call or text **988** (Suicide & Crisis Lifeline, free and available 24 hours), or call (800) 273-8255.
- Personally identifiable information from telemedicine sessions will not be shared with researchers or other entities without my written consent.
- I understand that I have a right to access my medical information and copies of medical records in accordance with federal and Washington State law.

Audio-Only Sessions

If we conduct a session by telephone (audio only) rather than by video, I will be informed in advance, and my consent to proceed will be documented. Audio-only sessions carry the same confidentiality protections as video sessions. Audio-only billing requires my advance consent and an established care relationship per RCW 48.43.735.

Potential Risks of Telemedicine

- Telemedicine-based services may not be as complete as in-person services.
- Transmission of information could be disrupted or distorted by technical failures.
- Transmissions could be interrupted by unauthorized persons.
- Electronic storage of information could be accessed by unauthorized persons.
- My privacy risks increase significantly if I use a public computer, a shared network, a work device, or a device set to auto-remember usernames and passwords. I am solely responsible for securing my end of the connection.

Potential Benefits of Telemedicine

Benefits may include: greater access to care, elimination of transportation barriers, easier access for clients whose concerns about travel or interaction would otherwise prevent service use, reduced risk for medically fragile individuals, and greater comfort in familiar surroundings.

I understand that results of telemedicine services cannot be guaranteed. If my therapist believes I would be better served by in-person care, I will be referred to a provider in my area.

ONLINE THERAPY INFORMED CONSENT (Cont.)

Client Responsibilities for Telemedicine

I understand that I am responsible for:

- Providing the necessary computer, phone, or telecommunications equipment.
- Maintaining personal security and privacy protections on my device.
- Choosing a location with sufficient lighting and privacy, free from interruptions.
- Maintaining a reliable, secure high-speed internet connection.
- Having a backup form of communication (e.g., phone number) available and on record if the internet connection fails.

Session Check-In Protocol

After connecting, I will assist my therapist with a brief check-in to confirm: my name, my current location, whether I am in a situation suitable for a private uninterrupted session, and my readiness to proceed. I will maintain current local emergency contact information with my therapist.

Client Acknowledgment

By signing below, I acknowledge that I have read and understood the Online Therapy Informed Consent (pages 13–14) — including my rights, responsibilities, the potential risks and benefits of telemedicine, and the session check-in protocol.

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date

TECHNOLOGY & COMMUNICATION POLICY

Between-Session Contact (Email, Text, and Voicemail)

Between appointments you can contact me by email at shanep@seattlechristiancounseling.com, or by text or voicemail at **425-951-0422.** I check messages during business hours as I'm able, but these channels are not monitored in real time and cannot be relied on for urgent matters. My aim, however, is to respond to all client inquiries **within 24 hours** whenever possible.

Privacy & Security: Please be aware that voicemail, standard email, and text messaging are not fully secure or encrypted communication channels and do not carry the same privacy protections as our clinical work together. While I take reasonable steps to protect your information on my end, I cannot guarantee the privacy of messages sent through these common channels. By choosing to contact me via voicemail, email, or text, you acknowledge and accept the inherent privacy limitations of those methods. With this in mind, limiting your use of these communication channels to more general matters is advised.

Emergencies and Crises

I am not available 24 hours a day, nor am I able to offer acute care or emergency services. If you are experiencing a mental health crisis or other emergency at any time:

Call 911 for any immediate emergency.

Call or text 988 — Suicide & Crisis Lifeline (free, 24 hours).

Crisis Text Line: Text HOME to 741741.

Crisis Clinic: (800) 244-5767 | (206) 461-3222.

Go to your nearest emergency room if you are in immediate danger.

Weather-Related Closures: Shane Patrick Counseling (SPC) follows the Northshore School District's weather-related schedule. If Northshore School District delays or cancels school on a given day, SPC will observe the same opening or closure. Weather-related cancellations on either side will not be subject to the standard late cancellation fee. Check nsd.org for current NSD status: https://www.nsd.org/resources/reference/closures-delays.

Therapist Cancellations: If I need to cancel a session due to an emergency, I will notify you as soon as possible.

Social Media Policy

To protect your confidentiality and maintain appropriate professional boundaries, I do not accept friend or follow requests from current or former clients on any personal social media platform. If we encounter each other online, I will not acknowledge or respond to you first; this is to protect your privacy, not a personal slight.

I maintain a professional online presence for practice information purposes. If you choose to interact with professional pages or accounts, be aware that doing so could indirectly disclose that you are a client. Any online communication with me is not a substitute for therapy and does not constitute a clinical interaction.

I do not conduct online searches or research about clients as a routine practice. In rare circumstances — such as a safety concern — I may search for publicly available information. If I do so, I will disclose this to you in session.

TECHNOLOGY & COMMUNICATION POLICY (Cont.)

Continuity of Care — Incapacitation or Death of Therapist

Should I ever become unable to continue practice due to illness, incapacitation, or death, Seattle Christian Counseling / WA Christian Management, LLC — the partner organization with which Shane Patrick Counseling is affiliated — will serve as my designated records custodian.

In that event, Seattle Christian Counseling will make reasonable efforts to notify active clients and assist with related inquiries and requests for referrals to other qualified providers. If you need to reach Seattle Christian Counseling for this purpose, find the custodian contact information here:

Designated Records Custodian: Seattle Christian Counseling / WA Christian Management, LLC
Phone: (206) 388-3929 | **Email:** connect@seattlechristiancounseling.com

Audio Recording of Sessions

To support more accurate clinical documentation and allow me to be more fully present with you during our sessions, I may use recording tools to capture session audio for the sole purpose of generating clinical session notes. Audio recordings are handled using HIPAA-compliant tools and practices to protect your privacy and health information. Recordings are permanently deleted immediately after notes are generated — they will not be stored, retained, shared, or used for any other purpose.

However, before any session recording can begin, I require your written consent. This is both a legal requirement for telehealth sessions under Washington law (RCW 9.73.030) and a professional standard I apply to in-person sessions as well. Your consent here covers all future sessions unless you withdraw it. You may withdraw consent at any time, verbally or in writing, and recording will stop immediately. Declining to consent will not affect your care in any way.

Client Acknowledgment

By signing below, I acknowledge that I have read and understood the Technology & Communication Policy (pages 15–16), including the between-session contact policy, emergency procedures, weather closure policy, social media policy, continuity of care provisions, and my consent to audio recording of sessions for the limited purposes described previously.

Client or legally authorized representative signature _____ Date _____

Client or legally authorized representative signature _____ Date _____

Dr. Shane Patrick, D.Min, Th.M, MA, LMHC _____ Date _____

CONSENT TO TREATMENT — RISKS AND BENEFITS

Benefits of Counseling

Counseling can offer significant benefits — including greater self-understanding, improved relationships, more effective coping strategies, healing from past wounds, reduced anxiety or depression, and greater overall wellbeing. My commitment is to provide you with skilled, evidence-informed, and scripturally grounded care.

Potential Risks and Limitations

Counseling involves some potential risks that you should be aware of:

- The therapeutic process may at times involve exploring difficult emotions, memories, or patterns. This can temporarily increase distress.
- Honest self-examination and growth may create changes in how you relate to people in your life, which can occasionally be disruptive to existing relationships.
- Not all therapeutic approaches are equally effective for all people or all concerns. We will discuss your progress and adjust our approach as needed.
- There is no guarantee of any specific outcome. Therapeutic results vary.

If at any point you feel our work together is not serving you well, please tell me. You are always free to seek a second opinion or to work with a different provider.

Informed Consent as an Ongoing Process

Informed consent is not a one-time event — it is a continuing conversation throughout our work together. If your treatment goals, approach, or situation changes significantly, we will revisit this consent. You may ask questions about your care at any time.

Client Acknowledgment

By signing below, I confirm that:

- I have received, read (or had explained to me), and understand the contents of this disclosure and informed consent packet.
- I have had an opportunity to ask questions and my questions have been addressed to my satisfaction.
- I freely and voluntarily consent to engage in counseling services with Dr. Shane Patrick.
- I understand that this consent does not create any new legal rights and is not intended to supersede applicable state or federal laws.

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date

CREDIT CARD PAYMENT AUTHORIZATION FORM

Payment Processing Note: Client fees are collected and processed through Seattle Christian Counseling / WA Christian Management, LLC, who provides administrative services for Shane Patrick Counseling. Shane Patrick Counseling is solely responsible for providing all clinical services.

PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize Seattle Christian Counseling / WA Christian Management, LLC to charge your credit card as described below.

Authorization terms:

- This authorization covers therapeutic treatment fees accrued while in treatment with Seattle Christian Counseling / WA Christian Management, LLC only. It does not authorize any unrelated charges.
- Your card may be charged if another payment method is not available at the time of a session.
- Your card on fille will be charged for late-cancelled or missed appointments (48-hour advance notice required; see rescheduling exception on Page 3). No more than two consecutive missed appointments will be billed.
- A credit card processing fee of 2.5%–4% of the transaction amount will be added in order to offset the fees charged to us by the credit card processing network.
- A receipt will be sent to the email address you provide below.

I, _____ (full name printed), authorize Seattle Christian Counseling / WA Christian Management, LLC to charge my credit card account (as indicated on the form below) at a rate of **$240 per 53-minute session** for individual or couples counseling, plus any applicable processing fee.

Billing Address _____ Phone Number _____

City, State, Zip _____ Email Address (for receipts) _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CVV2 (3-digit on back of Visa/MC/Discover; 4-digit front of AMEX): _____

I authorize Seattle Christian Counseling / WA Christian Management, LLC to charge the credit card listed above per the terms described. This authorization is for the services described above only. I certify that I am an authorized user of this card and will not dispute charges that correspond to the terms of this form.

Signature _____ Date _____

GOOD FAITH ESTIMATE OF EXPECTED CHARGES

Required under the No Surprises Act (45 CFR § 149.610) — For Uninsured and Self-Pay Clients

Important Notice: Under the No Surprises Act, you have the right to receive this Good Faith Estimate (GFE) of the expected cost of your care before scheduling services, or upon request. You may dispute any bill that exceeds this estimate by $400 or more through the Patient-Provider Dispute Resolution Process.

Provider Information

Provider Name	Dr. Shane Patrick, D.Min, Th.M, MA, LMHC
NPI Number	1598443020
Tax ID (TIN)	33-2111570
Address	10116 Main St., Suite 204, Bothell, WA 98011
Phone	425-951-0422
License No.	LH61643814 (WA LMHC)

Client Information

Client Name	_____
Date of Birth	_____
Date of GFE	_____

Expected Services and Charges

Service Description	CPT / Service Code	Diagnosis Code (ICD-10)	Expected Charge (per session)	Est. Sessions (12 mo.)
Initial Intake / Diagnostic Evaluation	90791	TBD at assessment	$240.00	1–2
Individual Psychotherapy (53 min)	90837	TBD at assessment	$240.00	Up to 52
Couples / Family Psychotherapy (53 min)	90847	TBD at assessment	$240.00	Up to 52

Important Disclaimers

- This Good Faith Estimate is based on currently known information and does not guarantee the exact charges you will be billed.
- Additional services may be needed over the course of treatment that are not reflected here. If that occurs, you will receive an updated GFE at least one business day before the new service is scheduled.
- Diagnosis codes are listed as "TBD at assessment" for initial visits and will be specified once a clinical assessment has been completed.

GOOD FAITH ESTIMATE OF EXPECTED CHARGES (Cont.)

- This estimate covers up to 12 months of services. Frequency and duration will be determined collaboratively.
- If you are billed an amount that exceeds this GFE by $400 or more, you have the right to initiate the *Patient-Provider Dispute Resolution Process* through the federal No Surprises Act. Contact the Centers for Medicare & Medicaid Services at cms.gov/nosurprises for more information.
- This GFE is not a contract and does not require you to obtain services from this provider.

Client Acknowledgment

By signing below, I acknowledge receipt of the *Good Faith Estimate* (pages 19–20), which describes the expected costs (i.e., potential costs) of services for the next 12 months as required under the *No Surprises Act* (45 CFR § 149.610).

Client or legally authorized representative signature	Date
Client or legally authorized representative signature	Date
Dr. Shane Patrick, D.Min, Th.M, MA, LMHC	Date