Irina Olson MSW, LSWAIC
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Licensed Independent Clinical Social Worker Associate
Lic # SC61344078
Family First — Eastern Region

Disclosure Statement

Method of counseling

Hello, thank you for choosing me for your counseling services. I look forward to this working relationship of watching you grow and accomplish your counseling goals. I take the humanistic approach to therapy which focuses on self-discovery and your potential. During this time, we will explore and develop a strong and healthy sense of self, inner well-being and focus on your strengths. We will work together as a team to find better coping skills, ways to reduce stress to increase your quality of life.

I have several years of experience working with the unhoused population in downtown Spokane. As well as with individuals experiencing substance abuse. I have experience with all ages and walks of life. In 2020 I graduated from Eastern Washington University with a bachelor's degree in social work. In 2022 I graduated with the Advanced standing master's in social work degree. My work will be supervised by Jenifer Nazarowski, LICSW, CMC

WA State Requirements

As a Washington State Licensed Clinical Social Worker Associate with a Master of Social Work, the Washington State Department of Health requires that I maintain records, provide disclosure information to my clients and make the flowing statement to clients.

Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of public health and safety. Registration of any individual with the department does not include recognition of any practice standards, nor necessarily imply effectiveness of any treatment.

The state of Washington also requires that I inform you that "the purpose of the counselor credentialing act, the law regulating counselors is (A) To provide protection for the public health and safety; and (B) to empower the citizens of this state of Washington to providing a complaint process against those counselors who commit acts of unprofessional conduct. "

As a counseling client, you have the right to choose a counselor/psychotherapist who will best suit your needs and purpose. If you wish to file a complaint, you may contact Washington State

Department of Health's health system Quality Assurance Complaint Intake at P.O Box 47857 Olympia, WA 98504-7857. You also have the right to discontinue therapy sessions with me at any time.

Fees and Cancellation Policy

My services include individual counseling. Sessions are 50 minutes unless otherwise stated. Fees will be charged for extensive telephone or email consultations.
My fee is $140 per session. Payment may be collected at the time of service by credit card or check. If you wish to be billed, the invoices are mailed out twice monthly and due upon receipt. I am a fee for service provider only and do not accept insurance, however, I am happy to provide you with information you can submit to your insurance for possible reimbursement.

Please understand when you make an appointment, I am reserving that time for you. If you are late, it may or may not be possible to extend your session for a full fifty minutes. If you are more than 15 minutes late, the session will be cancelled and rescheduled. If you miss an appointment, you may be charged for the full session. There will be no charge for appointments cancelled 24 hours in advance.

Uses and Disclosures with Neither Consent nor Authorization

- **Child Abuse:** If VP has reasonable cause to believe a child has suffered abuse or neglect, we are required by law to report it to law enforcement or the Washington Department of Social and Health Services (DSHS).

- **Vulnerable Adult Abuse:** If VP has reasonable cause to believe abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, we are required by law to report the abuse to the Washington DSHS. If FFSC has reason to suspect sexual or physical assault has occurred, we must report the abuse to law enforcement and DSHS.

- **Serious Threat to Health or Safety:** VP may disclose your confidential health information to any person without authorization if we reasonably believe disclosure will avoid or minimize imminent danger to your health or safety or the health and safety of another individual.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services VP has provided to you and the records thereof. Such information is privileged under state law and we will not release information without written authorization from you or your legal representative or a subpoena of which you have been properly notified and failed to inform FFSC you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.

Record Keeping

Washington state law requires that counselors document services rendered with the following information:

1. Client name
2. Fee arrangement and payment record
3. Date(s) of services rendered
4. Disclosure form signed by counselor and client
5. Presenting problem
6. Information about client from sessions or through release of information
7. Progress notes sufficient to support responsible clinical practice for counselors' approach

Clients may request that no treatment records be kept, except numbers 1-4 above, by providing a written request to the counselor.

For more information about client and counselor rights and responsibilities, confidentiality, and assurance of professional conduct, please refer to the Washington State Department of Health's brochure for counseling clients. Disclosure statement based on chapter 246-810 of WAC, Counselors and Draft Revisions. This notice goes into effect 1/1/19.

Client's Role

I do not make any claims that my counseling interventions will eradicate a particular problem or symptom. I provide tools, a supportive relationship and an environment for you, the client, to explore healing. I encourage you to take responsibility for your experience in counseling. If there is a counseling approach you do not feel is helpful or a conflict you sense between us, please inform me. Your success in therapy is dependent on feeling that the work we do is useful. My desire is to meet you in the place you feel most comfortable and support you as you seek to improve your life.

My signature below acknowledges my understanding and agreement of the above.

_____ _____

Client Signature Date

/Irina Olson/
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