Cedar Bridge Counseling
N. 9507 Division St. STE B
Spokane, WA 99218
509-624-3561

Counselor Disclosure

Debra Harris M. Ed, LMHC

Debra Harris M. Ed. Is a Licensed Mental Health Counselor (LMHC 0005330).She is certified with the National board of Certified Counselors (NBCC-28307) and certified in Washington State as a Mental Health Professional(MHP) and Child Mental health specialist. Deb Received her M.Ed in Guidance and Counseling from Whitworth University in 1986. She is certified in Choice Theory/Reality Therapy and uses this basis to utilize several different methods to assist clients. Deb is available to work with clients age 13 through adult addressing issues including Anxiety, Panic, Post Traumatic Stress Disorder, Depression, Bereavement, Self -mutilation, School Based Issues, Marital Therapy, Abuse Survivors, Adoption, Life Transition, Parenting and Blended family Issues. Clients of all faiths, orientations, and ethnic backgrounds are accepted.

Payment:

Many insurances accepted, please ask when making an appointment for a list of those insurances that are in-network. Payment arrangements are expected at the time of service based on insurance coverage. Co-Pays and Co-Insurance not paid at the time of appointment will be billed including a billing fee. When cancelling an appointment please call 24 hours in advance. Clients who do not cancel in advance may be charged a No Show fee ($35.00). Insurance companies will not pay No show fees and this will be the client's responsibility. Intake appointments are charged at $200 per session, (60-90 minutes). Individual sessions following intake are charged at $155.00 (45-50 minutes). Sessions of longer or shorter duration are billed accordingly.

Confidentiality:

The law protects the privacy of all communication between a client and mental health counselor. In most cases information about your treatment can only be released to others with your signed authorization. Exceptions from the above include but are not limited to:

- Reasonable cause to believe that a minor child is experiencing verbal, physical, and/or sexual abuse. This must be reported to CPS.(Child Protective Services)
- Reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred. This must be reported to APS (Adult Protective Services)

- Reasonable cause to believe that there is imminent danger to the health or safety of another patient or individual. This may require notification of a potential victim, police, or responsible family member.
- Response to a court ordered subpoena is required.

Please note that mental health providers are regarded as mandated reporters.

Records:

Client records and clinical progress notes may be kept of each session. These may include diagnosis, mental status at time of session and progress or prognosis. This information will also include billing information which includes time spent and type of appointment (individual, family, etc) You have the legal right to request that no written notes be kept of your session other than the minimum for billing purposes. If this is your decision please request a "no records kept" form. Please note this request and or releases of information can be added or ended at any point during therapy.

Counseling is a voluntary process and no outcomes are guaranteed. Per RCW 18.225.100: All clients have the right to refuse treatment and to participate in the planning of their treatment and selection of their provider which best suits their needs.

If you have concerns regarding your counselor and the services provided and you do not feel that you have been able to resolve those issues and believe that the following have occurred:

1. Misrepresentation/False Advertising
2. Incompetence, Negligence, or Malpractice
3. Violation of state or federal codes
4. Willful betrayal of confidentiality

You are encouraged to contact the Washington Department of Health : DOH Customer Service- PH: 360-236-1700: FAX 360-236-1818 : WWW. DOH.WA.GOV/HSQA

I have read and been provided a copy of the above counselor disclosure as required by WAC 246-809-700.

Client Signature and Date:_____

Client Name (Printed):_____

Counselor Signature and Date:_____