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Education and Background

I have worked in the human services field since 1980. I have been a registered nurse since 1986 working in a wide variety of medical settings including inpatient psychiatric units and emergency rooms. I completed a master's degree in Child, Couple, and Family Therapy at Antioch University in 2004. I have worked in a schools-based counseling service and with Family Preservation Services, teaching conflict management and parenting skills, and proving family, child, and individual therapy. I have advanced training in domestic violence, and experience working both with survivors and perpetrators. I provided therapy to individuals and couples through the Samaritan Center from July 2006 until July 2009. I have studied the therapy of Alexander Lowen MD, called Bio-energetic Analysis, since 2007 in both formal and self-directed contexts.

How I Work

I believe that joyful living is a birthright, but that our experiences have often led to a style of life that ensures survival in some sense but largely at the cost of joy. I believe that love, warmth and fulfillment are best relearned and recaptured through our closest present relationships. I agree with most therapists that early relationships are often the source of later joyless living, but I also concentrate on how this legacy of self-limiting and self-punishing behaviors is present and solvable in here-and-now relationships.

Therapy is a process of developing feeling and purpose. This is done by 1) increasing self awareness, 2) increasing direct self-expression, and 3) increasing the capacity to have and hold strong feelings. In our society, the first is encouraged but the latter two really are not. I believe that self-awareness is fundamental to happiness, but also that insight is usually the by-product, not the cause of change.

Change starts by doing something different, but only continues when we experience something different. My work focuses on increasing *freedom of feeling*, *freedom of expression*, and *freedom of action*. I address both limiting beliefs and limiting neuromuscular patterns.

My work is strongly influenced by the work of Alexander Lowen, and his combination of psycho-dynamic therapy and bodywork (physical exercises) which he called Bioenergetic Analysis. In the family therapy field, my approach draws largely from the structural, strategic, and solution focused schools.

My special interests include overcoming lack of fulfillment in life, work and relationships, the cumulative emotional effects of stress, high conflict couples, parenting, co-parenting after divorce, 'emotional intelligence, families facing addictive behavior, adult children of difficult parents, difficulties in high achieving families, body psychotherapy, sexuality, and 'deep' psychotherapy.

Scheduling and Venue

With counseling services, when a session is scheduled, that time is reserved just for that client. This differs from general healthcare where appointments are approximate and no shows are factored into scheduling. I ask that clients always call and notify me *as soon as they know* they cannot make a session. Clients will be asked to pay all of the fee for sessions canceled with less the 18 hours notice (and not rescheduled for the same week) , unless circumstances are such that, upon discussion, it seems unjust to both client and me. Insurers will not pay for missed sessions.

For all sessions scheduled, if a client has not arrived on time, it is my practice to remain in my office available until 30 minutes after the scheduled start. While on occasion I may allow a late-starting session to run beyond the normal stop time, starting late will never be in itself a sufficient reason for running over.

I believe therapy is not just an exchange of information, but a felt meeting of persons in which proximity plays a part. For this reasons I do not do therapy 'over the internet.' Phone sessions are possible, but only as a minority of total sessions. Each phone session should be agreed upon in advance. The most common purpose of phone sessions is to accommodate clients who travel for work. It is not possible to have a phone session with clients who are at home just for convenience.

Records

Washington State law covering the record-keeping of Licensed Mental Health Counselors is contained in **WAC 246-810-035.** I maintain treatment records on paper, and store them in a locked area. My practice is to wait until after the session to write, so as not to distract either myself or the client(s) from what is being said or done. My purpose in maintaining records is to aid therapy by recording topics discussed and my impressions. In addition the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording "what happens in a session." While I do make a good faith effort to summarize what happens in a session, I make no effort to capture sessions verbatim. In any case, if a client wishes an even more reduced record to be kept due to privacy concerns, that wish can be put into writing, and while a record must still be kept, it need only contain dates and times of sessions, not the content. While Washington State law requires the retention of records for only five years after last contact, I currently expect to retain records longer, as is the general practice in this profession.

The section below on confidentiality defines a few circumstances under which information may be disclosed to third parties. It is important to understand, that even in these limited circumstances, ***records*** are not usually disclosed but rather only ***limited information***. Unlike general medical provider relationships, I will never simply fax or photocopy a chart. Rather a judicious limited disclosure will be offered according to the guidelines described in the section below on confidentiality. This has always been the standard in psychotherapy.

These records are also now subject to the provisions of Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, and I treat them accordingly. What it is important to know, is that in psychotherapy, confidentiality standards have always been much stricter than HIPAA minimums anyway. However, HIPAA provisions do distinguish between, on the one hand, general treatment information, such as dates and length of sessions, intake assessments and diagnosis, and on the other hand, 'psychotherapy notes.' Insurance companies certainly cannot insist on seeing 'psychotherapy notes' as a condition of coverage, and 'psychotherapy notes' may also be deemed exempt from other avenues of disclosure.

HIPPA also affirms a client's right to see his or her own health records and obtain copies, as does Washington State law (**RCW 70.02.080**) Where records exist of joint sessions, however, a dilemma may arise. One party to a therapy may wish to use records in an adversarial way against another party of the same therapy. This is entirely against the spirit and traditions of family or couples' therapy, and it is my ethical duty to resist this use of records to the extent the law allows. Laws assuring access to health care records were conceived in the context of general medical care, where each record contains information about only one person. That is not the case with couples or family therapy. Therefore these laws should not be used to provide an 'end run' around the other party's testimonial privilege, as described under 'Joint Records' in the section on testimonial privilege.

Confidentiality

Therapy is a very private and confidential matter. The fact that we have spoken, and anything discussed, whether in session, or on the phone, will be treated by me as strictly confidential. My style of work does not focus upon, or expect, therapist exchange or disclosure of information to third parties, including other treating professionals. Rather, I develop a collaborative relationship with the client, who is expected to inform other professionals according to his or her own judgment and desire. In all cases, including the extremely rare instances described below where disclosure is not initiated by the client, disclosure will be limited to the minimum necessary information, and directed only to those individuals required, and the actual information released will be discussed with the client.

Client Initiated Disclosures: This is by far the largest category of disclosure. The client must fill out a written release of information, indicating to whom the disclosure is being made and for what purpose. The client and I will discuss the disclosure, and only what is mutually agreed to be will be disclosed. Clients are to be cautioned that the third party to whom information is being disclosed may well not be under the same legal and ethical constraints of confidentiality that I am. If more than one client has participated in sessions, then all clients must sign the release, and all clients must agree on the contents of the release. The release may be revoked by any signing party any time before the disclosure is actually made. Once the intended disclosure is made, I will consider the release 'spent.' Later disclosures will require a new release.

Event Initiated Disclosures: These are very rare. They do not require a release by the client. However, if time and safe practice allows, I will discuss the nature of the disclosure with the client. **RCW 18.19.180:** describes the following exceptions to confidentiality: 1) You are planning a *seriously* harmful act against yourself or another person, or you have caused serious physical harm to another person. 2) If you press criminal charges against me, 3) If you file a complaint of unprofessional conduct against me, or 4) If information concerning the abuse or neglect of a minor or vulnerable adult comes to light. **RCW 26.44** mandates that I report any suspected abuse of a minor child. **RCW 74.34** mandates that I report suspected abuse of a vulnerable adult. Also **RCW 70.05** provides for an exception to confidentiality if your mental condition poses an imminent danger to yourself or others, or you are unable to meet your basic needs.

Insurance Disclosures: This happens if either the client or I apply to an insurance carrier or a third-party payer for coverage of sessions. This will include a diagnosis from DSM-5, and possibly a treatment plan. Any diagnosis provided, other than 'adjustment disorder' will be discussed with the client first. The client should be aware generally, that in this era of electronic insurance transactions, that insurance carriers are making available in their electronic portals, some claims information from previous providers. My sole purpose in interacting with these portals, however, is to assist the client in obtaining his or her greatest re-reimbursement toward my services.

Parents or Legal Guardians: In the state of Washington it is possible for adolescents between the ages of 13 to 17 to consent to psychotherapy **(RCW 71.34.530)** Historically, in psychotherapy, consent implies confidentiality. However, in the law, the two issues are separate. Guardians are entitled to health care information of minors up to the age of 17. In practice, the dilemma is often handled by an agreement of minor client, guardian, and therapist about what information will be passed on.

Intra-family Disclosures: For clients having an individual session while participating in therapy with other family members or any third party, all information discussed in that session is considered confidential even for the other parties. However, for ongoing joint therapy, it is not humanly possible in every instance to guard against inadvertent disclosure of minor details in later joint sessions. Also if one party steps out for a time during a session, or arrives late, while I of course will use judgment in referring to what was said while they were not present, this again is a situation in which it is impractical to consider the material confidential from that party. Information provided between sessions may possibly be considered confidential, and this will have to be discussed at the time. The advisability of continuing joint sessions with any major 'secrets' is always a paramount consideration. If safety is an issue, safety planning will have to come to the forefront of the work

HIPPA provisions, as described above under 'Records' also cover the handling of information not in the form of records, such as verbal disclosures. While HIPPA dictates some administrative tasks that of course I comply with, about actual disclosures it defines a maximum not a minimum. To re-iterate, my disclosure practices as outlined in this Disclosure Statement are more restrictive and they are what will govern my actions.

Testimonial Privilege

The recognition of the legal system that the therapist-client relationship should remain confidential is referred to as 'testimonial privilege', or just 'privilege'. Since May 2009, in the State of Washington, all client communications with a licensed therapists are now considered privileged. This is set out in **RCW 5.60.060(9).** Testimonial privilege means that I cannot make and cannot be compelled to make any disclosure that the client does not wish me to make, with the exception of the 'Event Initiated' disclosures listed above. Testimonial privilege for therapists is relatively new and untested, and there may be other exceptions, but in this area I cannot be an expert and clients must rely on qualified legal advice. Testimonial privilege is very pertinent to three areas: subpoenas, joint records, and legal testimony.

Subpoenas Subpoenas potentially confound all the traditions of confidentiality in psychotherapy described above because they usually are requests for records, not just information limited to a purpose. Also, subpoenas may not be in the client's best interest. If the client does wish me to make a disclosure involving a subpoena, then all the aspects of client-initiated disclosures written above apply, including a release of information to confirm that testimonial privilege is being waived. Also the guidelines for legal discovery of health information outlined in **RCW 70.02.060** must be adhered to strictly

Joint Records. For client initiated disclosures of records or information from any sessions where two or more people were present as clients, all parties will have to agree. However, if one party to a joint session wishes me to fulfill a subpoena, and one does not, a dilemma arises, as first mentioned on the above section on records. I may ultimately be compelled to release some information, depending on legal ruling. However, my ethical duty will be to resist such release to the extent possible.

Legal Testimony It is my avowed belief that my testimony will not be in the long-term best interests of any of my clients. However, therapists, especially therapists who see couples in conflict, historically have been brought into legal proceedings. The client or clients are said to 'own' the confidentiality, and like any citizen I can be compelled to participate in legal proceedings under certain circumstances. I can only provide legal testimony, if at all, pursuant to a valid subpoena as described above.

I wish to emphasize strongly that the work that I do is clinical, not forensic. That is, it is not done with a skeptical eye intended to succeed in an adversarial or legal process. That would be demeaning, and would detract from the therapeutic work. Clients and their attorneys need to understand the detriment to the therapeutic relationship, even retroactive, risked by my involvement in a legal proceeding. They need also to understand the extremely limited partisan value of my clinical impressions. **Since I am a treating clinician, it is not ethically possible for me to have any position on the custodial arrangements of children**. This position is spelled out in the American Association of Marriage and Family Therapists (AAMFT) Code of Ethics Item 3.14. It is not possible to waive any of the professional fee for testimonial activities, as described below, even if clinical services have been rendered at a reduced fee due to hardship.

Fees

It is my intention to make these services as affordable as possible. I must consider what is equitable for the client and what is sustainable for me. In 2015, my full fee is $100 an hour (55-minute actual session). (If insurance is available and will only pay for a 45 minute session, the fee is $90.) If this is truly prohibitive, a lower fee can be negotiated, called a 'sliding scale.' For individual clients, a lower fee is based on a formula of $2 per $1000 of yearly household income from all sources, minus $4 for every minor child in the household. The bottom of the sliding scale is $50. For a couple a sliding scale of $75 is available if joint income is less than 60 thousand a year, or $50 if less than 30 thousand a year. Again, the bottom of the sliding scale is $50. Since the client's standard of living may exceed identified income, clients with informal forms of support or assets out of proportion to income should take that into account. Having a large amount of debt or expenses cannot be considered in the sliding scale because I cannot place myself behind other creditors without affecting the relationship between us. The goal is to achieve the benefit of an amount that has some significance, but also the assurance of an amount that is tolerable if the client wishes to continue longer term. Clients are responsible for initiating a change either up or down should circumstances change.

Payment must be by cash or check (made out simply to “Michael Samsel”); at present I cannot take debit or credit cards. If paying in cash, it is very helpful to bring correct change. For clients with insurance and typical or already fulfilled deductibles, I will bill monthly after insurance carrier processing. For privately paying clients payment is due at the time of the session. This is the community standard in psychotherapy and counseling due to smaller margins than in general healthcare. I collect the fee at the end of the first session, but prefer to collect it at the beginning of subsequent sessions. This has the advantage of keeping bookkeeping matters from intruding on any mood developed in the session. Advance

payment is not necessary, and substantial advance payment is discouraged in therapy on the ethical basis that it could influence clients to purchase more therapy than wanted from a particular provider. If a small advance payment has been made for convenience and not used, or an overpayment with insurance has been made, a refund will be provided. Accepting payment of fees by any third party (other than insurance) does not convey permission to release information to that party, but of course, the delivery of services will be confirmed by my acceptance of payment.

Writing reports or letters, 'case-management' services, or extensive planned phone discussions with third parties are generally inconsistent with how I work, but should they be agreed upon, they are re-reimbursable at a rate of $150 an hour, with a minimum of one hour, and paid in advance. Occasional client-initiated contact with third parties that wish merely to verify sessions or receive a very general 'progress report' is not subject to the fee above.

For any court appearance or legal deposition, my professional fee is $200/hr with a $800 retainer paid in advance. Charges will include all travel time to and from my office and all waiting time involved until I am released. If a deposition, my attorney fees must also be paid. This higher fee reflects the greater preparation required, disruption to schedule, impact to the therapeutic relationship. and the gravity of the situation

A therapist-client relationship is established from the first meeting. Prospective clients are encouraged to ask questions, by phone or email, and read this disclosure statement and my website if possible before scheduling a first appointment. At this time I am not scheduling any in-office free consultations because, I believe good value is provided in any in-person encounter. Moreover, any attempt not to get directly into the material, given my more direct and active style, would be disingenuous on my part.

Insurance

All clients with insurance should check with their carrier about the possibilities of coverage. For most major plans it is now reasonably convenient for me to bill electronically. With clients' permission, I generally can verify eligibility and provide some information about their insurance through the same portals. However, I cannot be an expert in any client's coverage. The client's insurance carrier is the expert in what the plan will cover. If insurance coverage is being used, the client's responsibility for co-pay may or may not be accurately determined at the first visit. In the present, very complicated insurance climate, it is not uncommon for insurance to ultimately pay differently than the carrier initially states.

The community standard in therapy (as in all healthcare) is that the client is responsible for payment for all services rendered, wherever and why-ever insurance fails to pay. A situation of a very high and/or unfulfilled deductible (greater than $2500) preventing insurance re-reimbursement also can allow for a sliding scale subject to income and discussion. In that instance, however, I cannot bill insurance as "apply to deductible." I can only bill insurance the full fee. If the full fee is paid by the client, I can and will bill insurance to help fulfill the deductible. If an insurance has no out-of-network coverage (such as Apple Health) then also a sliding scale can be discussed.

Out of Session Communications

I am glad to discuss with prospective clients by phone or email, general ideas and frameworks to aid in a selection process, but I must refrain from establishing a de facto therapist-client relationship until we have met formally.

For established clients, email or phone contact between sessions is welcome and generally I will respond within 48 hours. Though emergencies may happen, the ideal place for discussion of personal or 'clinical' material is in a session. That ensures the least possibility of a misunderstanding or mis-connection. Generally, communication in between sessions is generally limited to logistics of scheduling, or rarely insurance and payment. Established clients may text me at my professional phone number. On the day of a session, phone or text is preferable to email.

I do not participate in, and am not reachable through, social media, which means friending, joining, or linking requests will not be responded to—this is not personal but policy. This is because such applications risk blurring the boundaries between personal and professional, which are paramount in therapy.

Professional Accountability

The law governing the contents of a disclosure statement such as this one is included in **RCW 18.225.100** and **WAC 246-809-710.** The law defining unprofessional conduct of a therapist is **RCW 18.130.180.**

WAC 246-809-710 (1)(i) states: "Clients are to be informed that they as individuals have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits their needs."

Complaints or reports of therapist misconduct can be directed here: The Dept. of Health, Health Professions Quality and Assurance Division – PO Box 47869, Olympia, WA 98504-7869. Any health care provider's credentials can also be checked at https://fortress.wa.gov/doh/providercredentialsearch/

Signatures

Please sign only if all the following statements are true: I have been provided with a copy of this disclosure statement. I have read it. I have had a chance to ask questions about it. I understand it.

Client(s) Signatures

_____

_____

Date _____

Therapist Signature

_____

Michael Samsel, MA

Date_____