CALEB A. DODSON
PSYCHOTHERAPY

Fremont Space Building, 600 N 36th St, #311, Seattle, WA 98103
www.calebadodson.com
caleb.a.dodson@gmail.com
206.718.1952

Disclosure Statement
Professional Information & Policies

/EDUCATION & CREDENTIALS

I received my M.A. in Professional Counseling from *Liberty University* and my M.A. in Theology and Culture from *The Seattle School of Theology and Psychology*, both in June of 2016. I am currently in training to be a Existential Analyst through Canadian Society of Existential Analysis. I have professional membership through Northwest Alliance for Psychoanalytic Study. Additionally, I am licensed through the state of Washington as a Licensed Mental Health Counselor Associate (MC60685830).

/THERAPEUTIC APPROACH & PHILOSOPHY

I practice the art of psychotherapy via **relational** and **existential analysis.** My foundational approach is akin to the work of **Viktor Frankl, Rollo May, Irving Yalom, Stephen Mitchell, and Carl Rogers**. Therapy involves exploring processes that guide and determine our thoughts, feelings, beliefs, and behavior in conscious and unconscious ways. Working with unconscious activity can include: anxiety, loss/grief, anger, loneliness, desire/dread, shame, and dream-life. **The work of counseling is creating meaning from the material of our lives; feelings, thoughts, and stories.** I try to create a space of radical acceptance. **I will utilize the emotional relationship created by you and I in the room as primary medium to the understanding of your mind**. With the goal that you will get far more relief and life fulfillment than you originally sought or had in starting counseling. In general, this approach helps you better become aware of yourself, and aware of yourself in a relational context. **I cannot emphasis this enough, change happens through our relationship with one another, it can take time, but we are going far deeper than technical work. Think about the snowball effect, the same applies here. I am a better gardener than I am a mechanic.**

I do not begin the session. This continually reinforces that this is your space and your time for it to be whatever you need it to be. I encourage patients to begin our time with whatever is most pressing on your mind

/CONFIDENTIALITY

What you disclose in therapy with me is confidential and protected information. This information would only be revealed with your written consent, called a "Release of Information" except in unusual circumstances in which:

1) Not doing so would represent clear danger to yourself & others (this includes knowledge of an HIV positive diagnosis, with refusal to inform others);
2) Information is obtained suggesting the abuse or neglect of a child or a vulnerable adult;
3) I am served with a court order requiring me to disclose information.

I keep notes on the progress of treatment, as required by Washington State law. You have the right to request that I keep no records, except the dates of treatment. You also have the right to review these notes, subject to my clinical evaluation of any potential harm to you and after extensive, thoughtful conversation regarding this action.

I consult with a licensed training psychoanalyst bi-weekly regarding my cases. These consultations are designed and protected in such a way that your identity and confidentiality are secure and maintained.

/PATIENT RIGHTS & RESPONSIBILITIES

Adults
It is your responsibility to choose the treatment that best fits you and your needs. Psychotherapy can have incredible benefits, **but also a fair share of risk.** Since much of our task together is exploring/discussing unpleasant aspects of human life, you may experience uncomfortable feelings. On the other hand, if we can work with said discomfort together and get to know these uncomfortable feelings/aspects of ourselves, tremendous growth and change can occur. **When questions or concerns about our relationship and/or the psychotherapy arise, the most useful and helpful approach is to bring them honestly to our conversation so we can think about them together.** You have the right, at any point, to refuse or discontinue treatment; however, **it is understood that premature termination may result in the return or worsening of the initial problems and symptoms.**

In extreme case, if necessary, a review process can be obtained through Washington State Psychology Examining Board, (206) 753-1392.

Minors & Parents
Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine the minor child's treatment records. Since privacy and confidentiality in therapy is often crucial to successful progress, particularly with teenagers, it is common that I request an agreement with the parents that they consent to give up access to their child's treatment notes. If they do consent, I will provide them only with general information about the progress of their child's treatment, and his/her attendance at

scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which I may notify the parents of my concern. Before so, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

/FEES

Sessions—a clinical hour—are 50 minutes long. **Payment is due at the time of service, beginning the clinical hour.** You may pay for just the present session, a week's worth, or up to a month in advance. At this time, I accept cash, checks, and credit/debit cards. Please be aware that names appear to bank employees with checks, and to Square employees with credit/debit cards. **If you are late, we will conclude at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session.**

It is important to know that you will be charged in 1⁄4 hour increments of my full fee for telephone interactions with attorneys, physicians, and others on your behalf, and for reports and letters you request me to write on your behalf. Any phone conversation between ourselves over 5 minutes will be charged at a prorated fee based on our agreed upon rate.

There is an annual increase of my fee - typically 5% - that current patients will be notified of at least a month in advance.

/SESSIONS & CANCELLATIONS

Our mutual protection of the clinical hour is **extremely important; I strongly believe that continuity, momentum, and rhythm are vital to therapeutic work and deep change.** It is best for us to find a time that is consistent week to week for the duration of our work; this time is set aside exclusively for you.

How frequently we meet depends on a number of factors; **I require that we meet once a week**. Initial and ongoing conversation will be had around whether or not multiple sessions a week would be useful for you.

If you are unable to attend your scheduled time, you are responsible for paying the full fee unless you've notified me at least 72 hours prior to our scheduled time. If unable to attend, but have not given the 72 hour notice, we will try to reschedule the hour. However, if no other time that works for us both is available, you will still be held responsible for payment of your session. Exceptions can be made. Please be aware that communication via email is not a reliable way to reach me, so to guarantee that you have given correct notice, notify me in person or through my office voicemail.

If planning to be away for more than two consecutive weeks worth of sessions, a conversation will be had to whether or not the missed time will be paid for—to hold your session hour in my

schedule and the relationship moving forward– or whether these weekly hours will be released.

A releasing of our agreed upon hour runs the risk of the hour being potentially filled and us, if room in my practice allows, needing to find another session time. A more serious risk is possible termination of our working relationship, if no other agreed upon session time can be discovered.

You are not charged for the sessions when I am unavailable because of a preplanned absence or illness. I typically take around three weeks of holiday a calendar year, and will notify you of these times at least one month in advance.

/FINANCIAL AGREEMENT

I acknowledge that each session ranges from $80 to $130. I understand that **Caleb A. Dodson Psychotherapy, LLC** does not accept insurance. I understand that **Caleb A. Dodson Psychotherapy, LLC** can provide a "superbill", which will require diagnosis, that I can submit to my insurance. I understand that understanding my insurance company's out-of-network benefits is my responsibility. I acknowledge that full payment is due at the time of service. I understand that any phone conversation over 5 minutes will be charged at a prorated fee based on $80-130/hour. I understand that any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time, will be charged at the full fee of $80-130. I authorize **Caleb A. Dodson Psychotherapy, LLC** to charge my card, which will be kept on file using secure systems, for office charges. I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice. I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due & paid in full. I acknowledge that credit card transactions could be linked to Protected Health Information.

/CONTACT INFORMATION

If you need to reach me for matters related to scheduling, you may do so at caleb.a.dodson@gmail.com or by my office voicemail at 206.718.1952. I try to reply to the email or phone call within 24 hours. I ask you to be aware that any emails are private and protected, there is still a great risk of exposure in these methods of communication. Which is to say, I cannot be assured of confidentiality like I can in person. So please not only be aware, but reserve for our clinical hour important therapeutic dialogue.

While texting and email are popular forms of communication, it is important to know that I do not practice psychotherapy across these mediums. **I do not respond to texting communication (iMessage, SMS, etc).** If you email me outside of our arranged session hour, I will respond that I've received it and ask us to hold conversation until the next session. I typically check email between 7:30am and 6:00pm Monday through Saturday.

/CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Caleb A. Dodson Psychotherapy, LLC** to debit your credit card as listed below.

By signing this form, you give me permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with **Caleb A. Dodson Psychotherapy, LLC**, and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I, _____ (full name printed) authorize **Caleb A. Dodson Psychotherapy, LLC** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of **$105 per 50-minute session for individuals, and $130 per 50-minute session for couples** and charged **up to** 3.7% plus $0.15 for electronic processing of the charge.

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CVV Number (3-4 digits on back of card): _____

Billing Address: _____ City: _____ State: ____ Zip:_____

I authorize **Caleb A. Dodson Psychotherapy, LLC** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature: _____ Date: _____

/EMERGENCIES

Do not use my voicemail or email for disclosure of life-threatening emergencies, as I do not and am not a 24-hour "on-call" emergency services. You are free to call me after hours and leave a message on my confidential voice mail. Should you have a mental health emergency and are unable to reach me, please go to your nearest hospital emergency room, call #911, the King County Crisis Line at #211, or call 1-800-SUICIDE, call your psychiatrist/physician, or most importantly a family member or close friend that you trust.

/AUTHORIZATION FOR SERVICES

Signature: _____

Date: _____

Therapist Signature: _____

My signature below indicates that I have read, understood, and agree to the above policies, and have been given a copy. By signing below, you authorize me to express my gratitude to the person, agency, or organization that referred you to me.

Signature: _____

Date: _____

Confidential Patient Intake Form

Name:

Address:

Phone:

Cell Phone:

May I leave a message for you at this number?

Email:

Please list preferred form of communication:

Local Emergency Contact, Name and Phone Number:

Parent or Guardian if you are under 18:

Please Select:

Length of time on any of the above:

Employer:

Date of Birth (month, day and year):

Gender:

Children, please list with age:

Who were you referred by:

Have you been in therapy before:

Please list the last mental health professional you saw:

Please list any medications you are currently taking:

Please list any health problems you currently have:

Do you smoke (how much/often:

Do you drink alcohol (how much/often):

Do you engage in recreational drug use (how much/often):

Have you ever taken psychiatric medication:

Please list the psychiatric medication with dates:

Are you religious or spiritual (please state faith or belief):

Current state of physical health:

Do you have any current health issues:

Do you have sleep problems:

How often do you exercise:

What type of exercise:

Are you experiencing problems with eating or loss /gain in appetite:

Are you currently depressed:

Have you recently experienced a death of a loved one (how long ago):

Do you have panic attacks:

Do you have any phobias:

Do you have chronic pain:

Date pain started and how often:

Have you recently experienced a stressful life event:

Please list a family member for the any of the following:

Alcohol and or substance abuse:

.....

Anxiety:

.....

Depression:

.....

Domestic violence:

.....

Eating disorders:

.....

Obesity:

.....

Obsessive compulsive behavior:

.....

Schizophrenia:

.....

Suicide or attempts:

.....

What would you like to get out of therapy or your reason for seeking therapy

.....

.....

.....

.....

Are you currently experiencing thoughts of harming yourself or someone else. If yes, please explain.

.....

.....

Cancellation Policy:

I must be notified 72 hours in advance of a cancellation. If you do not notify us within 72 hours of your scheduled appointment you will be billed for your appointment. Please note if you miss your appointment due to an emergency you will not be billed.

Signature

.....

Date

.....