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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 of Puget sound 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. In 2017 I became certified by Robert Glover Ph.D in Nice Guy Recovery work, which is a maturity-oriented cognitive behavioral approach to assertion and satisfaction.

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 but at the cost of joy. I believe that love, warmth and fulfillment are best relearned and recaptured through our 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 the here-and-now.

Therapy is a process of 1) increasing self awareness, 2) increasing 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.** Real change cannot be forced, but rather is *cultivated,* by setting the conditions of change, and in fact, change usually comes to us as a *surprise*. The first condition for change is paradoxically, accepting what is.

While I address presenting problems, I mostly target underlying patterns, issues, attitudes, and beliefs that make present problems so tough. I listen. And then I listen some more. But I don't just nod my head. At times, I question, and I challenge. Sessions should not be boring, not because either of us is an entertainer, but because nothing is boring if done with contact and feeling.

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

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 more just to receive a partial fee. 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 reason I carefully consider any request for a 'remote' or 'virtual' session either by phone or internet video conferencing. For therapy clients, remote sessions should be a minority of total sessions, and never include the first session. Please note that insurance generally will not pay for remote sessions of therapy (this may change in the future). Moreover, I cannot establish a therapeutic relationship with a client in another state (where I am not licensed). Occasional paid 'virtual' consults may be made with clients in other states or countries who want to discuss niche areas where I have expertise and have published on the web. This is not therapeutic contact, and so will be brief and limited and should not be considered a template for therapy clients.

Out of Session Contact

Appointments not made at the end of a session, and other logistical issues, can be discussed by email or text. Extensive clinical material is best discussed in session. The availability of emergency contact between sessions is a community standard for psychotherapy, and my phone number is listed at the top of this document. Clients and concerned persons should, if there is ***any issue*** of danger to self or others, avail themselves of the 911 emergency response system. If there is no concern of danger, contacting me by phone or email is welcome, but my response must therapeutically be directed at containing feelings of crisis, so as to be able to process them in the next session.

I do not participate in social media. This is because I cannot ensure my professional presence will not in some way be commingled counter-therapeutically with private information. Therefore 'friend' and 'join' requests will not be accepted or acknowledged—this is not personal or selective.

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.

HIPAA 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 ICD-10. My sole purpose in interacting with these portals 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.

Guardians ad litem. An unfortunate development in Washington State family courts, is the extreme reliance on using the services of various mental health professionals practicing as 'guardians ad litem', whenever a dissolution proceeding is contentious and provokes accusations of parental incompetence or mistreatment between the parties. In the therapy community the request from the guardian ad litem for disclosure is often considered mandatory, under the mandatory disclosure of suspicion of abuse of a minor, covered above. However, this constitutes an end run around testimonial privilege discussed below. Because there is no standard training or formation process for guardians-ad-litem, I cannot assume that an 'open-book' policy will be consistent with the therapeutic interests of the children or parents involved. In these situations (which hopefully remain rare) I will seek legal advice when warranted, and I will discuss the matter with all

clients involved to the extent possible.

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 over the phone 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 question. If fear for safety is an issue disclosed individually, safety planning will have to come to the forefront of the work.

Group Therapy: Please understand that when participating in group therapy sessions, that while other participants will be asked (as will you) to consider anything heard from or about another participant be considered confidential, participants are not professionals and do not have any legal or ethical madates about confidentiality.

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 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 opinion 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. Starting January 1st 2019, my fee is $110 an hour (55-minute actual session (90837). (In some circumstances insurance might only allow a 45-minute session (90834) for which the fee is $100)

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 $2 for every minor child in the household. The bottom of the sliding scale is $60. For a couple a sliding scale of $80 is available if joint income is less than 60 thousand a year, or $60 if less than 30 thousand a year. Again, the bottom of the sliding scale is $60. 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. 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. Please understand that a sliding scale fee only applies to clients who are sincerely intending several sessions, and may become long-term clients. It cannot apply to any virtual or long-distance session, or to a few consult sessions, because the overall cost will not be prohibitive.

Payment is preferred by cash or check (made out simply to “Michael Samsel”); for larger balances payment through Venmo or PayPal can be arranged. 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 clients monthly after insurance carrier processing. For privately paying clients, or clients with known large unfulfilled deductibles, (generally more than $1000) 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 over-payment with insurance has been made, a refund will be provided. Payment of fees by any third party (other than insurance) does not convey permission to release information to that party, but of course, the mere 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 $175 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 $220/hr with a $1760 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 and retainer requirement reflects the greater preparation required, disruption to schedule, impact to the therapeutic relationship, the risk of client dissatisfaction, 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 full-length free consultations because, I believe good value is provided 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. I will work with any form or carrier to document services etc.. While I may attempt to verify eligibility and provide some information about insurance, 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 remains responsible for payment for all services rendered, and that the provider may bill insurance for efficiency and 'as a courtesy'

A situation of a very high and/or unfulfilled deductible preventing insurance reimbursement may allow for a sliding scale (discussed earlier in this document). 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.

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_____