



PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

Dr. Shannon Lilja, D.BH, LPC, LMHC, CADC-II, CDP (WA)

Philosophy and Approach to Counseling

My therapeutic style in working with clients is warm, a little humorous, collaborative, and straightforward. Practicing from cognitive behavioral, solution- and emotion-focused theoretical models, I believe exploring your relationship between heart and mind can strengthen core functioning and encourage the change you seek, often leading to a more fulfilled, empowered, and authentic self. My role as therapist is to assist in facilitation toward self-discovery and personal growth, to unveil the strength and possibility within you.

While I may offer suggestions for growth or change, the responsibility to grow and change is yours. Please be aware therapy can have both benefits and risks. You may experience uncomfortable feelings such as sadness, guilt, fear, frustration, loneliness, or helplessness. Learning new ways of thinking, behaving, and relating to others may be difficult. While there is no guarantee of what you will experience, research indicates that therapy has many benefits for most clients, often leading to better relationships, solutions to specific problems, and a reduction in feelings of distress.

You may end our counseling relationship at any time. Should either of us feel a referral is appropriate, I may assist with recommendations; the responsibility to pursue referrals or recommendations is yours. While counseling sessions feel personal, our relationship is professional and limited to our sessions. If we cross paths outside of our sessions, I will not acknowledge you unless contact is initiated by you. Designed for your welfare and privacy, this allows our efforts to be directed toward the counseling process.

Education, Training, and Experience, Licensure, and Certification

I am a licensed mental health counselor in both Oregon (C2687) and Washington State (LH60129047) and abide by the Code of Ethics of both Washington & Oregon Board of Licensed Counselors and Therapists. I am also credentialed as a drug and alcohol counselor/professional in both Oregon (CADC-II) and Washington (CDP).

I hold a Doctorate of Behavior Health. Major coursework included integrated medical and behavioral interventions, psychopharmacology, medical terminology and population health management, research, and ethics. I also hold a Masters of Arts Degree in Counseling Psychology. Major coursework included Human Growth & Development, Personality and Counseling Theory, Advanced Marital Therapy, Social and Cultural Foundations, Psychopathology, Human Sexuality, Group Theory, Research, Traumatology, Career Development, and Ethics.

I am trained in several evidence-based treatment modalities including Moral Reconciliation Therapy (MRT), Seeking Safety, Living in Balance, Matrix, Thinking for Change, Staying Quit. I am regularly enrolled in continued education and training (including ethics) related to the subjects relevant to my profession.

Payment for Treatment Services:

Fees per session: 50-minute \$100.00 75-minute \$150.00

Payment is due at the beginning of each session. If payment is not made, the session may be rescheduled.

Cancellation Policy

Counseling is by appointment only. In the event you are unable to keep your appointment, it is your responsibility to notify me 24-hours in advance to avoid the **\$60.00** no-show, or late cancellation fee.

Insurance does NOT cover this fee.

Alcohol and Drug Policy

Please refrain from using either, at least 24-hours prior to your counseling appointment. If I perceive that you are under the influence, I may terminate at my discretion and charge the full fee for that session.

Emergencies

If you feel you need to speak with me prior to our next appointment, please call my office at 503.260.5118. I will return your call as soon as I am able (I do not return calls on Sundays). If you feel your situation is urgent or an emergency and cannot wait, call the Washington County Crisis (503.291.9111) or the Clatsop County Crisis (503.325.5724), dial 9-1-1, or go to the nearest hospital emergency room.

Confidentiality and Duty To Warn

Confidentiality belongs to you. You may direct me to release information to others, in writing. Release of information without your consent may only take place under certain circumstances: I have an ethical and legal obligation to prevent you from physically harming yourself or others. If I believe danger is imminent to self or others, I will use reasonable and conscientious effort to both protect you and/or warn a potential victim of your violence. As required by State law, I must report suspected abuse or neglect of a child, dependent adult, or developmentally disabled person if I have reasonable cause to believe that such an incident has occurred. I will attempt to inform you of my report, but cannot guarantee doing so. Further, I must respond to a court-ordered subpoena. Medical emergencies may also result in sharing your identity and/or confidential information. Your confidentiality also will not be guaranteed if your account is placed to collections.

Client Bill of Rights

The following client rights have been established by both the Oregon and Washington State Board of Licensed Professional Counselors and Therapists. Consumers of counseling or therapy services offered by licensees have the right:

1. To expect that a licensee has met the minimum qualifications of training and experience required by state law;
2. To examine public records maintained by the Boards and to have the Boards confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving as defined by rule and law, including the following exceptions:
 - a. Reporting suspected child abuse, elderly abuse, or otherwise vulnerable adult.
 - b. Reporting imminent danger to client or others.
 - c. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies.
 - d. Information that would facilitate treatment of a medical emergency.
 - e. Sexual exploitation, abuse, illegal, or unethical and unprofessional conduct by a mental health professional.
 - f. If you are a minor, access to your records by parents.
 - g. Providing information concerning licensee case consultation or supervision, and
 - h. Defending claims brought by the client against licensee
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the Board at the following address and phone number:

Oregon Board of Professional Counselors and Therapists.
3218 Pringle Road SE, Suite 250. Salem, OR 97302. 503.378.5499

Please print off and sign the following page, and bring to session, showing that you received the [above professional disclosure statement] and to confirm your understanding and consent to treat. Thank you.



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5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving as defined by rule and law, including the following exceptions:
 - a. Reporting suspected child abuse, elderly abuse, or otherwise vulnerable adult. b. Reporting imminent danger to client or others. c. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies. d. Information that would facilitate treatment of a medical emergency. e. Sexual exploitation, abuse, illegal, or unethical and unprofessional conduct by a mental health professional. f. If you are a minor, access to your records by parents. g. Providing information concerning licensee case consultation or supervision, and h. Defending claims brought by the client against licensee
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

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3218 Pringle Road SE, Suite 250. Salem, OR 97302. 503.378.5499

Consent Agreement

I have read and understand this consent form and have had an opportunity to have my questions answered. I agree to the above limits of confidentiality and understand their meaning and ramifications. My signature affirms my informed and voluntary consent to enter into a therapeutic relationship with Sandalwood Counseling LLC.

Client Name: _____

Last four/SSN# _____

Client Signature: _____

Date: _____ (SC: _____)