



formerly Presbyterian Counseling Service

restoring hope . . . reconciling relationships . . . transforming lives

Welcome to "The Clinic" at Samaritan Center of Puget Sound

**We are pleased that you have chosen Samaritan Center for assistance at this time in your life.
We hope that you will find this to be a positive and useful experience.**

About Samaritan Center

Samaritan Center of Puget Sound is accredited by the Samaritan Institute and affiliated with the Presbytery of Seattle. Our therapists come from a variety of Christian faith perspectives and represent a wide range of ages and life experiences. They are interested in and respectful of the spiritual values, beliefs and cultural heritage of all persons.

In providing therapy, we seek to engage in a process that is attentive to the integration of mind, body and spirit. We believe that healing occurs on multiple levels – mind, body, spirit and soul – and are always willing to consider with our clients the physical and spiritual as well as psychological aspects of healing. We are curious about the part that spirituality plays in wrestling with life's dilemmas and transition points, and we bring our own heartfelt responses to the situations in which our clients find themselves. We endeavor to promote growth and well-being in our clients, engaging with them in a collaborative manner to make the changes that they desire in their lives.

APPOINTMENTS

Sessions are 50 minutes in length. Consistency in keeping appointments is integral to the counseling process. If you are unable to keep an appointment, your counselor must have 24 hours notice or you will be charged for the session.

FEES

Clients in The Clinic at Samaritan Center are seen on a fee-for-service basis only and may not use insurance benefits to see a clinic provider. Counseling fees are based on client income and are agreed upon during the first therapy session. Payment is made at each session.

PARKING AT RAVENNA OFFICE

Off-street parking is available in the lot adjacent to the north of the Building, as well as on Ravenna Blvd..

YOUNG CHILDREN

Please do not leave young children unattended in the waiting room. We cannot be responsible for their safety.

EMERGENCIES:

In the event of a personal crisis, clients may call Samaritan's on-call therapist at 206-527-2266. To leave a message for the on-call therapist during office hours (M-F 9-6), clients should press 0 during the recorded message, or, if the call is made outside of office hours, press 6. If the call is not returned by the on-call therapist after a half hour, clients should call the Crisis Clinic at 206-461-3222.

To leave a non-crisis message, to cancel or change an appointment with your therapist, call 206-527-2266 and follow the voice prompt.

On these pages you will find information that will ensure that your needs as an informed client are met. This includes the training and professional background of your counselor, the rights of clients in counseling, and information about confidentiality.

DISCLOSURE STATEMENT

Martha (Mindy) McGovern

THE RIGHTS OF CLIENTS IN COUNSELING

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of therapy and the cost. As informed consumers, it is the client's responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

All therapists at Samaritan Center of Puget Sound are bound by the ethical codes of their professional organizations, by the laws of the State of Washington, as well as by agency policy regarding the special nature of the therapist-client relationship. This agency expects all counselors continually to be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her therapist is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the therapist and/or bring it to the attention of the agency's clinical director.

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless that law authorizes or compels us to do so. To see your record or get more information about it contact your therapist.

CONFIDENTIALITY

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside Samaritan, and then only with a release signed by the client. Exceptions to this rule: Washington state law mandates that there is no confidentiality when child abuse or abuse of a developmentally disabled adult has occurred within the last seven years. The counselor may also be required to break confidentiality in life-threatening situations when the client poses a clear and present danger to self or others or is unable to provide minimum life-sustaining self-care. If this occurs, the counselor will take the steps necessary to secure the safety of the client or others.

TRAINING AND PROFESSIONAL BACKGROUND OF YOUR COUNSELOR

Mindy McGovern earned a Master of Arts in Marriage and Family Therapy from Pacifica Graduate Institute and is licensed Marriage and Family Therapist in the State of Washington (license number MG 60760164). She began practicing as a therapist in 2018 and has worked with clients on concerns such as depression, anxiety, perfectionism, trauma, and life transitions.

Mindy is committed to pursuing continuing education and has completed professional trainings on topics including Emotionally Focused Therapy, Internal Family Systems (parts work), and Cognitive Behavior Therapy for anxiety and depression. She is also currently in the process of attaining national certification as a Sex Therapist. At Samaritan Center of Puget Sound, Mindy is supervised by Matthew Percy, Psy.D.

THEORETICAL ORIENTATION AND APPROACH TO COUNSELING

Mindy works with clients from a person-centered perspective, believing that clients have within themselves the potential to grow and find healing and that part of her role as a counselor is to help people find and utilize that potential. Mindy focuses on exploring emotions that come up in unhelpful ways and working with emotions to facilitate emotional change and growth. Mindy also helps clients explore various parts of themselves to foster increased self-understanding and self-acceptance and to help uncover one's authentic self. Mindy sees her role as partnering with clients to help facilitate growth in a creative and individualized manner.

THE USE OF AUDIO-VISUAL RECORDINGS

In order to help you most effectively, we may ask you to videotape counseling sessions. These tapes are used by your counselor to double-check their understandings of your concerns.

All records, tapes, or other identifying materials are kept confidential. The use of observation, taping, and supervision is an integral part of our training program and allows for instruction and/or supervisory input ensuring you the highest quality services possible. If you have any questions about these practices, please discuss them with your counselor.

RISKS OF COUNSELING

We are committed to helping you make informed choices as we work with you to address your concerns. This participation includes determining how counseling might benefit you and what techniques to use to help with your concerns. At any time you may ask us to explain why we're gathering information or prescribing a new approach. We will be glad to explain the purpose behind our techniques.

The greatest risk of counseling is that it may not by itself resolve your problem or concern. Thus, we do our best to assess progress on a week-to-week basis. Chronic non-improvement is treated as a reason for immediate referral.

As a professional training facility, we keep close track of research on how to help families most efficiently with least risk. We have learned from research, for example, to minimize conflict and steer around loaded issues early in therapy. You can trust that we will use such trusted information to help you. Should we fail to help you, we'll work with you to find someone who can.

APPOINTMENT POLICY: I understand that consistency in keeping appointments is integral to the counseling process. If I am unable to keep an appointment, my therapist must have 24 hours notice or I will be charged for the session.

FEE POLICY: I understand that having a reduced fee in the Samaritan Clinic means that I will not use any insurance benefits when seeing a clinic provider. I understand that the fee which is arranged at the first session may be adjusted as my financial circumstances change. I agree to pay my full fee to the therapist at each session. I understand that, if I fall behind in my payments, I cannot schedule additional appointments until overdue payments have been paid.

I agree that my fee for each counseling session is \$_____ Please initial here _____

Your Consent:

When you have read to this point and asked for clarification if necessary, please read the paragraph below and sign on the lines underneath it.

I have received and read the Disclosure Statement. I have read and understand the above statement on audio-visual recordings and risks of counseling. I consent to participating as a client with a student counselor-in-training, and understand that my therapist will be reviewing recordings or sessions within the context of scheduled supervision sessions. My signature below indicates that I give my full and informed consent to receive services.

Client Signature

Date

Client Signature

Date

Therapist Signature: *Martha (Mindy) McGovern, MA, LMFTA*

Date

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Samaritan Center for Puget Sound.

Signature of client (or personal representative)

Date

Signature of client (or personal representative)

Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

You will receive a copy of this form and one will be kept in your Samaritan records.

Name _____

Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure to have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

☐

Somewhat difficult

☐

Very difficult

☐

Extremely difficult

☐

—

GAD-7	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

☐

Somewhat difficult

☐

Very difficult

☐

Extremely difficult

☐

During the past 12 months...

Do you have concerns about your drug/alcohol use?	Yes	No
How many alcoholic drinks do you have daily/ Weekly?		
Did you spend time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	Yes	No
Did your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	Yes	No
Did you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	Yes	No
Is somebody close to you concerned about your alcohol consumption or drug use?	Yes	No

Over the past 2 months, please rate on a 0-7 scale to what extent these symptoms have being a problem for you. (0= not problem at all; 7= major problem).

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Diminished capacity for pleasure	<input type="checkbox"/> Manic/hypo-manic
<input type="checkbox"/> Low motivation	<input type="checkbox"/> Diminished sexual interest	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Anger: aggressive/abusive	<input type="checkbox"/> Eating and food problems	<input type="checkbox"/> Obsessive thinking
<input type="checkbox"/> Anger: irritability/temper/yelling	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Pessimism
<input type="checkbox"/> Anxiety: (symptoms of o.c.d.)	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Poor impulse control
<input type="checkbox"/> Anxiety: panic	<input type="checkbox"/> Gambling problems	<input type="checkbox"/> Procrastination/avoidance
<input type="checkbox"/> Anxiety: phobic	<input type="checkbox"/> Grief, loss	<input type="checkbox"/> Regret/remorse/shame
<input type="checkbox"/> Anxiety: worry	<input type="checkbox"/> Guilt thoughts/feelings	<input type="checkbox"/> Relationship/interpersonal problems
<input type="checkbox"/> Body image problems	<input type="checkbox"/> Impaired attention/concentration	<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Compulsive behavior	<input type="checkbox"/> Intrusive thoughts	
<input type="checkbox"/> Pain	<input type="checkbox"/> Self-esteem difficulties	
<input type="checkbox"/> Health problems (specify): _____		
<input type="checkbox"/> Other (specify): _____		

Comments: _____
