



Cascade View Counseling Services
12918 Mukilteo Speedway C-23 Box 178
Lynnwood, WA 98087
206-227-6139
cascadeviewcs.com

NAME _____

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

I hereby authorize Cascade View Counseling Services, LLC to evaluate, treat or provide consultation to the above-named person.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- All therapists are required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company. _____(inl)

Professional disclosure statement:

_____ Althea Brandis MA, LMHC is a mental health professional, licensed with the state of Washington (60237548). She has a master's in counseling – Psychology degree from Saint Martin's University in Lacey, WA which she obtained in 2008. Specialty includes diagnostic assessments, psychodrama/psychotherapy, and case management. She has over 15 years of clinical experience providing clinical support, individual, couple, family, and group counseling to clients struggling with relationship issues, personality disorders, adjustment disorders, depression, trauma and childhood abuse, grief/loss issues and anxiety disorders. Theoretical approach combines psychodrama, client-centered, cognitive-behavioral, solution-focused and family systems therapies to meet the individualized needs of each client.

_____ Claire Noonan, is a mental health intern completing her master's degree from Antioch University in August 2026. She is under the supervision of Althea Brandis, MA, LMHC, NCC. Her approach is person-centered, meaning she tailors her therapeutic work to meet each individual's unique needs. She brings social justice to her practice and specializes in working with LGBTQIA2+ individuals, life transitions, trauma, anxiety, depression, domestic violence, grief and loss. She is sex and body positive; kink and non-monogamy affirming and is currently pursuing full certification in domestic violence intervention.

I understand the Washington State Department of Licensing would like me to know:

“Counselors practicing counseling for a fee must be registered with the Department of Licensing for the protection of the public health and safety. Registration of an individual with their department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.”

As a client you have to right to:

- Be provided quality treatment, tailored to your best interest and particular needs.
- Actively participate in developing or modifying your plan of treatment.
- Be treated with respect and dignity.
- Receive treatment in an environment that is safe and not intimidating. Be provided services in a manner acceptable to persons who are of varying racial, ethnic, and cultural backgrounds, national origin, or veteran status.
- Be protected from invasion of privacy and have your treatment information handled in a confidential manner in accordance with applicable laws and regulations.
- Disclose your own treatment information to an individual or organization of your choosing.
- Be free of any sexual exploitation or harassment.
- Seek resolution of a care or access to care issue. Seek the support of an ombudsman. Ombuds Service contact 1-800-790-8049. ____ (inl)

As a client you are expected to:

- Accept a certain amount of responsibility for your care and to behave in a manner that will enhance the care process.
- Actively participate in your own treatment process by: participating in the planning for your treatment, working to meet treatment goals, and keeping scheduled appointments.
- Treat other clients and therapist with respect by: behaving in a manner respecting the individual’s dignity, and avoiding behaviors which are intimidating, exploitative, threatening, disruptive or violent.
- Take responsibility for financial reimbursement for services.
- Help maintain a safe environment by: not bringing any weapons onto the grounds or into the office, not bringing any alcohol or drugs onto the grounds or into the office, and not physically damaging any property. ____ (inl)

Appointments:

- All office visits are by appointment and may be scheduled through the office manager or your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.
- Late cancellation (less than 24 hours before) and/or no-show appointments are charged for the full session amount as insurance cannot be billed. If your appointment is cancelled or missed, contact your counselor to reschedule. We will not charge you for your first late cancellation.

- Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations and will be charged at a proration of the hourly fee for all consultations in person or by phone that are over 5 minutes in length. _____(inl)

Fees:

- The client portion (co-pay/Co-insurance) of fees is expected at the time of service. We accept cash, check, flexible spending account cards, and credit cards.
- Insured clients are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement reflecting any balance due on your account. This office cannot accept responsibility for negotiating a settlement on a disputed claim. You are responsible for payment (and unpaid insurance claims) on your account.
- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged and agreement signed.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts 90 days in arrears will be turned over for collections.
- Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from Cascade View Counseling Services your account must be paid in full. _____(inl)

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize Cascade View Counseling Services to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of Cascade View Counseling Services Privacy Policy

Client(s) Signature(s): _____ Date: _____

Parent or Guardian Signature(s): _____ Date: _____

Therapist Signature: _____ Date: _____