

Aging Well LLC
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Care Mediation Sessions Agreement

I, _____, understand, that *Care Mediation Sessions* facilitated by Joan McGinnis, MSW, are conducted solely for the benefit of the client, _____.

I understand that Joan McGinnis, MSW, is a *healthcare* professional, operating under the State of Washington license, [Licensed Independent Clinical Social Worker \(LICSW\)](#). As a healthcare professional, Joan McGinnis must keep healthcare records, and these records may be obtained by an official request from the client or from the client's Power of Attorney. Therefore, Joan McGinnis and Aging Well LLC cannot guaranty that any or all communications between Joan McGinnis and members involved in any way in the Care Mediation Sessions, whether or not these communications take part in face-to-face sessions, phone calls, e-mails, or any other form of communication, are confidential.

Signature _____ Date _____

mail to

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