Therapist Disclosure **R. Garth Retallick, MS, LMHC**

Center for Child and Family Therapy Washington License # LH60344426

Purpose of Disclosure Statement

This statement provides information about me and my treatment methods to better help you understand if I best suit your needs. Each professional at CCFT is an independent therapist and therefore not responsible for the actions of the other professionals, at this office. Every client has the right to choose a practitioner and treatment modality that best suits his/her needs. Please read the following information and discuss any concerns with me or the office staff.

Education/Training/Experience

I received my Master's Degree in Family Psychology from Capella University and 2 years doctoral training in classical clinical psychology. I have spent the last 19 years working with various environments and working with multiple populations and am a licensed mental health counselor in accordance to Washington Chapter 18.225 RCW, 246-809.

In accordance with RCW,246-809 and the WAC 18.225 I am bound to adhere to the state code of ethics. In your best interest and following the state code of ethics, I can only be your therapist. I cannot have any other role in your life for 2 years after services have completed. Even though you might invite me, I will not attend your family gatherings. I can never have a romantic relationship with any client during or any time after therapy.

Treatment Orientation and Methods

My theoretical orientation is in Cognitive-Behaviorism in that I believe as we think we do. I also am of the understanding that many of our thoughts and behaviors come from a combination of our families of origin and life histories. I believe that change comes when we realize where our thoughts and behaviors originate and that with guidance, love, and positive acceptance as human beings we can make the adjustments needed to make positive life-long changes.

I use a variety of methods in my interventions including talk therapy, eye movement-desensitization and restructuring (EMDR), relaxation/mindfulness training, trauma based cognitive behavioral therapy, and hypnotherapy to name a few. My services are designed to help people to identify goals and to access their internal strengths. Together we can concentrate on the steps needed to meet your individual and/or family's goals.

There are some risks as well as many benefits of therapy. You should think about these both when making any treatment decision. One risk is the a temporary increase in uncomfortable or negative feelings and the recall of unpleasant memories. These feelings and memories may bother you for a while. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt relationships and sometimes a client's problems may worsen, for a time, after beginning therapy. Risks like these are usually temporary and should be expected, especially when people are making important changes in their lives. Finally, even with our best efforts, therapy may not work as you would like. All of these should be weighed against the cost of not changing and continuing as you are. I do not take clients I don't feel I can help.

My focus is working with teens from 12 to 19, families, couples, and individuals. I see clients for such issues as: Depression, anxiety, stress, trauma/PTSD, phobia's, intimacy, divorce, marriage, pre-marital counseling, communication, coping, family conflict, parenting, self-esteem, mood and personality disorders. To be successful I have found it is essential for me to have a working knowledge of a client's family, social, cultural, educational, and emotional experiences to effectively treat an individual or family in therapy. As such we have to have an open and honest communication

Billing

The name on the billing statement you receive will be *Inlet Counseling*, the name of my business, an associated business with the Center for Child and Family Therapy, which is an association of private practitioners. Payments need to be made out to *Inlet Counseling*. If payments are not made in a timely fashion services may be terminated and accounts sent to collections. Additional costs may be added and may include collection fees, court, and attorney fees.

Consultants

I sometimes consult with other professionals about my clients. This helps me provide high quality therapy. These professionals are also required to keep your information private and confidential. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.

Communication with Your Therapist

I can be reached through the office phone at (360) 698-9258. At times I will be available to take your call. At other times, it will be necessary to leave a message with my voicemail, which is operational 24 hours per day and is confidential. I typically do not check my voicemail on weekends, days off, or vacation time. I am willing to communicate with you electronically through email. If you would like to communicate via e-mail, I can be reached at the general email: admin@ccftherapy.com.

Client e-mail Informed Consent and Risk of using email

a. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. E-mail senders can easily misaddress and it may not be secure and therefore confidentially may be breached, which I am not liable for.
c. Back-up copies of e-mails may exist even after the sender and/or the recipient has deleted his or her copy.
d. E-mail can be used as evidence in court.
e. E-mail does not contain contextual information normally acquired through in-person meetings, which can lead to misunderstandings. If we have a misunderstanding, lets resolve this over the phone or in-person.

I cannot guarantee, but will use reasonable means, to maintain security and confidentiality of e-mail information sent and received. I am not liable for improper disclosure of confidential information that is not caused by my intentional misconduct. E-mail is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email will be read and responded to within any particular period of time. All e-mail will be printed and filed into the client's medical record. Clients/parents/legal guardians should not use e-mail for communication of sensitive medical information. If you would like to secure our email conversations, please let me know and I can secure and encrypt our email communication.

_____ **initial here**

Records and Record Keeping

I use Office Ally for billing and scheduling. This business is certified HIPPA compliant. I will keep your records for 5 years after we end therapy unless I am contractually obligated by your health insurance to keep them longer. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes and records constitute my clinical and business records, which by law, I am required to maintain. Records are the sole property of me. You do have the right to request that I correct any errors in your file. Should you request a copy of your records, such a request must be made in writing. I also reserve the right to refuse to produce a copy of your record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. If you have questions, please ask me.

State requirements

Therapists practicing counseling for a fee must be licensed with the Department of Licensing and the Department of Health for the protection of the public health and safety. Licensure of a therapist does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment. The full law and regulations can be found in RCW 18.19.

Cancellation of appointments

Please understand that when you make an appointment, I am reserving that time for you. If you miss an appointment, that is time that could be spent with another client, please notify me 24 hours prior to your appointment if you need to cancel or reschedule. Failure to provide 24 hours' notice will result in a $50.00 late fee, and "no show's will result in a $100.00 out of pocket fee, that your insurance will not cover. Failure to attend 3 appointments will constitute notification of termination of services on your part and we will send notification of such via Post. _____ **initial here**

I have read all of the above information and have received clarification as needed. I agree to the terms as stated above. I hereby enter into therapy with this therapist and to cooperate fully and to the best of my ability, as shown by my signature below.

_____ Responsable Party/Client Signature _____ Date

_____ Responsable Party/Client Signature _____ Date

_____ R. Garth Retallick, MS, LMHC

❑Copy accepted by client ❑ Copy accepted by additional person