THERAPIST DISCLOSURE
Center for Child and Family Therapy

Sharon Booker, LMHC
Washington License No. LH00009326

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. Every client has the right to choose a practitioner and treatment modality that best suits his/her needs. Each professional at CCFT is an independent therapist and therefore not responsible for the actions of the other professionals, at this office. Please read the following information and discuss any concerns with me or the office staff.

Education/Training/Experience

I received a Masters of Mental Health Counseling Degree from Washington School of Professional Psychology at Argosy University and have a BA in Psychology from the University of North Carolina at Chapel Hill. I have experience working with children, teens, individuals, couples, families and people with disabilities in a variety of settings.

I am a Licensed Mental Health Counselor and a professional member of the Association of Play Therapy. I adhere to the codes of ethics of the above and the professional standards of the Washington State Department of Health. My code of ethics states that; I can only be your therapist, I cannot have any other role in your life. I cannot be a friend to or socialize with any of my current and past clients. I cannot have a business relationship with any of my clients other than the therapy relationship.

Treatment Orientation and Methods

My approach to counseling is to focus on the strengths and help to assist with solutions rather than telling you what to do. For adults and adolescents, my focus is to address short term problems as well as long term psychological well-being. The more you can tell me about what and how you are feeling, the more effectively I will be able to assist you in resolving your personal problems and issues. I am trained in many different treatment approaches. It is my approach to discuss these various techniques and let you participate in choosing the ones that are most appropriate for you.

There are some risks as well as many benefits of therapy. You should think about these both when making any treatment decisions. One risk might be that for a time, there may be an uncomfortable level of negative feelings. Clients may recall unpleasant memories. These feelings or 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 marital or couple relationship. Sometimes, a client's problems may worsen after the beginning of treatment. Risks like these are hopefully temporary and should be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out 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 on clients I do not think I can help.

Communication and Emergencies

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 confidential voice mail, which is in operation 24 hours per day. I do not check my voicemail on weekends, days off, or vacation time.

The nature of my practice does not allow me to provide continuous emergency services. If you have an **EMERGENCY,** call the **Crisis Line at (360) 479-3033;** or in case of a **life-threatening emergency, call 911.**

Records and Record Keeping

I use Office Ally for billing and scheduling. This business and software is 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 reserve the right, to provide you with a treatment summary in lieu of actual records. 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.

Billing

The name on the billing statement you receive will be *Sharon Booker* and payments need to be made out to *Sharon Booker*.

Appointment and Cancellation Policy

I require *24 hour* notice for any canceled appointment. I am rarely able to fill a canceled session with-in 24 hours, so you will be charged for the missed appointment. If you do not show up and you do not contact my office by phone within 24 hours of your appointment, you also will be charged a fee for the missed appointment. If you are late, we will be unable to meet for the full time because it is likely I will have another appointment after yours. Your insurance **WILL NOT** pay for this. The charges are as follows:

$25 for the first missed appointment
$75 for the second missed appointment
$150 for the third missed appointment

If you miss THREE appointments in a row or no show TWO appointments in a month consistently, all future appointments will be canceled and you are responsible for initiating rescheduling. We will talk about the circumstances for missing appointments at your next session and work together to find a reasonable solution. _____ initial here

Other Fees

Any other services, such as letter writing, etc. will be calculated and prorated at $150 per hour which will be discussed ahead of time. However, a letter of attendance for a school is available upon request for no charge. _____ initial here

Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with your attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in your legal matters. I will generally not provide records or testimony unless compelled to do so. Fees for telephone or any other consultation for legal matters will be billed at the regular therapy hour $150 per hour. For any court appearances and or other legal matters are billed at $250 per hour. Concerning court appearances, the time starts when the clinician leaves the office until the court, judges, or attorneys dismiss them and they return to the office (portal to portal). This includes appearance by phone. You will not be reimbursed by your insurance company, therefore you will be responsible for all fees. _____ initial here

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. The two professionals that I consult with are Terry Boyle, MFT and Dr. Tony Stanton, MD.

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.

Consent

By signing below, I acknowledge that 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 Sharon Booker, LMHC and to cooperate fully and to the best of my ability, as shown by my signature below.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (relationship to client) Date

_____ _____
Sharon Booker, LMHC Date

❑ Copy accepted by client ❑ Copy accepted by additional person