THERAPIST DISCLOSURE

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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. Please read the following information and discuss any concerns with me or the office staff.

Education/Training/Experience

I hold a Masters of Counseling Psychology degree from City University of Seattle and a Bachelor's degree in Psychology from the University of Washington. I have been working in mental health since 2000 in various capacities including providing counseling, mental health assessment, group therapy, psychoeducation, teaching undergraduate psychology students, and creating curriculum for undergraduate psychology courses.

I am a licensed mental health counselor (LMHC). I am a Washington State Licensed Mental Health Therapist and trained to mental health counseling (not law, medicine, finance, or any other profession). I am not able to give you advice from these or other professional viewpoints. I am a mental health supervisor. I adhere to the codes of ethics and the professional standard of Washington State Department of Health. I cannot have any other role in your life. I cannot, now or ever, be a close 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 treatment approach is individually, strength, and behaviorally based. I believe you come to therapy already equipped with inherent skills to help address your areas of concern, my role is to help you identify and access those strengths and skills, gain insight into and address problematic behaviors, provide education, and information in order to achieve your goals. I expect you will be an active participant in the therapy process and complete any outside activities agreed upon during our sessions. A large part of behaviorally based therapy is continually applying the information from therapy to your life and experiences outside the treatment sessions. The more active you are in your therapy process, the more you will benefit from the work we do together. Participating in therapy may involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. **During the therapeutic process, many clients find that they feel worse before they feel better.** This is generally a normal course of events. You should address any concerns you have regarding your progress in therapy with me.

My treatment methods include but are not limited to cognitive behavioral therapy, positive psychotherapy, dialectical behavioral therapy, brief solution focused therapy, psychoeducation, play therapy, and family systems therapy. I utilize positive parenting approaches when treating children and families. The delivery of these methods is accomplished via individual, couples, family and play therapy. We will maintain an open dialogue throughout your therapy process to ensure the methods and focus of treatment remain aligned to your goals.

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 voice mail, which is operational 24 hours per day. I do not check my voicemail on weekends or days off.

The nature of my practice does not allow me to provide continuous emergency services. If you have an EMERGENCY, please call the Crisis line at 479-3033; or in case of a life-threatening emergency, call 911. In the event that I will not be available for a prolonged time such as during vacation periods or during professional workshops, advanced notice will be given.

Records and Record Keeping

I use an encrypted password protected hard drive with a secondary encrypted password protected back up to store all client records. 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.

Billing

The name on the billing statement you receive will be Center for Child and Family Therapy. Any payments need to be made out to Center for Child and Family Therapy. I use Office Ally for billing. This business is certified HIPAA compliant.

Client 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. If I am subpoenaed and required to attend court proceedings you will be charged my hourly rate of $220.00 per hour, in most cases, will not be reimbursed by your insurance company, therefore you will be responsible for this amount.

_____ initial

Other fees

Any other services, such as letter writing and any time spent on other services over 15 minutes, will have an additional charge of $50 per 30 minute increments.
_____ initial

Communicating with Your Therapist

I would like to communicate with you electronically, preferably through email. Email is not secure and nor encrypted which can possibly be read by others. I have found email to be more effective than calling me and then leaving a confidential voicemail. Most times it will be necessary to leave a message with my voice mail, which is operational 24 hours per day and is confidential. I do not check my voicemail and email on weekends or days off.

Client e-mail Informed Consent

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, let's 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.

If you would like to secure our email conversations, please let me know and I can secure and encrypt our email communication.

If you would like to communicate via e-mail, I can be reached at stacie@ccftherapy.com

Please initial:

_____Agree to communicate via email
_____Disagree to communicate via email

Email address:_____

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and myself. I consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with client by e-mail. _____ initial here

Other Fees and Credit Card Authorization

Any other services, such as letter writing, etc. will be calculated and prorated at $150 per hour which will be discussed ahead of time. _____ initial here

Consultation

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.

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

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 agree to cooperate fully and to the best of my ability, as shown by my signature below.

_____ _____

Responsible Party/Client Signature Therapist Signature

_____

Date

❑ Copy accepted by client ❑ Copy accepted by additional person