Disclosure Statement

Alison Withey, LMHC
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LMHC LH# 60304093

Purpose and Credentials

In accordance with Washington State law, the Washington Administrative Code (WAC) and the Revised Code of Washington (RCW), a Disclosure Statement is written to provide clients with information to help assist them in making decisions about their counseling. This Disclosure Statement must be signed by both the client(s) and the counselor. The client(s) signature will indicate that they have read, and understand the information provided.

I provide therapeutic counseling and psychotherapy for individuals, families, couples, and groups. I am a Licensed Mental Health Counselor with the State of Washington (LMHC LH# 60304093), and a member of American Mental Health Counselors Association (AMHCA).

Methods or Techniques used

I use an eclectic approach to counseling, drawing from a wide range of therapeutic modalities that are interwoven to the systemic and developmental needs of my clients. The models I use are strength-based, relational approaches. Using a relational model I examine the development of problems in our lives as often occurring within the patterns of our relationships, the multitude of our wider connections including families, community, work, and our environment. As a strength-based counselor it is my belief that each of us possesses our own inherent personal strengths and innate wisdom that steer us toward health and fulfilling our life's purpose.

The therapeutic orientations I draw from and use in my counseling sessions include: Systems Theory, Family Systems, Relational Therapy, Cognitive Behavioral, Guided Therapeutic Imagery, Journal Therapy, Gottman Method Couples Therapy, Emotionally Focused Couples Therapy, Lifespan Integration, Hypnotherapy, Narrative Therapy, Positive Therapy, and Solution Focused Therapy. To find out more about these therapeutic orientations you can visit www.goodtherapy.org on the web and click on "types of therapy/models of therapy" in the site navigation on their main page.

Education, Training, and Experience
I received a Master of Arts in Applied Behavioral Science, Systems Counseling Track, from the Leadership Institute of Seattle (LIOS) program at Bastyr University. Additionally I am a Positive Discipline Parent Educator. I have worked for many years in the nonprofit sector with organizations serving individuals and families with facing issues surrounding cancer, homelessness, as well as mentoring teen mothers. Prior to beginning my private practice I provided counseling to children and families with a wide range of issues at a community mental health center. I am regularly seeking out and participating in workshops and retreats that further my growth and nourish my life as an individual, a community member, and as a counselor. I am passionate about my chosen path, a lifetime of learning, and serving my clients to the best of my abilities.

Fee Information
My fee of ______ for a fifty minute session, ______ for an eighty minute session, and $_____ for a ninety minute group session is payable at the end of your session.

Cancellation Policy
If you must cancel your appointment please contact me, during office hours, at least 24 hours in advance.
You will be responsible for the full fee if cancellations are received with less than the required 24 hours notice.

Appointments
Therapeutic counseling appointments are generally fifty minutes in length. Longer appointments can be arranged if mutually agreed upon. If you arrive late for an appointment, we will still conclude the session at the scheduled ending time. I accept personal checks, cash and major credit cards (there will be a $20.00 fee for returned checks).

Professional Standards
I am accountable for my work with you. If you have any concerns about my work, please discuss them with me.

Clients Rights
You have the right to choose a counselor who bests suits your needs and purposes.
You have the right to:

1. Decide whether or not to receive therapeutic counseling from me. If you wish, I can provide you with names of other qualified professionals.
2. Know the course of treatment and my preferred treatment methods. Please ask if you have any questions.
3. End therapy at any time without any legal or moral obligation. You do need to let me know if you wish to end our therapeutic relationship, in person, by phone, or by letter.

4. Review your records, or request in writing that no records be kept except the minimal identification information.

Ethics and Professional Standards
The Washington State Licensing Department asks that you be informed of the following:

“Counselors practicing for a fee must be credentialed with the department of health for the protection of public health and safety.” Credentialing of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of such treatment.” WAC 246-810-031

I honor all regulations in the Counselor Credentialing Act 18.19 RCW. The purpose of the law is:

The Counselor Credentialing Act is in place to provide protection for public health and safety and to empower citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. Contact information for reporting is: The Washington State Department of Health, Health Professions Quality Assurance Division, at P.O. Box 47869, Olympia, WA 98504-7869. Phone: (360) 236-4902 Mondays through Fridays, 8am to 5pm.

Limits of Confidentiality
Within certain limits, information revealed by you during treatment will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. The following are exceptions to this law RCW 18.19.180:

1. With your written consent (or in the case of death or disability, your personal representative, other person authorized to sue, or the beneficiary of a life insurance policy on your life, health or physical condition.);
2. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
3. If disclosure is compelled or permitted by the fact that you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
4. If disclosure is compelled by the Washington State Child Abuse and Neglect Reporting Act (for example, if I have a reasonable suspicion of child abuse or neglect).
5. 5. If disclosure is compelled by the Washington State Elder/Dependent Adult Abuse Reporting Law (for example, if I have a reasonable suspicion of elder abuse or dependent adult abuse).

6. You waive this privilege by bringing charges against me.
7. If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.

I *may* inform you of my actions although law does not require notice to you.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed in formal or informal sessions with my colleagues or with other professionals. During these consultations, neither your last name nor other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services and I will thank them for the referral. I will not discuss your situation with them unless I have your written permission.

I have received and read this Disclosure Statement. I have also had the opportunity to ask questions and do now satisfactorily understand the information presented above. With this signature, I indicate that I have read and understood the above policies and procedures of the office of Alison Withey, MA and consent to counseling in the terms described above. (For clients under the age of 13, consent must be given and this form must be signed by either a parent or legal guardian).

You are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement.

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(Client Signature) (Date)

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(Print Name) (Email address)

____

(Client Signature) (Date)

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(Print Name) (Email address)

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(Counselor signature) (Date)