



Disclosure Statement

Chuck Britt, MA, LMFT

SKAGIT FAMILY STUDY CENTER

Washington State Licensed Marriage & Family Therapist No. LF 00001447
Children's Mental Health Specialist W.A.C.



We have agreed to do important work together. I have designed this agreement to establish a safe structure for us and also to conform to Washington State Regulations. This structure, along with established professional ethics, protects our work and helps to make our relationship a safe place for growth and change. Please read the following carefully. If, for any reason, you have difficulty understanding any part of it please ask for assistance.

CLIENT RIGHTS:

- You have the right and the responsibility to control your own therapy.
- You have the right to choose a counselor that best suits your needs.
- You have the right to privacy, and information shared during the therapy process will remain confidential unless a signed release is obtained. (See exceptions below.)
- You have the right to ask questions at any time. I will do my best to be responsive.

Therapists practicing counseling for a fee must be registered or certified in accordance with the Counselor Credentialing Act with the Department of Health for the protection of the public health and safety. This empowers you with a complaint process against counselors who would commit acts of unprofessional conduct. Licensing of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you believe I have violated my responsibilities as your therapist, you can contact your local law enforcement agency or the State of Washington Department of Health at (360) 664-9098.

CONFIDENTIALITY:

Under the law, I will disclose confidential information in the following situations:

- When there is reason to suspect the occurrence of child abuse or neglect.
- When there is a clear threat to do serious bodily harm to self or others.
- To a court under court order.
- In the event that you bring charges against me.
- To the office management website, Office Ally, for the purpose of medical record keeping and medical insurance billing. Office Ally has signed a confidentiality statement, which is on file in my office and conforms to HIPPA requirements.
- When necessary to insure best practice I will seek consultation from other qualified professionals who are also bound by and respect your right to confidentiality.

COUNSELING GOALS:

The goal is **Voluntary** change. You can choose to change the way you think, and/or behave. It is possible that you may "get worse before you get better." Some experience this as they work at changing. In parenting situations you can choose to save money and speed up results by coming to one of our parenting groups.

TREATMENT PROVIDED:

I am trained and licensed to provide individual, group and family therapy. I have a Masters Degree in Counseling Psychology, and over 20 years experience in the field. I do not discriminate on the basis of race, sex, age, religion, sexual orientation or physical challenges. I approach the therapy process from a family systems theoretical framework using a variety of interventions including but not limited to Gestalt, Reality Orientation, Play Therapy, Active Listening, Transactional Analysis, Strategic Interventions and I teach Therapeutic Parenting skills. I operate from a philosophical belief that the therapy process is most effective when the whole family participates. Duration of treatment will be negotiated as the therapy progresses. Good therapy is non-judgmental. I can invite you to look at the consequences of your choices. I have no right to judge anyone.

FEES, PAYMENTS AND CANCELLATION POLICY:

I charge \$85.00 for therapy sessions lasting 45-50 minutes in length. The initial evaluation session may cost up to \$125.00 depending on complexity. As a courtesy we will check on your insurance and attempt to collect electronically using our billing service. Benefits quoted to you by your insurer are not a guarantee that they will pay for the services you receive here. You are responsible for payment in full for each session. I expect full payment or your co-pay at the time of the session unless other arrangements are made. If your co-pay amount is not known at the time of any visit a standard fee of **\$20.00 is due at each visit**. Your account will be adjusted once the insurance company has made payment or when you benefit is clear. I require a minimum of **24-hour notification** for cancelled appointment. If you choose to **No Show or Cancel** with less than 24-hour notice you will be choosing to pay the **\$60.00 No Show / Late Cancel Fee**. (Genuine emergencies excepted)

URGENT OR EMERGENCY SITUATIONS:

EMERGENCY..... **911**
 CARE CRISIS RESPONSE SERVICES (24 HOUR)..... **1-800-584-3578**
 CHILD PROTECTIVE SERVICES..... M-F 8:00AM TO 5:00PM **1-360-416-720**. After hours **1-800-794-9402**
 FOR HELP WITH A SELF TIME OUT CALL CHUCK AT..... Call **360-336-3882**. Chuck will pick up if he can or return urgent calls as soon as he gets the message. Also go to our website at <http://www.selftimeout.org> for help with a Five Step Self Time Out.

CLIENT SIGNATURE AND AGREEMENT:

I have received and read this sheet and understand it's content and intent. I understand the limits of confidentiality. I have received my copy of **Counseling or Hypnotherapy Clients, We Want You to Know** provided by the State of Washington for Counseling Clients. I understand that I am responsible to pay for each session in a timely manner. I understand that I may not get the results I want and that I can stop treatment at any time.

Chuck Britt, MA, LMFT: _____ Date: ____ - ____ - ____

Client: _____ Date: ____ - ____ - ____