**Elaine J. Webster, M.A., LMHC**

**226 Summit Avenue East**

**Seattle, WA 98102**

**206-355-9932**

**DISCLOSURE STATEMENT**

# **PROFESSIONAL QUALIFICATIONS**

I am a Licensed Mental Health Counselor in the state of Washington (license #: LH00006691).

I completed my Master’s degree in Psychology from Seattle University in 1990 and received my Bachelor’s degree in Psychology from the University of Washington in 1983.

Over the past 20 plus years, I have completed hundreds of hours of post graduate training in therapy techniques, theory and ethics. I have thousands of hours of professional experience working with a wide range of client issues from chronic mental illness to mild depression and anxiety as a therapist and a supervisor.

I have advanced training in Emotionally Focused Couples Therapy and I am a Certified Gottman Educator for the Bringing Baby Home Workshop for couples.

I have a child specialist designation from the state of Washington.

I participate in ongoing training and consultation seeing this as vital to my ability to work with clients responsibly.

# **THERAPEUTIC ORIENTATION**

My goal is to help you as my client to trust yourself and your emotional process more deeply as a path toward healing. I am focused on what works best for you as we come to understand what you need from therapy and what may be in the way of living your life to the fullest.

The therapeutic relationship is unique in that it allows you a safe place to explore thoughts and emotions without judgment. You do not have to know where the process will lead from session to session, nor do you need to feel alone in your struggles.

I encourage you to direct your sessions and allow me to act as an experienced guide to assist in identifying what is needed to help you reach your goals.

For couples, I am a support to both partners. I do not take sides. I encourage kindness and honesty and learning to communicate with each other in ways that promote connection and deeper understanding. Negative emotions are viewed as guideposts identifying things that get in the way of intimacy and meeting each other’s deepest needs. We identify the negative cycle together and learn new ways of self-expression and fulfillment in relationship. Often this involves one or both partners seeking individual therapy. If that is the case I am able to provide a list of skilled therapists for referral.

# **CONFIDENTIALITY**

# I participate in group supervision with other highly trained and licensed therapists. All case consultations are discreet, with a constant awareness of the unquestionable right of client privacy. Limits of confidentiality are imposed by your insurance company as explained in the insurance discussion in this disclosure statement.

# It is important to realize that mobile phones, cordless phones and electronic communications carry with them an inherent danger of being intercepted.  Please keep this in mind when you are emailing or calling. I discourage the use of email for anything other than appointment information.

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**LIMITS OF CONFIDENTIALITY**

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

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**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

**RECORD KEEPING**

I am required by the Health Care Information Act to provide you the following.

NOTICE: I keep a record of the health care services I provide you. You may ask me to see a copy of that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information upon request.

**CLIENT RIGHTS**

You as an individual, have the right to choose a counselor who best suits your needs and purposes. You are in control of your therapy. You have a right to ask questions if you do not understand what I say. You have the right to determine your needs and to participate actively in the development or modification of the therapy plan and you retain the right to refuse the use of any therapeutic techniques that are uncomfortable or unwanted.

 You have the right to considerate and respectful treatment, in a manner that promotes dignity and self-respect, regardless of race, age, religion, marital status, sexual or gender identity, political ideology, legal status, economic status, physical status or national origin.

 The law that regulates counselors is known as the Counselor Credentialing Act. The purpose of the law is (a) to provide protection for the public health and safety, and (b) to empower the citizens of the state of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct. Attached is information that includes the acts subject to discipline as found in RCW 18.30.180 as well as the name, address and contact telephone within the department of licensing.

 State law requires the following statement be provided:

"Counselors practicing counseling for a fee must be registered or licensed with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."

The term Licensed Mental Health Counselor indicates the completion of post graduate training, post graduate supervision, and a written examination to indicate advanced status.

**CLIENT RESPONSIBILITIES:**

Full payment is expected by the end of each session unless other arrangements are negotiated.

My fee is $120 per session for couples and $100 per session for individuals. Sessions are 45-50 minutes long.

**It is helpful to have your check prepared before your session**.

 An appointment is a reservation of my time. The earliest possible notice is appreciated when you are unable to keep the appointment. Please contact me at least 24 hours in advance when cancelling an appointment. I charge a full session fee for missed appointments. Insurance will not pay for missed sessions.

**INSURANCE PAYMENTS:**

You are responsible for getting all authorizations needed prior to your first full session. If you do not get the proper authorization you will be responsible for full payment for the sessions attended that are not covered by your carrier. All co-pays must be paid at the time of each session. You are responsible to be in compliance with insurance company requirements for deductibles and co-payments as well as any specific demands of your individual company. Your signature to this contract is considered authorization for them to make payment to me. Please be aware that you will be responsible for paying for all sessions not authorized by your insurance company for any reason.

**SIGNATURES: Please sign to indicate you have read and received this complete statement and agree to payment and insurance billing arrangements, if applicable:**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ THERAPIST**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Insurance Information for Billing: (note: I cannot bill insurance without complete information)**

**Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy No. :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Address of insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Insurance Contact Phone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**