

Bethany Anderson, M.S., MFT

9431 Coppertop Loop, Suite B

Bainbridge Island, WA 98110

206.780.7822

www.collaborativefamilytherapy.com

DISCLOSURE AND AGREEMENT

It is an honor to walk alongside you in your therapeutic journey. This agreement outlines what to expect from our work together. Please ask me any questions that you may have regarding this document.

Background:

I have a Master of Science Degree in Marriage and Family Therapy from Seattle Pacific University and I am a Registered Counselor in the State of Washington. Registration #: RC00052927.

I provide therapy to children, adolescents, adults, couples, and families. I have experience working in the areas of disability, chronic illness, life transitions, relationships, identity, depression, and anxiety.

I am an independent private practitioner who shares office space and collaborates with Michelle Naden, Ph.D., Kurt Johns, Ph.D., Sally McIntosh Stoehr, M.A., Kimberly Delaney, M.S., and Jeremy Mays, M.S within the offices of Collaborative Family Therapy. There is no implied or expressed professional or business relationship between practitioners within this clinic.

Therapeutic Orientation:

My therapeutic orientation is Narrative Therapy. I am interested in the meanings that you make from your life experiences and the influence that these have on your perspectives of yourself, your relationships, and your future. I find that viewing problems as separate from personhood helps to lessen feelings of guilt and shame so that we can work together in a collaborative environment. My training in family systems theory informs my view of people in the context of their relationships, environment, and culture.

Course of Therapy:

Each course of treatment is unique to those who participate in it, and thus your therapy will be a blend of what you and I do together. In order to best serve you, I will look for a rich description of the problems that you face and your goals for treatment so that our work together is congruent with your needs. You are responsible for your decisions and your degree of interaction with treatment. My role is to educate and support you during this period of change. I may encourage you to see your problem from multiple perspectives and ask questions to develop a rich description of your problem and preferred way of functioning but you are in charge of the changes and choices that you make and how you implement them.

Rights and Commitment:

I will collaborate with you and your family to provide you with the best service possible. I encourage questions and conversations about our work together. You may stop participation in therapy at any time or ask for a referral to another qualified therapist. You may ask any questions concerning my treatment methods. I commit to adhere to the Code of Ethics of the American Association for Marriage and Family Therapy and the ethical and professional standards of the Washington State Omnibus Credentialing Act for Counselors and the Uniform Disciplinary Act for the Regulation of Health Professions.

Fees:

The fee for therapy sessions is \$85 for a 50 minute session. Phone, computer, and collateral contact time are prorated per hour. **If you cannot keep an appointment, please notify me at least 24 hours in advance, otherwise you will be billed for the full fee.** If you are ill, contagious, or have a fever, please do not come to the session. Payment is due at the time of services rendered and can be made in the form of cash, money order, or check. When appropriate, I can provide you with a statement including necessary information for insurance reimbursement.

In the event that you become a participant in a legal action either while in treatment with me or after treatment concludes; and that legal action results in my being subpoenaed and/or having your records subpoenaed, I must charge you \$85.00 per hour for all of my time devoted to responding to that subpoena, and/or preparing for and participating in any depositions and/or court appearances – regardless of whether the subpoena is later quashed or excused.

Communication and Emergencies:

You may leave a confidential message on my voicemail. I will make every effort to check messages regularly during the week. However, I typically do not check voice mail messages on weekends unless I have made prior arrangements with you to do so. In case of emergency, if you cannot reach me, please call the 24 hour crisis clinic at (360) 479-3033 or 1-800-843-4793 or dial 911.

Confidentiality:

It is my legal and ethical duty in the State of Washington to preserve private and confidential information regarding our sessions. When working with couples or families, I reserve the right not to keep secrets between individuals within the therapy process due to my belief that open communication is important to growth in relationships. It is my intention to stay in continued conversation regarding our contract, the relationships involved, and confidentiality. Please note that in the state of Washington, children ages 13 and older have the right to full confidentiality regarding their psychotherapy process if they so choose. Questions and conversation are welcomed about this process. I keep written notes of our sessions, and you may review these notes and obtain copies at any point in time. Any written communication, including collateral contacts, will be included in your file. Email communication addressing issues other than appointment scheduling and billing will be addressed at the next session and/or by phone and deleted. I reserve the right to respond to emails that pertain to scheduling and billing, and will delete them after doing so. Please be aware that cellular phone and email contact have limited confidentiality.

There are certain circumstances in which I am legally obligated to release information **without** your consent:

- **You give strong indications that you are likely to harm yourself or someone else.**
- **I have reason to believe that a child, adolescent, elder, or dependent adult is experiencing abuse or neglect.**
- **An involuntary commitment for mental health assessment appears necessary.**
- **You bring charges against me as a legally registered counselor.**
- **I receive a court order to share information with a judge or attorney.**

DOH Statement:

The Department of Health requires the following statement to appear:

Counselors practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department of Health does not include recognition of any practice standards, or necessarily implies effectiveness of any treatment.

Consent to Treatment:

I hereby acknowledge that I have read and understand this disclosure and agreement document and have received a copy for myself if I so desire. I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to treatment under the terms described above and understand that I have the right to terminate treatment at any time.

Client's Signature _____ Date _____

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____