Katherine E Reeves, MA, LMFT
Washington State Licensed Marriage and Family Therapist #LF60603397
325 118th Ave SE Suite 210 Bellevue, WA 98005
425.998.8059

Disclosure for Treatment

I would like you to understand and agree to important aspects of therapy and the process of change.

1. You have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs.

2. For some people, the process of change can be stressful and uncomfortable. If you experience undue discomfort, please discuss this with me.

3. After the first session or two, the diagnosis and treatment plan will be discussed with you for your approval.

4. Therapy may not by itself resolve your problems. Progress will be periodically jointly evaluated.

5. Modes of Treatment: narrative therapy, family systems and genograms, cognitive-behavioral (including exposure & response prevention), psychoeducation, interpersonal therapy, supportive therapy.

6. If you have any questions regarding any of these forms of treatment and how they are being used in your therapy, please discuss them with me. If an alternative form of treatment seems appropriate to your case, this will be discussed with you and a referral will be made.

7. Qualifications: Master's degree in Clinical Psychology from Antioch University Los Angeles, specialization in LGBT Affirmative Psychology; Washington State Licensed Marriage and Family Therapist #LF60603397; AAMFT Clinical Member; Professional Member, Anxiety and Depression Association of America; Professional Member, International OCD Foundation. I have completed the Level 3 Practicum Training in Gottman Method Couples Therapy.

8. Please note that I work as an independent solo practitioner; **not in a group practice**. Only I am responsible for your therapy.

9. The acts of unprofessional conduct for LMFTs are listed under RCW 18.130.180. Should you wish to make a complaint, the Department of Health may be contacted at:
   Health Systems Quality Assurance
   Complaint Intake
   P.O. Box 47857
   Olympia WA 98504-7857
   (360) 236-2620

10. Confidentiality: It is your right and my duty to keep the content of our counseling sessions in the strictest confidence at all times. No identifying information will be released without your written consent (or in the case of a minor under age 13, without the written permission of their parent or legal guardian). If I am seeing a couple or family, no information will be released without the written consent of all parties.

However, according to Washington law, the following situations are exceptions to your right of confidentiality:

• If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.
• If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Child Protective Services or Adult Protective Services.
• If you submit claims to your insurance company, they may require information about your treatment.
• If a court of law issues a legitimate court order, I am required to provide the information specifically described in that order.
• If you commit a crime on my premises or against me or if I need to defend claims against me, I am allowed by law to disclose your healthcare information.

Furthermore, in order that I am at my most effective and authentic I request that domestic partners, married couples and members of the same nuclear family waive their rights to confidentiality among each other. This does not mean that I will necessarily disclose any such information. It does mean that I may do so, if I believe it is necessary for the success of your work. I would first discuss this with you and encourage you to share the information yourself.

Additionally, I meet regularly with a consultation group so that we may gain a better understanding of how we can work with our clients more effectively. In consultation your identity will be protected, as will unique identifying information. The other professionals with whom I meet are bound to the same standards of confidentiality as I am.

State law requires that the disclosure statement include the following two paragraphs:

a. WAC 308-109-040: “Counselors practicing 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 recognition of any practice standards, or necessarily imply the effectiveness of any treatment.”

b. SHB 1828: “A record of the mental health care provided to you is kept by this office. You may ask to see and copy that record. You may also ask this office to correct that record, if you believe the information within your record is in error. A copy of your corrections to the office records will be placed within your record, at your request. This office will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it at this office.”

Client Acceptance: I/We have read this document, understand the content, accept the terms, and have received a copy of this agreement. I/We consent to therapy with Katherine Reeves, M.A., LMFT under the terms described above.

Client Signature_____ Date_____

Client Signature_____ Date_____

Client/Parent/Guardian Signature_____ Date_____
(In the case of divorce, I certify that I am the custodial parent and have legal authority to sign). *Initial___

Therapist Signature_____Date_____

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