



BRENDA KINSMAN, LMFT

DISCLOSURE AND CONSENT

I am a Licensed Marriage and Family Therapist in the State of Washington (LF00002612). The Counselor Credentialing Act empowers citizens of the State of Washington by providing a complaint process against those who would commit acts of unprofessional conduct. The following disclosure of information, policies and procedures is given so that you are able to be fully informed about me and thereby offer your consent to treatment.

Education and Experience. I received my Masters in Marriage and Family Therapy from Seattle Pacific University in 2003. I have worked as a marriage and family therapist since 2002. My work has taken place in private practice settings

Therapeutic Orientation. It is important to me to understand your experience of your problems, the preferences you have for your life and how you relate with others. It is important to me that we talk together to determine your goals for therapy and that we discuss the different ways we may work together to accomplish your goals. My work has been influenced by many sources, chief among them are ideas from the narrative therapy perspective, family systems ideas, and my own life experiences. You have the right to choose to work with someone who best suits your needs and purposes. I encourage conversation about your sense of what perspective and approach best fits you.

Confidentiality. All information disclosed in your session is confidential. That is, I will not tell others about our work unless you give me written permission to do so. There are a few exceptions to confidentiality: (1) Where there is reasonable suspicion of abuse of children, the elderly or dependent persons; (2) Where you present a serious danger to another person or to yourself; or (3) If your records are subpoenaed by a court of law. I regularly consult with colleagues about my work. Such consultations are conducted with utmost care to protect the confidentiality of my clients. If you choose to use e-mail or a cell phone to communicate with me, please understand the inherent limits of confidentiality with these ways of communicating. Any written communication by letter or email will be included in your therapy record.

Fees and Course of Treatment. My standard fee is \$110 for a 50-minute session. The same rate applies to therapy sessions conducted via phone or e-mail (charted in 10 minute increments). Payment may be made at the beginning or end of each session, unless we agree to other arrangements based on your circumstances. The risks associated with treatment, the number and frequency of our sessions, and the ending of therapy, will be discussed and determined by your own needs and progress. If you have to cancel an appointment please provide a minimum of 24 hours notice. You will be responsible for payment of fees for appointments missed without notice. You have the option of discontinuing therapy at any time. I encourage you to ask questions or raise any concerns you have about the ways we work together.

Emergencies. If there is a life threatening emergency please phone 911 immediately. You may call the Crisis Line at 211 if you are experiencing a crisis and cannot reach me.

State Laws. WAC 308-109-040 Counselors practicing for a fee must be registered or certified within the department of licensing for protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. SHB 1828 A record of the mental health care provided is kept in this office. You may ask to see a copy of that record. You may also ask this office to correct that record, if you believe the information in 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.

I have read and understand all the information provided in this disclosure statement. I hereby give my consent for treatment.

Client: _____ Date: _____

Client: _____ Date: _____

Therapist: _____ Date: _____