



**Professional Disclosure Statement**  
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### **Disclosure of Information, Policies, and Client Agreement**

Clients are not liable for any fees or charges for services rendered prior to receipt of the disclosure statement. Provision of the following information and written acknowledgement of its receipt are required by Washington State Law. Please read this document carefully! I welcome the opportunity to discuss any question/concerns that you may have regarding my services or this agreement.

#### **Your Rights as a Client in Counseling**

You have the right to choose the therapist and treatment approach that best suits your needs, or to refuse treatment. Please let me know if you have any concerns or are dissatisfied, and we can discuss alternative ways to support you in reaching your treatment goals. My goal is to serve you in the best way possible, and I am committed to the highest standards of honest and ethical treatment. If my services do not meet your needs, please let me know and I will assist you in finding another treatment provider.

All information discussed during therapy will be held in strict confidence. 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 his/her 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 State law (RCW 18.19.180), the following situations are exceptions to your right of confidentiality:

- 1)** If I believe 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.
- 2)** If I believe you may be physically or sexually abusing or neglecting a minor child (under 18 years of age) or vulnerable adult (one who is dependent upon another adult for physical and/or emotional caretaking), or if you report information to me about the possible abuse or neglect of a minor child or vulnerable adult I am required by law to report this to Child Protective Services or Adult Protective Services.
- 3)** If you submit claims to your insurance company, they may require information from me about your treatment. Most of the time they only request basic information, which many times includes a psychiatric diagnosis. You have the right to know your diagnosis.
  - Should you plan on using insurance to cover my services there are a few things you should know. For many insurance providers, I am an out-of-network provider. I do not bill insurance directly so you will have to submit a claim for reimbursement. I will provide you with a billing summary that will provide your insurance company with the information they will need. You are responsible for paying my full fee at the beginning of every session.
- 4)** If a court of law issues a legitimate court order, I am required to provide the information specifically described in that order.

5) 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.

6) If you are seeing me to do couples or family therapy, and you, your partner, or another family member should see me individually, information revealed in the individual session may be shared by me in a couples or family session. This will only happen if I believe it to be in the best interest of the work we are doing and, of course, I will discuss the matter with you first before sharing that information.

If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner), I will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together.

Michelle S. Elsdon BFA, Certified Relationship Coach and I work as a team in providing a service to you which we feel is unique. All information and files are shared in our work with you in order to provide our best service to you. All discussions between Michelle and I regarding your sessions are subject to the same provisions of confidentiality discussed above.

In some cases, it will be useful to the therapy for me to discuss your situation with others such as: your physician, your former therapist, your attorney, etc. In such cases, I will seek your written permission for this exchange of information.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. This is done so as to provide you with the best possible treatment. My work with you may be discussed in formal or informal sessions with my colleagues, or with other professionals. During these consultations, neither your last name nor other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services, and I will thank them for the referral. I will not discuss your situation with them unless you have provided your written permission.

At any time, you are free to terminate therapy with me; however, I ask that you discuss your decision and reason for termination at the beginning of a regularly scheduled appointment. I believe that discussing the termination of a counseling relationship is of therapeutic value and will ensure that all counseling issues have been dealt with to the best of my and your ability. Regardless, notifying me of your desire to terminate counseling will result in my scheduling other clients into your regularly scheduled time slot. If you cancel/miss an appointment without leaving notice to reschedule on my voicemail, notice of termination will be assumed and your time slot will be given to another client.

Finally, while some clients choose to email me to schedule appointments and occasionally share information pertinent to their cases, please be aware that all electronic communications come with the risk of potential loss of confidentiality.

My confidential voicemail box can be reached at (425) 358-8558. I check my voicemail several times a day. If you are unable to reach me and are urgently in need of help, please call the Bellevue Crisis Clinic at (206) 461-3222, or the King County Crisis line 1-866-427-4747. If you require immediate help call 911.

### **Philosophy and Approach**

I believe that everyone can reach an optimum state of health. I employ an eclectic approach with a strong reliance on cognitive-behavioral aspects. Everyone experiences one or more periods of emotional stress throughout his or her lifetime. My goal is to be a helper by giving you the grace and freedom needed to truly

understand your values, perspectives and thoughts. By doing this, I hope to help you understand how you want to live your life.

My primary purpose is to respect the dignity and promote the welfare of my clients while we maintain a relationship that includes trust and understanding. Through this, we will explore your challenges, problems or difficulties and work together towards new goals and healing. I hope to offer empathy combined with the truthfulness necessary for true understanding and change.

The client and I explore possible choices together with the understanding that the client will do additional work outside of the office to achieve their hoped-for goals. The client has the right to expect me, as a counselor, to help them achieve their higher potential, personal growth and healing by using a variety of approaches, strategies and theories. I believe in using a combination of different theories including but not limited to Person-Centered Therapy and Rational-Emotive Behavioral Therapy. With Couples, I use The Gottman Methods.

**Areas of special interest include but are not limited to:**

Individuals ~ Couples/ Families ~ Groups

Dating ~ Relationships ~ Sexuality ~ Lifestyle Counseling

Men's Issues ~ Addictions ~ Trauma

Please note: In order to develop a therapeutic treatment plan, a diagnosis will be made of your mental health status based on criteria from the most recent edition of the Diagnostic and Statistical Manual, and this diagnosis will become a part of your client record.

**RISKS TO THERAPY**

While therapy can help facilitate important life changes, the process itself may present you with new challenges. Some individuals experience discomfort or discouragement during therapy, especially during the early stages. These are common experiences and may be important in your developing new abilities to manage difficulty in other areas of your life. I encourage you to talk with me about these challenges when or if they occur.

**Public Encounters**

Given that Bellevue is a popular community, it is likely that we may inadvertently see each other in other public settings outside of my office. Should this occur, I would like you to know that my intent is to always protect your privacy and confidentiality. Therefore, I will not initiate contact with you in public. However, should you choose to do so, I am happy to respond appropriately.

**Formal Education and Training**

I graduated from Southern Oregon University with a Master's Degree in Clinical Mental Health Counseling, having successfully completed the CACREP (Council for Accreditation of Counseling and Related Educational Programs) I have a M.S., NCC, and am a Clinical Mental Health Counselor in the State of Washington.

**As a Licensed Mental Health Counselor I conduct myself as a professional counselor with the Washington Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics.**

**Fees:** Sessions are generally scheduled as follows:

- Individual sessions 50 minute \$165.
- Couples Sessions 80 minutes \$225.
- Family 3+ people 80 minutes \$275

**All fees are due at the beginning of the session**

**Payment options:** Cash, Debt, Visa, Mastercard, American Express, Discover.

**Cancellations:** Your session is reserved for you. Should you miss your appointment without cancelling or if you cancel without providing 24 hours' notice, you will be billed in full for that session. Should you arrive late to your session I will see you for the duration of your scheduled time and you will be charged the full session rate.

**Quality of Service/Complaints**

I abide by all regulations in the Counselor Credentialing Act (18.19 RCW). The purpose of the law is:

**(A)** To provide protection for public health and safety;

**(B)** To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

**The Washington State Licensing Department asks that you be informed of the following:**

“Counselors practicing counseling for a fee must be credentialed with the Department of Health for the protection of the public health and safety. Credentialing of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.”

If you have any concerns about your experience or feel that I have been unethical or unprofessional, please discuss this with me so that the problem can be clarified or resolved. If you believe this does not resolve the issue, you can contact the following agency:

Washington State Department of Health,  
Health Systems Quality Assurance  
Division, P.O. Box 47857,  
Olympia, WA 98504-7857.

You may also call them directly at (360) 236-2620 or access online forms and information at [www.doh.wa.gov\hsqa](http://www.doh.wa.gov\hsqa).

**Client Consent to Treatment**

I/We have read or have had satisfactorily explained to me Shane Elsdon’s Disclosure of Information, Policies, and Client Agreement and understand it. I/We have asked any questions that I/we had about this statement, and about statements regarding fees and payment policies. I/We understand and agree to the description of confidentiality and its exceptions as stated above. I/We consent to counseling under the terms described above with Shane Elsdon, MS, NCC, LMHC and understand that I/we have the right to terminate counseling at any time. My/Our signature below indicates that I/we have received a copy of this agreement

**Signature of client:** \_\_\_\_\_ . **Date:** \_\_\_\_\_ .

**Signature of client:** \_\_\_\_\_ . **Date:** \_\_\_\_\_ .

**Counselor:** \_\_\_\_\_ . **Date:** \_\_\_\_\_ .