Carolyn Ratley, MS, LMFT
WA License #LF00002687

Tel: (206) 588-5140 Email: ratleylmft@gmail.com
Website: www.carolynratleylmft.com

Disclosure Statement and Consent to Treatment

Services Provided

I provide services that include individual, family, and child therapy. These services may include the participation of parents/guardians, other significant family members, and consultation with outside individuals (e.g., teachers, doctors) when appropriate. Any participation by, or consultations with others are first approved by the client with written permission.

I am under an ethical duty to terminate treatment when I determine that the client is not sufficiently benefiting from the treatment or that the client needs a different level or type of care. A client has the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits their needs.*

I am in business as a sole proprietor, operating my practice independently from others in the office suite where I provide services. I am an independent private practitioner.

The Department of Health requires the following statements to appear in the information forms of all mental health care providers: “Counselors practicing counseling for a fee must be registered or certified 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 a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.”

Unprofessional Conduct

The state brochure called “Counseling or Hypnotherapy Clients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the address and phone number:

State Contact Information:
Department of Health
Counselor Programs
P.O. Box 47869
Olympia, WA 98505-7869
(360) 664-9098

Risks of engaging in therapy

When engaging in therapy it is important that you understand some possible risks which may include but are not limited to: increased symptoms and intensity of feelings, as well as possible social/relationship difficulty.

Choosing a Counselor

You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

* Clients may contact the WA State department of health to obtain a copy of the acts of unprofessional conduct listed under RCW 18.130.180. Health Professions Quality Assurance may be contacted by calling (360) 236-4700 or writing to P.O. Box 47865, Olympia WA 98504

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Coverage due to Absence or Death

Should I be unavailable to provide care, you will be informed of a therapist that can provide care and will protect/store your health records.

Theoretical Orientation

I am a Systems therapist, which means that I consider the impact of the nuclear and extended family, and community on the client, as well as the client's impact on those larger systems. While following this comprehensive approach, families may be asked to come to therapy in different combinations (e.g., sometimes as a family, sometimes as a couple, sometimes as an individual).

My approach is strength-based. I focus on identifying the client's special strengths and utilizing them to solve problems. I do not believe in blaming or pathologizing the client or his/her family.

I use a direct, problem-centered approach, which involves identifying a problem the client wishes to solve and developing a treatment plan that will help the client achieve this goal as efficiently as possible.

Degrees and Affiliations

M.S. – Master of Science in Marital and Family Therapy, 2003, Fuller Theological Seminary, Pasadena, CA.
B.A. –Bachelor of Arts in Psychology, 1999, University of Washington, Seattle, WA.

I am a Licensed Marriage and Family Therapist in the state of Washington and I am a Clinical Member of both the WAMFT and AAMFT. I am also a Child Mental Health Specialist.

I am a Washington State Approved Supervisor.

I have been working with clients since 2001.

Billing

Clients or their responsible legal guardian are responsible for payment of all fees associated with services I provide you. My fee for a fifty-minute individual session is $140, and $175 for a 90min family session. I reserve the right to revise my fee, given appropriate advance notice to the client. Payment is to be made at the time of the session in the form of cash or check. My fee for returned checks is $7. If you would like to use a credit card there will be a service fee of 2.75% per transaction. I am currently a provider for First Choice and Regence insurance companies. If you would like to use your insurance benefits for either of those companies please sign the disclosure addendum. If you wish to seek reimbursement for my services from any other health insurance company, I will complete a receipt that you may submit to your insurance carrier. Insurance companies vary greatly in their coverage of "outpatient mental health services", so you may wish to call your carrier to make certain that services provided by an "out of network provider" and/or registered counselor are covered. If your carrier requires a diagnostic code, I will discuss my diagnosis with you before I submit this information.

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Therapy sessions will not be extended due to late arrivals. A session may be canceled by telephone or email without charge if I am given 24 hours' notice; otherwise the full session fee will be charged for cancellation or failure to show. This includes those using their insurance.

_____ (initial here)

Additional services such as the reading of documentation, collateral professional contact, and telephone consultations will be billed at the regular session rate of $2.00 per minute.

It is my policy to not get involved in legal matters (such as consulting with attorneys, drafting letters of opinion, or appearing in court). If I am subpoenaed to do so my fee is $250 per hour.

I reserve the right to hire a collection agency in the situation that a balance remains unpaid after I make two direct attempts to collect it.

Confidentiality

All information between therapist and client is strictly confidential. By law, information concerning our professional relationship can be released only with the client's prior written consent. Notable exceptions to this law include the following:

1. If the client makes a statement that reveals the contemplation or commission of a crime or harmful act;
2. If the client is a minor, any information pertaining to the client having been the victim or subject of a crime;
3. If there is suspicion of child abuse or neglect, I am required by law to inform Child Protective Services;
4. Subpoenas from a court of law.
5. If you chose to communicate with me over email or text message, your confidentiality can not be protected. Please do not email or text clinical or sensitive information about yourself or the client.

I believe that privacy is the utmost importance in providing care in therapy. Therefore it is best practice and my policy to protect minor's therapy records while they are receiving services from me. I will not share that private information unless subpoenaed. I am happy to meet with parents to update them on questions, concerns, and treatment summaries as needed.

Emergencies

If you are in a general emergency and cannot reach me, then please call one of the following numbers for help:
General Emergencies: 911
Care Crisis Response Service: (800) 584-3578 (425) 258-4357
Suicide Prevention: 1-800-273-8255
King County Crisis Line: 1-800-273-8255
Pierce County Crisis Line: 1-800-576-7764

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"My signature below indicates that I have been provided with a copy of the above disclosure information and that I read and understood this information. I agree that I, or my child, will commence therapy with Carolyn Ratley at the specified fee per session."

_____ _____
Signature -Client Printed name

_____ _____
Signature -client/Parent or Guardian Printed name

_____
Date

I have explained the meaning of this consent form and the above signed acknowledge(s) that they understand the nature and extent of the consent granted.

Carolyn Ratley, MS, LMFT

_____ _____
Therapist signature Printed name

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