COUNSELOR DISCLOSURE STATEMENT

WAC 246-810-031 requires the disclosure of the following information in written form by counselors to their clients.

TRACY G. BELL, MA, LMHC
Psychotherapist
PO Box 30925
Seattle, WA 98113
(206) 945-4133

Licensed Mental Health Counselor
License # LH 60200557

Explanation of Counselor Disclosure Statement

Counselors are required by Washington state law to provide written disclosure of the following information to clients before counseling begins, and to obtain signed consent to counseling once the client understands the information to their satisfaction. As a client, you have a right to choose a counselor who best suits your needs and objectives.

Please read this statement thoroughly and when it is understood and agreed to, sign the consent for treatment on the last page. This signed statement is our written contract to enter into the therapeutic process. If you have any questions or concerns, please tell me and I will be happy to discuss them with you.

Client's Rights and Responsibilities

You have the right to ask questions about treatment at anytime throughout the period of our counseling sessions. You have the right to refuse or end counseling at any time.

Licensure, Education, Experience and Treatment Philosophy:

I am a Licensed Mental Health Counselor in the state of Washington. I have a BA in Business Administration from the University of Washington and an MA in Counseling Psychology from Pacifica Graduate Institute.

I began my study of psychology and psychotherapy during midlife as an outcome of seeking my own solutions to life issues as they emerged in early and mid-adulthood. My graduate education is grounded in the study of depth psychology. This foundation has helped me to develop my perspective that human beings migrate naturally, by means of their transitions, symptoms, and yearnings, toward wholeness. I base my therapy practice on the belief that the wisdom for growth and healing lies within us, and that the issues and difficulties we encounter are not roadblocks, but directional signs and teachers. I have many years of experience in hospice care and mindfulness meditation practice, both of which are essential to how I think and practice as a psychotherapist.

My approach to psychotherapy is to companion you in your search for wholeness and meaning, in your endeavor to relieve or resolve difficult feelings, and in the examination of issues that get stuck or repeat themselves in your life.

My post-graduate work is focused on an ongoing study of psychoanalytic psychotherapy, Self Relations (the practice of integrating all aspects of self), and somatic (body) oriented ways of working with trauma, grief, and developmental wounds.

I am a member of the Seattle C.G. Jung Society and the Northwest Alliance for Psychoanalytic Study.

My commitment to you:

I am ethically and personally committed to providing you with counseling treatment that is effective for you. I recognize that clients, counselors, and the relationship between them are extremely individual. Uncomfortable feelings can come up during psychotherapy and are a natural part of the process. However, if at any time you feel our counseling work is not right for you, please talk to me about it so that I can address your concerns.

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Privacy and Confidentiality:

As a psychotherapist, your privacy and confidentiality are of the utmost concern to me. I am committed professionally, ethically, and personally to maintain confidentiality regarding our counseling sessions. You have a right to this confidentiality, including the fact that you are or have been a therapy client. There are certain exceptions to my responsibility to keep our sessions confidential which are itemized below.

I reserve the right to release information regarding our counseling sessions or their content under the following circumstances:

As an ongoing part of my clinical development, and in pursuit of providing you with the best care, I consult regularly with psychotherapy consultants and with other therapists who are required to keep client information confidential.

I am required by Washington state law to report suspected abuse or neglect of a child, dependent adult, or developmentally disabled person to the appropriate regulating agency. I am also required by Washington state law to inform others if a client threatens to harm herself/himself, or others. In addition, I will not keep information confidential which may jeopardize the safety of staff or clients of the Phinney Professional Center.

In the event of a subpoena, counselors may be required to disclose information to the court. It is my policy to keep minimally required notes on file regarding our counseling sessions. I do not see clients who are accessing counseling for the purpose of fulfilling court requirements.

I will share information regarding our counseling sessions with a specific person (i.e. your doctor) if you provide me with a signed release form asking me to do so.

If you contact me by email, please note that our email communications will not be encrypted. By nature of the inherent limitations of Internet security, privacy and confidentiality of any email communications we have cannot be assured.

Appointments, Fees, and Cancellations:

My fee for a 50-minute individual counseling session is $180. Payment for counseling sessions must be made by cash or check at the time of service unless special arrangements have been made. I do not provide billing services for clients or their insurance companies, unless I am an in-network provider for your insurance plan. I am happy to provide you with a record of your sessions showing receipt of your payments.

When we make an appointment, I will hold that 50 minute time period open for you. If you are unable to keep your scheduled appointment for any reason, please notify me of the cancellation by voice mail at least 24 hours prior to the time of your appointment. There will be no charge for appointments cancelled 24 hours or more in advance. The regular fee for the session will be charged for appointments cancelled for any reason less than 24 hours in advance, and for missed appointments. I ask that you pay this fee before your next regular appointment.

For in-network insurance clients, please note that I cannot bill your insurance for missed sessions.

Contacting me:

I can be reached by confidential voice mail at (206) 945-4133 or by email at tracybelltherapy@gmail.com

I check my messages frequently Monday thru Friday and I will return your call or email as soon as possible. If you want to talk with me in person, it is best to leave a specific time and number where I can reach you. Please talk to me if you have questions or concerns about these contact arrangements.

I am flexible with regard to phone or email contact for the purpose of introductions, answering brief questions or discussing the scheduling of appointments.

If you are experiencing an emergency situation, please call 911, or call the Crisis Line at (206) 461-3222, or go to the nearest hospital emergency room.

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TRACY G. BELL, MA, LMHC
Psychotherapist
PO Box 30925
Seattle, WA 98113
(206) 633-6367

Licensed Mental Health Counselor
License # LH 60200557

Disclaimer by the State of Washington:

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

Washington state law requires me as a counselor to provide clients with a copy of the acts of unprofessional conduct, along with contact information for the department of health should you have any complaints against me. A copy of RCW 18.130.180 is attached for that purpose. The contact information is:

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 47865
Olympia, WA 98504-7865
(360 236-4700

Informed Consent and Authorization for Counseling:

With my signature, I acknowledge that I have read and I understand the attached disclosure statement describing the profile, qualifications and policies of Tracy G. Bell, MA, LMHC with regard to her practice of psychotherapy. I have had the opportunity to ask questions, and I have received a copy of this disclosure statement and informed consent form.

Having read and understood this information, I consent to counseling with Tracy Bell, according to the terms described here.

Client Signature(s)	Counselor Signature
Date	Date

Fee Agreement:

I agree to pay the fee as specified in this disclosure statement, and I understand that I am expected to pay at the time of service.

If I need to cancel an appointment for any reason, I understand that I must give at least 24 hours advance notice by voice mail, and that if I do not give this advance notice I must pay the fee for the appointment unless it is waived at the discretion of the counselor.

Client Signature(s)