Carin Christy, MA, LMHC License #LH00010421
521 Union Ave SE Suite 205
Olympia, WA 98501
360-357-7965

Therapist Disclosure

Washington State Law (WAC 246-810-031) requires that Mental Health Counselor disclose professional information about themselves and the techniques they use to assist you in therapy.

Areas of Focus: Counseling and Art Therapy for children, teens, and adults, sexual abuse and trauma recovery, anxiety, relationships, grief and loss, self esteem, body image issues, depression, and parenting issues.

Methods and Techniques: Mindfullness, Relational Therapy, CBT, Art Therapy, Internal Family Systems, Sandtray Therapy, Existential Therapy

Education, Training, and Experience: Master of Arts in Art Therapy, The School of the Art Institute of Chicago; Bachelor of Arts in Fine Arts, The University of Northern Iowa; Private Practice since 2002; Clinical Case Manager, Greater Lakes Mental Healthcare; Art Therapy Intern, Midwest Family Resources; Art Therapy Intern, Deborah's Place Shelter for Homeless Women; Art Therapy Intern, Highland Park Hospital, Psychiatric Unit; Case Manager, Brentwood Group Home.

Confidentiality and Professional Records

According to the law and professional ethics, whatever you say or do in a therapy session can not be shared with anyone without your written consent. However, Washington State Law requires a break in confidentiality and for the therapist to inform appropriate agencies or persons in the following circumstance:

Information disclosed within sessions, including that of minors, is kept strictly confidential except when the following legal limitations apply:

1) Where there is a reasonable suspicion of child or elder abuse or neglect;
2) Where there is a reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm themselves unless protective measures are taken;
3) Pursuant to legal proceeding;
4) In the course of my receiving regular professional consultation.

According to the standards of my profession, I keep records of the mental health services I provide you. If necessary, you may see, copy or correct that record. I do not disclose any records to others without your written consent, or unless I am mandated to do so by law. There is a fee for copying of records to cover photocopies and time reimbursement.

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Office Hours and Availability

Office hours are by appointment only. Please make every effort provide at least 24 hours notice if you need to cancel or reschedule your appointment. Except in an emergency, clients will be charged $50.00 if there is no prior attempt to cancel or reschedule.

Emergency Procedure

I do not provide crisis services so in case of an emergency, please call the Thurston and Mason County Crisis line at (360) 586-2800 or go to the nearest emergency room, or call 911. When stabilized, please call my office number and leave me a message and contact number. I will contact you as soon as I am able. I do not carry a beeper and do not provide 24-hour emergency call coverage. I will provide follow-up help as soon as possible. Please discuss any concerns you have about this emergency policy.

Electronic Communication

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. If you use these methods to communicate with me, there is a chance that a third party may be able to intercept and eavesdrop on those messages.

The kinds of parties that may intercept these messages include but are not limited to:

-People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.

-Your employer if you use your work computer to contact me.

-Third parties on the internet such as server administrators.

If these are examples of third parties that you would not want to have access to your private health care information, please talk to me about ways to keep your communication confidential and private.

I prefer to keep email communication to appointment scheduling and any other communication to be by mail or phone. My voicemail at 360-357-7965 is confidential and only heard by me, therefore it is the best way to give me information regarding your treatment needs.

Please refrain from contacting through any social media site such as Facebook, Messenger or Twitter.

Financial Policy Agreement

Professional services will be provided to you at a fee of 120.00 for a 60-minute session, 100.00 for a 45-minute session, 160.00 for initial intake, couples or family sessions. If you are paying cash with cash or check at the time of service I offer a discount of $25.00. At time of service sessions are $95.00. Payment for each session is expected at the time of services rendered, unless other arrangements are made in advance. If you are using your insurance, provider accepts the contracted amount if considered a preferred provider in network. Client is responsible for co-pay at time of service or deductible not met at time of service. I accept cash, check, debit/credit card.

You are responsible for any portion of the bill that your insurance company refuses to pay.

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Other fees are as follows: Report writing: $120.00 an hour. Court appearance: $120.00 an hour billed from time of leaving my office to the time of return. Copies of mental health record: $25.00 minimum

Termination of Therapy

Therapy is a joint effort between therapist and client. In order for the therapy to work, it is vital to keep the lines of communication open. Please come and talk to me about any concerns you have at any time during our work together. At any point in treatment you have the right to terminate therapy and receive a referral to another therapist. Please be aware that a therapist also has the right to terminate therapy: 1) If a therapist feels that it is in the client's best interest to be treated by another professional who has specialized expertise in the area needed by the client; 2) If a therapist feels threatened by a client or they are being treated abusively by a client; 3) If a client repeatedly attempts to violate the boundaries of the therapeutic relationship; 4) If the therapist should lose objectivity; and lastly; 5) If a therapist is not being paid for services.

Washington State Law requires that the following paragraphs appear on this disclosure statement:

> "Counselors practicing counseling for a fee must be registered or Certified with the Department of Health for the protection of Public health and safety. Registration of an individual with the Department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of treatment"

> "The purpose of the Counseling Credentialing Act (chapter 18, 19 RCW) is (A) to provide protection for public health and safety; And (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."

I affirm that I am a licensed mental health counselor in the state of Washington in good standing since 2006. My license number is LH00010421.

If you feel that in some way my services have been unfair or unprofessional as defined by RCW 18.130.180, you have a right to make a complaint. To make a complaint contact: Washington State Department of Health, 101 Isreal Road SE, Tumwater, WA 98501, 360-236-4700

Your signature below indicates that you have read this disclosure statement and agree to enter therapy under these conditions. It indicates an understanding that you may stop therapy if you are not satisfied and/or that I may recommend stopping the therapy, if in my professional judgment, the therapy relationship is not working. I have read the above office, financial, and emergency policies. I understand these policies and agree to the conditions stated above.

I, _____(client name), have been provided with a copy of this disclosure statement via email or in hard copy form.

Client signature: _____ Date: _____

Parent or Guardian signature (if under 13): _____

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Therapist Signature: _____ Date: _____