

THERAPIST DISCLOSURE

*Center for Child and Family Therapy
7500 Old Military Rd NE Suite103
Bremerton, WA 98311 (360) 698-9258*

*Lisa Burress, MSW, LICSWA
Washington License No. SC60664784*

Purpose of Disclosure Statement

This statement provides information about me and the treatment modalities used in my practice to better help you and assist in deciding if I best meet your needs. Every client has the right to choose a practitioner and treatment modality that best suits his/her needs. Please read the following information and discuss any concerns with the office staff or me.

Education/Training/Experience

I have a Master's Degree in Social Work from the University of North Dakota, and a Bachelor's Degree in Sociology from Westmont College. I am a Licensed Independent Clinical Social Worker Associate (LICSWA) and am trained to practice social work. My experience includes working with adults, children, and families in a variety of settings.

I adhere to the code of ethics of the National Association of Social Workers (NASW) and the professional standard of Washington State Department of Health. In your best interest and following the NASW code of ethics, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend to or socialize with any of my current or past clients. Even though you might invite me, I will not attend your family gatherings. I can never have a romantic relationship with any client during or any time after therapy. I cannot have a business relationship with any of my clients other than the therapy relationship.

Treatment Orientation and Methods

I hold the belief that each person is an expert in their life and approach treatment from a strengths-based perspective. As a result, I use a collaborative process with the individual or family to develop treatment goals that fit realistic outcomes likely to be achieved through therapy. Additionally, education plays an important role in the therapeutic process as individuals are empowered by knowledge to make informed decisions to enhance their own well-being. I urge you to make the most of the planned activities, appointments, and assignments, including active involvement on your part and full participation of those who are involved. It is through this participation and partnership that change occurs and progress is made.

My scope of practice includes play therapy, family therapy, trauma-focused cognitive behavioral therapy, parent child interaction therapy, collaborative problem solving, motivational interviewing, client education and insight, and solution-focused brief therapy. My focus is working with children, adolescents, and adults on many issues relating to the mental health, parenting, behavior and social problems, depression, anxiety, stress, anger management, and recovery from physical, sexual and/or emotional abuse.

I have found it essential for me to have a working knowledge of a client's family, social, cultural, educational, and emotional experiences in order to effectively treat an individual or family in therapy. My treatment of young children is typically play therapy. The theoretical grounding of play therapy is that children use play to communicate/process their experiences and difficulties more effectively than they can through language. A critical aspect of play therapy is the relationship that is established with the therapist. As such consistency in maintaining therapy appointments is imperative.

Electronic Health Records

I use EHR 24/7 Electronic Health Records by Office Ally to store all client records. Additionally, I use Office Ally for billing. This business is certified HIPPA compliant. I will keep your records for 5 years after we end therapy unless I am contractually obligated by your health insurance to keep them longer.

Billing

The name on the billing statement will be Center for Child and Family Therapy. Any types of payments need to be made out to Center for Child and Family Therapy.

Communicating With Your Therapist

I am willing to communicate with you electronically, preferably through email. My email service is secure, encrypted, and HIPPA compliant. However, if your email is not secure and not encrypted then others possibly can read it. If you would like to communicate via email, I can be reached at lisa@ccftherapy.com. If you do not have access to the Internet on a regular basis you can call the office (360) 698-9258 and leave a voicemail and I will get back with you during my normal business hours. If it is an emergency, I encourage you to call 911 or The Crisis Clinic of the Peninsula a 24-Hour Crisis Line 1-800-843-4793.

Please initial:

Agree to communicate via email

Disagree to communicate via email

Supervision & Consultants

As a LICSWA, I continue to receive supervision and will have the opportunity to consult about my clients with my supervisors, Jeffrey Weist/Jenny Fisher, MSW, LICSW. Jeffrey and Jenny are licensed in WA State and have gone through the required training as supervisors. They are also required to keep your information private and confidential. I sometimes consult with other professionals about my clients. This helps me provide high-quality therapy. These professionals are also required to keep your information private and confidential. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation. The two professionals that I consult with are Terry Boyle, MFT and Dr. Tony Stanton, MD.

State Requirements and Complaint Procedure

Therapists practicing counseling for a fee must be licensed with the Department of Licensing and the Department of Health for the protection of the public health and safety. Licensure of a therapist does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment. The full law and regulations can be found in RCW 18.19., or contact the Washington State Department of Health, PO Box 1099, Olympia, WA 98507-1099, www.doh.wa.gov or call 360-236-4700. Also, it is my intention to fully abide by all the rules of the National Association Social Workers and by those of my state license. Problems can arise in our therapy relationship. If you are not satisfied with any area of your work, please raise your concerns with your therapist at once.

Consent

I have read all of the above information and have received clarification as needed. I agree to the terms as stated above. I hereby enter into therapy with this therapist and agree to cooperate fully and to the best of my ability, as shown by my signature below.

Responsible Party/Client Signature

Therapist Signature

Date

Copy accepted by client

Copy accepted by additional person