

THERAPIST DISCLOSURE

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

R. Garth Retallick, MS, LMHC
Washington License # LH60344426

Purpose of Disclosure Statement

This statement provides information about me and my treatment methods to better help you understand if I best suit 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 me or the office staff.

Education/Training/Experience

I received my Master's Degree in Family Psychology from Capella University and 2 years doctoral training in classical clinical psychology. I have spent the last 19 years working with various environments and working with multiple populations and am a licensed mental health counselor in accordance to Washington Chapter 18.225 RCW, 246-809.

In accordance with RCW,246-809 and the WAC 18.225 I am bound to adhere to the state code of ethics. In your best interest and following the state code of ethics, I can only be your therapist. I cannot have any other role in your life for 2 years after services have completed. 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.

Treatment Orientation and Methods

My theoretical orientation is in Cognitive-Behaviorism in that I believe as we think we do. I also am of the understanding that many of our thoughts and behaviors come from a combination of our families of origin and life histories. I believe that change comes when we realize where our thoughts and behaviors originate and that with guidance, love, and positive acceptance as human beings we can make the adjustments needed to make positive life-long change.

I use a variety of methods in my interventions including talk therapy, eye movement-desensitization and restructuring (EMDR), relaxation/mindfulness training, trauma based cognitive behavioral therapy, and hypnotherapy to name a few. My services are designed to help people to identify goals and to access their internal strengths. Together we can concentrate on the steps needed to meet your individual and/or family's goals.

My focus is working with teens from 12 to 19, families, couples, and individuals. I see clients for such issues as: Depression, anxiety, stress, trauma/PTSD, phobia's, intimacy, divorce, marriage, pre-marital counseling, communication, coping, family conflict, parenting, self-esteem, pornography/sex addiction, mood and personality disorders.

To be successful I have found it is essential for me to have a working knowledge of a client's family, social, cultural, educational, and emotional experiences to effectively treat an individual or family in therapy. As such we have to have an open and honest communication

Billing

The name on the billing statement you receive will be Inlet Counseling., the name of my business.

Consultants

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.

State requirements

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.

Cancellation of appointments

Please understand that when you make an appointment, I am reserving that time for you. If you miss an appointment, that is time that could be spent with another client, please notify me 24 hours prior to your appointment if you need to reschedule or if you are ill or in an emergency.

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 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