Christina C. Hanson, MS, LMFT
Therapist Disclosure, Client Rights & Consent to Treatment

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LICENSE AND CERTIFICATIONS

*Licensed Marriage and Family Therapist
Washington State License #: LF60618144

*Trauma-Focused Cognitive Behavior Therapy Certified

*Mental Health Professional

*Child Mental Health Specialist

*Externship in Emotionally Focused Couples Therapy (completed 2016)

BACKGROUND AND THERAPEUTIC PRACTICE

I am a Licensed Marriage and Family Therapist, license number: LF60618144, with a Master of Science degree from Seattle Pacific University (2013) and a Bachelor of Arts from University of Washington (2002). I completed my graduate internship and was subsequently employed at Kent Youth and Family Services, conducting individual, family and group therapy with a culturally, ethnically and socioeconomically diverse population. I have experience working with adults, adolescents and children, in the contexts of individual, couple family and group therapy. In addition, I conducted assessments for the Collaborative Adolescent Research on Emotion and Suicide (CARES) study—a shared research study by the Behavioral Research and Therapy Clinics at the University of Washington, Seattle Children's Hospital and the University of California, Los Angeles. I believe collaboration is essential, and work together with clients to identify goals, set expectations and assess the therapeutic process.

I work with clients dealing with a variety of concerns, including, but not limited to:

Anxiety Depression Trauma Change/Transitions Premarital Blending Families Stress Relationships (couple, parent/child, family and peers) Communication Parenting Grief and Loss Emotion-regulation Divorce/Separation Postpartum Issues
*Chronic/Terminal Illness *Addiction

*Although I do not provide medical treatment or treatment for addiction, I am passionate about collaborative care and understand that therapeutic support surrounding chronic or terminal illness and addiction is valuable, and often essential, for both patients and family members.

I am trained in Narrative Therapy and work with clients to identify elements of their life stories, relationships and contexts that inhibit desired growth, satisfaction or change. Our families, work, peers, finances, etc. influence our lives and emotional state; therefore, I believe these systemic factors are important to consider in therapy. I also incorporate concepts from Emotionally Focused Therapy (EFT), Cognitive Behavior Therapy, and I am certified in Trauma-Focused Cognitive Behavior Therapy (TF-CBT).

APPOINTMENTS & FEES

A typical session is 50 minutes for individuals and 80 minutes for couples and families; however, session time is negotiable depending on personal preference and circumstance. My rate is $100 for a 50-minute session and $125 for an 80-minute session. I also offer a student rate of $75 for a 50-minute session. Payment is due at the time of service. If you need to change or cancel an appointment, please provide me with 24 hours notice to avoid being charged for your session.

I do provide sliding scale services on a limited basis, depending on specific needs and circumstances. I do not bill insurance directly, but I am happy to provide an invoice—including diagnostic information—to submit to your insurance company as an "out of network provider." Please check with your insurance company regarding mental health benefits.

In addition, if we believe that it would be helpful for me to consult with another paid professional regarding your situation; you will be responsible for all fees, including phone calls or when asked to write up letters, evaluations and summary of treatment (over 15 minutes).

PERSONAL RELATIONSHIPS

In accordance with the guidelines of most counseling associations, I have an ethical responsibility to *not* develop personal friendships with clients or their immediate family members during the course of therapy and for a minimum of two years following the end of treatment, and to not provide professional counseling services for existing personal friends of myself or of my spouse. This is for your protection and the protection of our professional relationship.

CONFIDENTIALITY

a. All information discussed during therapy is held strictly confidential.

b. Information about clients may only be released upon written consent of all parties treated or by parent or guardian, (if the person is under age 13) except as allowed by federal and state law.

c. When a family comes in for therapy, I will uphold their right to confidentiality. However, <u>within</u> the family unit, I reserve the right to use my professional judgment about whether to maintain individual confidences from the other family members who are attending therapy with me. Most likely I will encourage any “secret” relevant to therapy to be disclosed by the member holding it.

d. In order to give you the highest quality service possible, I consult regularly with other professionals. I only refer to clients on a first name basis (if that) and am happy to disclose to you the names of professionals I may consult with regarding your situation.

e. I keep all records for seven years after the last date of service, and after that shred them to protect your confidentiality.

f. There are a few cases under which I am under both professional and legal obligation to release confidential information (1) cases of suspected abuse or neglect of a child or elderly person, (2) when you confide or give strong indications that you may commit or have committed a crime or harmful acts to yourself or others, or (3) to a court under court order. When records are requested by court order, it is my policy to protect your privacy to the best of my ability. If you believe it is in your best interest for me to comply with the order, it is my general policy to provide a summary of treatment (vs. copies of my notes). I will charge for my time to write up the report.

g. When meeting with couples & families, in order to provide the safest environment possible, it is my policy not to release information requested in the future for divorce or other legal proceedings that may ensue. When you sign this disclosure, you are agreeing not to subpoena my records in order to defame the character of your spouse or family in the process of a legal matter, except in cases of clear, severe, and observable abuse that I have personally witnessed.

h. If you have been directly referred to me by a physician, friend, colleague or, other person, I may, as a good business practice thank them for the referral.

i. Please initial here if you a **NOT** comfortable with me leaving brief messages on your voicemail or answering machine (Client or parent/guardian initial) _____

CLIENT RIGHTS AND RESPONSIBILITIES

a. You have the right to be treated with respect and dignity in therapy with respect to gender, ethnicity, culture, socioeconomic status, sexual identity/orientation or spiritual beliefs and values.

b. In the case of a crisis, if you are unable to reach me, please call the King County Crisis Clinic line: (206) 461-3222. In case of life threatening emergency, please call 911 immediately.

b. You have the right to ask questions if you do not clearly understand what I am doing in therapy.

c. If for any reason you become dissatisfied with the therapy, your have the right to voice h your concerns. You have the right to request a referral for a different therapist at any time.

d. You have the right to terminate therapy at any time.

e. The following statement and information is required by the State of Washington:

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

The State of Washington cannot guarantee the effectiveness of my treatment. You, the client, have the responsibility to determine whether the therapy is helpful for you.

If you wish to receive a copy of acts of unprofessional conduct listed under RCW 18.130.180, you may contact the Washington Department of Health at PO Box 47869, Olympia, Washington 98504-7869 or call 360-236-4700.

CONSENT TO TREATMENT

I trust this information has helped you understand my background, therapeutic orientation, policies and scope of practice, as well as your own rights and responsibilities as we begin therapy. Please sign to acknowledge you have read, understood and agree to the terms previously described.

I/we have read and understand the background, philosophy and approach that Christina C. Hanson, MS, LMFT has disclosed in this statement. I/we also understand and accept the terms as outlined in this statement regarding confidentiality, fees, client rights and responsibilities. I/we understand that our fee is $100 for 50-minute session and $125 for an 80-minute session unless sliding scale fees have been discussed.

CLIENT NAME: _____ DATE:_____

CLIENT SIGNATURE:_____ DATE: _____

CLIENT NAME: _____ DATE:_____

CLIENT SIGNATURE:_____ DATE: _____

PARENT/GUARDIAN NAME:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE: _____ DATE:_____

THERAPIST SIGNATURE:_____ DATE: _____

OTHER AGREEMENTS

OPTIONAL: PAYING BY CREDIT CARD - If you prefer to pay by credit card, please read and sign:

"I, the undersigned, hereby authorize Christina C. Hanson, MS, LMFT to take payment by credit card electronically, and to send payment/billing invoices via email. I understand with any electronic transition or communication, there is a risk of breach in confidentiality but understand Christina will make every effort to protect my privacy."

CLIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE_____ DATE: _____

OPTIONAL: USE OF EMAIL COMMUNICATION – Due to possible breaches of confidentiality, I prefer to keep email communication to a minimum. Specifically, **I use email for scheduling purposes, billing and administrative questions.** If you wish to communicate via email, please read and sign:

"I, the undersigned, hereby authorize Christina C. Hanson, MS, LMFT to respond to communicate with me via email. I understand that Christina cannot guarantee confidentiality within this form of communication, but will make every effort protect my privacy."

CLIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE_____ DATE: _____

OPTIONAL: CONSULTING WITH MEDICAL PROFESSIONALS - I believe it is often valuable to work in conjunction with your primary care physician and/or psychiatrist for occasional consultations regarding the medical nature of your treatment. If you agree to this consult, please ready and sign below:

"I, the undersigned, hereby authorize Christina C. Hanson, MS, LMFT to exchange all pertinent information relating to my emotional/psychological well-being with the following medical professional(s). I understand that all such communications are strictly confidential and limited by the laws of the State of Washington."

_____ &/or _____
(Name of Primary Care Dr.) (phone) (other medical professional) (phone)

CLIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE_____ DATE: _____