

Christine Phelan MA, CMHS, LMFT

P.O. Box 276
Bellingham, WA 98227-0276
360 927 0600

Disclosure Statement & Consent to Treatment

Education, Training, and Experience

Washington State Department of Health License in Marriage and Family Therapy - LF 60059062
Masters, Applied Behavioral Sciences, Bastyr University, LIOS, Kenmore, WA
BA Psychology, Western Washington University, Bellingham, WA,
Hypnotherapy Certification, Bellingham Technical College, Bellingham, WA, .

Psychotherapy Experience: 2005 – present, Private Practice Psychotherapy for families and individuals. 2007 – 2011, Out-patient Psychotherapist for adults and children, Whatcom Counseling and Psychiatric Services. 2006 – 2007 Emergency psycho/social assessments, St. Joseph Hospital. 2004 – 2007, Northwest Youth Services, Out-patient Psychotherapist for families and children. 2000 – 2004, Individual Treatment Aid, Case Management for: CHAP, Out -Patient and Hospitalization Prevention, programs, Catholic Community Services, Skagit.

Therapeutic Approach

My practice involves assisting individuals, couples, and families in clarifying and reaching their treatment and life goals. I generally approach treatment from a systemic and transpersonal perspective; I see human struggles as part of complex psychological and social systems. I may focus on interpersonal as well as intrapsychic understanding of personality development, and explore the central role that relationships and family dynamics play in influencing behavior and attitudes.

I am interested in discussing your dreams and body symptoms as possibly reflective of your subconscious processes. Besides talk therapy I also use art, active imagination and other creative and expressive means to help people meet their goals. I will likely give you personal feedback, ask clarifying questions, support you, and challenge you.

Length of treatment will vary according to the nature of your difficulties. I generally recommend we meet weekly for three sessions and then decide on a treatment approach that makes the most sense to both of us.

I refer clients to appropriate available resources as needed.

Practice Standards

My fee for services is \$144.00 per session (160.00 intake) due at the time of the session. A session is 50 minutes. Credit can be extended on a limited basis if full payment is not possible at the time of the session. Though insurance will be billed if you wish, you agree to be financially responsible for all charges. A late fee may be applied to overdue accounts.

Since regularly kept appointments are essential for effective therapy, I emphasize the importance of attending all scheduled sessions. If you are unable to keep a scheduled appointment, I require 24 hr advance notice or you will be charged the regular fee for the session. Changes for Monday appointments should be called in by Friday.

If you need to discuss, clarify, or bring up any issues on the phone between appointments, please feel free to do so. Should an emergency arise between your scheduled appointments, please do not hesitate to call me. For any call exceeding 15 minutes, you will be charged for

the additional time in 1/4 hr. increments at my current session rate. Any writing/documentation you request will be billed at my current session rate.

Therapist will not communicate with clients via social media. Professional note taking is for insurance billing and this clinician's tracking, not for litigation purposes.

Client Rights

As a client you have the right to choose a therapist who best suits your needs and goals. If you work with me you have the right to raise questions about my therapeutic approach and to request a referral if you believe you might make better progress with another therapist. If you believe I have engaged in unethical or unprofessional conduct you have the right to report your concerns to the Department of Health by calling 360-236-4902.

You have the right to confidentiality. I am bound to not release any information to anyone without your written permission. The main exceptions to this are consultations with other clinicians and disclosures that indicate you (1) are about to commit a serious crime, (2) are involved in child or dependent adult abuse, (3) are a danger to yourself or others, or (4) are unable to meet your own basic life support needs.

If I see you together with your partner or with other family members, confidentiality extends to all those involved in therapy and I will not release to third parties any information without first obtaining signed releases from everyone involved. However I will not necessarily be bound by confidentiality in joint session with information I have obtained in individual sessions and discussions. This means I reserve the right to discuss in joint sessions information that you have share in individual sessions and discussions if I believe it helps facilitate the achievement of the goals set forth in therapy.

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Date

Acknowledgment of Disclosure & Consent to Treatment

I (we) understand the information and agree to the terms set forth in the above disclosure statement.

Client or Guardian Signature

Date

Client Name (print)