Carol Odell

MSW, LICSW

THERAPIST DISCLOSURE STATEMENT

It is my hope that the following statement will answer most of the questions you may have as you consider coming to see me in therapy. Please feel free to ask any additional questions about me as a therapist or about my therapeutic approach.

Qualifications

I received my undergraduate degree from Indiana University, and my Master in Social Work degree from the University of Washington in 1984. I am a licensed therapist with the State of Washington (# 00004175), and am an active member of the National Association of Social Workers.

For seven years following graduation, I worked for Family Counseling Services, as a clinical therapist and supervisor. For eight years following that I was employed by the University of Washington School of Medicine as a therapist for medical students and their families. I have been maintaining my own full-time private practice since 2000.

Orientation

I believe that we heal through our relationships with others. I find that by in-depth exploration of the intense positive and negative feelings evoked in relationships—be that with a significant other, family member, co-worker, friend or one's therapist—that the opportunity for lasting change exists. It is within these exchanges that problems and issues become most keenly illuminated; it is through exploring and learning from the resulting emotions and freeing up different behavioral responses that one's life transforms. Progress, however, requires commitment to this work.

Client Rights

As a client and a consumer, you have the right to understand and question the actions and methods used in therapy, to be well-informed regarding my qualifications, and to choose a therapeutic style that is most appropriate for you. If you are dissatisfied with what is occurring in our work together, I encourage you to discuss it with me; however, you also have the right to discontinue treatment at any time.

From WAC 246-810-031

"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the 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 any treatment."

Confidentiality

The fact that you are coming to see me and all that we discus will be kept confidential unless you give me your written permission for a specified purpose. There are, however, certain disclosures which I am required by law to report. The bounds of confidentiality do not apply under these conditions:

- If I suspect any form of abuse or neglect involving a child
- If you indicate serious harmful intent towards yourself or another person
- If I am served a court order for your records

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INFORMATION SHEET

Name: _____ Birthdate: _____

Cell Phone _____ Work Phone: _____

Name: _____ Birthdate: _____

Cell Phone: _____ Work Phone: _____

Address: _____ Address: _____

_____ _____

_____ _____

Referred By: _____

Fee Policy:

Once the fee has been established, it is the client's responsibility to uphold this financial agreement. Generally individual and couples sessions are $125, group fee is $60. Payment is required in full at the time of each session unless other arrangements are negotiated. Insurance statements will be provided for the client to submit directly to their Claims office.

Cancellation Policy:
24 hours notice is required in order to cancel a scheduled appointment otherwise, you will be charged full fee for this missed session.

I (WE) understand and agree to the FINANCIAL terms written above AND I (We) ACKNOWLEDGE THAT I (WE) HAVE READ THE THERAPIST DISCLOSURE FORM IN FULL.

Client Name(s)_____Date_____

Client Signature(s)_____

Client Name(s)_____Date_____

Client Signature(s)_____

Therapist_____Date_____

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