

Disclosure of Information and Office Policy (revised February 2020)

Well With Art, PLLC

Brigid Blume, ATR-BC, LMHC

Board Certified Art Therapist, Licensed Mental Health Counselor

WA License #: LH 60732583

ATR Registration #: 17-165

Education: MA, Art Therapy Counseling, Marylhurst University, OR;

BA, Studio Art, Photography/Painting, Northeastern IL University, IL.

Approach

I have been a registered counselor in Washington State since January of 2013. I work from a diverse and culturally sensitive background, focusing on the individual needs of my clients, while incorporating a variety of theoretical orientations. I have worked with children, teens and adults in a variety of setting including: community mental health, hospitals, schools and privately. I try to meet my clients where they are at and move forward from there, building on existing strengths, while encouraging growth, learning and wellness throughout the therapeutic process.

Therapist and Client Responsibilities

My responsibility to you includes: confidentiality, honesty, safety, knowledge, support, experience, and an on-going clinical consultation and training. I see my responsibility as providing a safe space in which you can learn more about yourself and your coping styles through making art and talking within confidential boundaries. I will likely make suggestions and provide feedback on what I observe through our interactions. I will periodically check in with you to see how you are feeling about the work that is happening. If it becomes clear that I cannot meet your needs in therapy, I will provide you with referrals to other therapists.

I encourage you to be honest, open and will to make your own changes, though I realize this can be a challenging task. I believe that art therapy counseling is collaboration between client and therapist, and the more open the communication is, the more growth will occur. You are in control of your therapy and your life. If you have any concerns, questions or are dissatisfied with your therapy, I strongly encourage you to discuss this with me. You have the right to request a change in how we are working together, to take a break, or to discontinue therapy at any time. Since it is a collaborative, two-way relationship, I believe it is important to maintain open communication about breaks, changes and termination.

Confidentiality

All information you share with me is confidential and will not be shared with any other person or agency except under the following circumstances:

1. There is a medical or psychiatric emergency.

2. You sign a release of information form specifying the information to be disclosed as well as the person(s) to whom this information can be released.
3. I have reason to believe that you may be in danger of harming yourself or others or cannot meet your basic needs.
4. I have reason to believe that a child, elderly person, or developmentally disabled person is being abused in any way.
5. Parents and legal guardians of non-emancipated minors have the right to request access to client records.
6. You are involved in a lawsuit or legal situation and the court subpoenas your records.
7. Insurance providers and other third-party payers request information regarding service to clients. Information that may be requested includes: types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.
8. During supervision or clinical consultation.

I obtain clinical supervision on a regular basis. Supervised consultation is used to help ensure that I provide you with the highest quality of therapy. During supervisory consultation, efforts will be made to disclose as little information as possible to ensure continued confidentiality. Artwork is often used during supervision to improve the quality of art therapy.

In addition, I seek occasional consultation with other clinicians. These discussions are done under strictly confidential and professional circumstances, and I make every effort to hide the identity of clients to protect privacy.

Appointments, Fees and Scheduling

I charge \$125 for a 60-minute individual therapy session.

I charge \$150 for a 60-minute session for two or more persons (couple, family, child & parent dyad).

Fee established: \$ _____

******All fees are due at the end of each session.***

Cancellation Policy: If you cannot make your scheduled session, please call me as soon as possible so that I can reschedule your appointment. If you miss or cancel session with less than 24 hours notice, you will be charged the full amount for that session.

To make an appointment or to cancel/reschedule an appointment, please call me at (206) 450-9027. I will check my voicemail periodically and try to return your call within 24 hours. In the event of an emergency or crisis, please call

(206) 467-3222 (or dial 211 from a landline) to speak with someone at the Crisis Line. If I will be unavailable for an extended period of time (1 month or more), we will make arrangements to see other therapists when necessary.

Your Rights

I keep some records of the meetings that we have and the services I provide to you. You have the right to see those records at any time. You have the right to know your diagnosis (if applicable) and I hope that you will participate actively in guiding your own therapy. If you feel unhappy or unsatisfied with something that occurred in our work, I ask that you please talk with me about it.

The state of Washington requires me to provide the following disclosures:

WAC 308-190-040: *“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.”*

My license number: LH 60732583

I do not engage in close personal or sexual relationships with clients or former clients.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signatures

By signing below, I acknowledge that I have read this disclosure statement and have been given a copy for my records. I also understand that my records are protected under federal and state laws (HIPAA) and cannot be released without my written consent, unless otherwise provided for in those regulations. I further understand that I may revoke any consent in writing at any time, but my revocation will not apply to action already taken based on my prior consent.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature (if client is under 13 years of age):

Date: _____

Therapist Signature: _____ **Date:** _____