BOTHELL NATURAL HEALTH

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CLINICIAN DISCLOSURE STATEMENT

EDUCATION/TRAINING/EXPERIENCE

- Master's in Counseling Psychology
- Bachelor's of Science is Human Services/Management
- Experience and training in child, adolescent, and children in care issues
- Experience and training in issues of Geriatric mental Health
- Developed and delivered curriculum for working with families with disabled children
- Developed and delivered curriculum around grief and loss issues in the foster care system
- Developed and delivered curriculum around issues of working with individuals with Fetal Alcohol Spectrum Disorder
- 30 years group facilitation

DESCRIPTION OF METHODS AND TECHNIQUES USED IN COUNSELING

Philosophy of treatment consists of: client centered approach using rapport building and active listening as an opportunity for client and therapist to become comfortable and well acquainted with each other. Modalities utilized in treatment consist of: a combination of client centered approach; cognitive behavioral therapy (addresses thought distortions). Solution focused counseling which centers on strengths and positive coping skills as well as client expertise combined to form a collaborative approach towards change.

Confidentiality: Client confidentiality is a foundation for a trusting relationship. As a rule, all client information is considered confidential. There are few exceptions to this rule. These exceptions will be discussed at the beginning of our first session.

I consent to treatment

Name_____ **Birth Date**_____

Address_____

_____

Phone number _____ **Alt. Phone Number**_____

What is/are your goal(s) from counseling?

Have you ever seen a counselor before? If yes, please tell me more.

How will you know when this/these goal (s) is/are met?

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Eileen Bowen regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Signature_____ **Date**_____

Printed Name_____