Disclosure Statement

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Client Rights and Responsibilities

Clients have the right to refuse treatment and the responsibility to choose the provider and treatment modality which best suits their needs.

Education and Training

I received a Master of Arts degree in Clinical Mental Health Counseling from Antioch University Seattle in December, 2015. During my graduate program, I completed an internship at Sound Mental Health, a community mental health clinic in Bellevue, Washington. Currently, I am licensed as Mental Health Counselor Associate, working under the supervision of an approved supervisor.

Therapeutic Orientation

I take an integrative approach in my therapy practice, grounding my work in Person Centered, Attachment, Mindfulness, and Trauma informed therapies. I believe that each individual has within them the resources to learn, grow, and pursue more of the life that they would like. While I have knowledge and expertise in psychotherapy, I believe that my clients are the experts on their own experiences and my goal is to help them to pursue their goals authentically. In helping my clients in their pursuit, I take an eclectic approach, relying on a variety of well-established theories and interventions and striving to match these to the needs of each individual client. Please feel free to ask me for more information and/or resources about my therapeutic orientation.

Course of Treatment

Sometimes, work in psychotherapy is relatively short, lasting only a few sessions, and other times it takes much longer. How long you spend in psychotherapy depends on your individual goals. I recommend that we start off meeting once per week for 50 minutes. Both the duration and frequency of treatment can be flexible and determined collaboratively.

Fees

My fee is $120 per 50 minute session; payment is due at the time of service and can be made by cash, personal check, and via Paypal. I do reserve several sliding-scale fee appointments each week, based upon financial need; however these appointments are subject to availability.

In order to avoid being charged your full session fee for missed appointments, a 24-hour cancellation by telephone is required.

Confidentiality

With the exception of circumstances which I will describe below, what you say as well as your participation in psychotherapy will remain confidential. Exceptions to confidentiality exist when: there is an imminent threat of harm to the client or others, abuse or neglect of children or vulnerable adults, a court ordered release of information, if you bring a legal suit against me, or a third-party payer requests a diagnosis or other relevant clinical information. I will be receiving supervision and may discuss details of your therapy with my supervisor in order to better serve you. Additionally, I may seek out further support in consultation with other professionals in regards to my work with you. Any supervisors or other professionals with whom I speak will also be covered by confidentiality. If you would like me to share information about your engagement in therapy, you may provide a release of information. Additionally, your work with me in psychotherapy is protected by the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA), which requires that information about you which is transmitted electronically remain confidential. In compliance with HIPPA, I will take steps in order to maintain your confidentiality.

Consent to Treatment

The undersigned practitioner has gone over this document with the undersigned client and has answered all questions to the client's satisfaction.

_____ _____

Benjamin Scott Braaksma, MA, LMHCA Date

The undersigned client has been provided with a copy of this disclosure statement, has read the statement, and understands the rights and responsibilities contained herein. The undersigned client authorizes treatment under the conditions of this document.

_____ _____

Client Date

The undersigned legal guardian of the client has been provided with a copy of this disclosure statement, has read the statement, and understands the rights and responsibilities contained herein. The undersigned legal guardian of the client authorizes treatment under the conditions of this document.

_____ _____

Client's Legal Guardian Date