

**PLEASE READ AND SIGN THIS STATEMENT BEFORE BEGINNING THERAPY**

**Bob Goettle, MA LMHC**  
**Counseling & Psychotherapy**  
**Professional Disclosure Statement**  
**WA State License # LH00004179**

Welcome to my practice. Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy, methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to facilitate our work together, here is some basic information about me and my practice.

**Qualifications**

I am a Washington State Licensed Mental Health Counselor. I earned a Masters degree in Psychology from Antioch University in Seattle, Washington in 1997. I also have a Bachelor's degree in Psychology from Penn State University (1990). I have received post graduate training at the following institutions: The Gottman Institute, Seattle, WA; The Behavior Research and Therapy Clinic at the University of Washington, Seattle, WA; Brain Gym International, Ventura, CA; The Northwest Alliance for Psychoanalytic Study, Seattle, WA; Behavioral Tech, Seattle, WA; FACES, Redmond WA; The Marriage and Therapy Training Center at Presbyterian Counseling Service, Seattle, WA; The SASSI Institute, Springville, IN.

**Experience**

I have sixteen years of experience providing counseling and psychotherapy. I have worked for the following institutions: Stormbreak Homeless Youth Center, State College, PA, as a counselor; The Meadows Psychiatric Center, Centre Hall, PA, as a mental health technician; Northwest Mental Health Services, Renton, WA, as a case manager; Community Psychiatric Clinic, Seattle, as a therapist; Behavior Research and Therapy Clinic at University of Washington, as a research therapist.

**Treatment Philosophy and Methods**

**Individual Therapy**

I construct a unique psychotherapy program for each client, drawing from cognitive-behavioral therapy and psychodynamic psychotherapy techniques.

Your therapy will consist of four parts: assessment, treatment, “phasing out” of therapy, and termination. In the first session, we will talk about your personal history, areas of concern, and your goals for treatment. I may ask you to complete written questionnaires to help me understand you better. Next, I will share with you my recommendation for treatment and we will work to define mutually agreed upon goals for treatment.

**Couples Therapy**

When working with couples, I generally employ the Gottman Method. The Gottman Method of couple's therapy is based on Dr. John Gottman's twenty-seven years of research in what makes marriages succeed or fail. From this research, the Gottmans have created a therapy that emphasizes the “nuts and bolts” approach to improving your relationship. In our work together with this method, you will learn specific tools to deepen friendship and intimacy in your relationship. To help you productively manage conflicts, you will be given methods to solve resolvable problems and to dialogue about “grid locked” (or perpetual) issues. We will also

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work together to help you appreciate your relationship's strengths and to gently navigate through its vulnerabilities.

Couples therapy, like individual therapy, consists of assessment, treatment, "phasing out" and termination. Prior to meeting, I will send you a packet of questionnaires that you will complete separately and bring to our first session. These questionnaires will help me to understand you and your relationship. Assessment consists of three sessions: the oral history interview, during which we will talk about the history of your relationship. The second session will be split up into two halves for each of you to discuss your individual concerns, hopes, and goals. In the third session we will summarize your relationship's difficulties and strengths and plan our treatment strategy.

Most of our work will involve sessions where you are seen together. However, there may be times when individual sessions may be recommended. You may also be given suggested exercises to practice between sessions.

### **The Length of Therapy**

The length of our therapy together will be determined by your specific needs and goals. In the course of our work together we will establish points at which to evaluate your satisfaction and progress. Also, please feel free to raise any questions or concerns that you have about your therapy at any time you wish. In the latter stage of therapy, we will "phase out", or meet less frequently in order for you to test out your new skills, in preparation for termination. Although you may end your therapy whenever you wish, it is most helpful to have at least one session together to summarize your progress, define the work that remains, and to say good-bye.

### **Benefits and Risks**

It is important that you understand that counseling has both benefits and risks. You may experience uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Your therapy may also involve recalling unpleasant aspects of your history. Psychotherapy has been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships and resolution of specific problems. However, I can make no guarantees about how the therapy process will be for you specifically.

### **Office Policies, Procedures**

#### **Basic Fees**

My basic fee for service is \$90.00 per hour session, or \$135.00 per 90-minute session. Please check with your insurer as to your deductible, your co-pay, number of sessions covered per year and, if you are interested in couples work, if couples therapy is covered. Your insurance company may pay a percentage of the cost of your therapy per session. In this case, your co-pay becomes your fee, while I collect the remainder from your insurance company. Please remember, however, that you are ultimately responsible for payment of your therapy costs, not your insurance company. In addition I hold a limited number of spaces available for Adjusted Fee situations, on a "space available basis". Adjustable fees are determined at the intake session. Payment for all services is due at the time of service. Please have your payment ready at the beginning of each session, as the therapy session includes time for rescheduling and fee payment.

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I do not provide oral or written opinions regarding child custody, special reports or narratives for the court, or court-ordered treatment. In the event I am subpoenaed, my normal hourly fee will be charged for all written reports, oral testimony and travel/waiting time. I will provide written reports for accident claims or Social Security applications at my normal hourly fee.

### **Cancellations**

Your appointment times are reserved for you alone. If you need to cancel your appointment for any reason, appointments must be canceled 24 hours in advance. Otherwise you, not your insurance company, will be charged a cancellation / no show fee equal to the full fee for the session. Telephone therapy time is prorated at the same rate as in-office therapy, \$90 per hour session.

### **After Hours Coverage**

I return phone calls as quickly as possible during the work day. I do not provide after hours coverage. In case of an emergency, during the day or in the evening, please call the King County Crisis Clinic at (206) 461-3222. You will hear this number in the message on my answering machine.

### **Confidentiality**

I keep a record of the health care services I provide for each client. All client records are kept in a locked file cabinet in my office. No one besides myself has a key to those file cabinets. You may ask to see and/or copy your record by making an appointment specifically for that purpose. You may also ask me to correct your record. The information in your record is confidential, and will be disclosed to no one without your written consent, unless the law requires otherwise.

As part of providing services to you, I also may seek consultation about your therapy from another therapist. In all cases, your name and identifying information are not disclosed.

Anything discussed in therapy, and all information obtained about you from any source, including the fact that you are my client is confidential. There are, however, seven (7) exceptions to the privilege of confidentiality, as required by law.

1. If the client, (or a dependent child), is in immediate danger to himself/herself, the law demands that the therapist act to protect the life of the client and/or dependent child. This may require notification of family or other appropriate persons, including the County Designated Mental Health Professional, who will decide if involuntary hospitalization is necessary.
2. If the client threatens harm to another person, and there is a possibility of injury or death, the law demands that the therapist acts to protect the lives of potential victims. This may require various appropriate interventions, including informing the police and potential victims.
3. If the client reports his/her behavior or action against a child, elder, or other dependent adult which is considered abuse, including physical violence, neglect, and/or sexual molestation, or if the client reports such acts by another, the law mandates that the therapist must make a report of suspected abuse to the legal authorities.

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4. If the client is involved in legal action where he/she places his/her psychological condition before the court, the client forfeits his/her right to confidentiality in matters before the court. In such cases, I will discuss the situation with you in order to clarify alternatives.
5. You should also be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis to the insurance company. Sometimes additional information such as a treatment plan or summary, or in rare cases, a copy of an entire record, may be requested. This information will become part of the insurance company files. I will, at your request, provide you with a copy of any reports that I submit. In signing this document you authorize me to release any information, reports, or records to your insurance company and their managed care firm that are necessary to process your claim. You have the right to pay for my services yourself and avoid the complexities of the insurance process.
6. If I am aware that an identifiable individual is being unknowingly exposed to HIV infection, I will discuss the case with the local health officer or an authorized representative to determine what actions should be taken to protect the public health. Identifying information about the HIV-infected individual or their partners will be released consistent with state law rules and regulations.
7. Other situations where the law allows disclosure of information without client authorization are to other health care providers, to public health authorities, and to any other person who requires information for audit, quality assurance, peer review, or administrative, legal, financial or actuarial services to the therapist.

### **Confidentiality in Couples Therapy**

There are issues of confidentiality, which are unique to couples therapy. It is not therapeutically advisable for the therapist and one partner to hold confidential information from the other partner. This does not mean that information will be automatically shared. However, clients will be strongly encouraged to share pertinent information as necessary to augment the therapy process. A culture of “secrecy” disrupts the effectiveness of couples therapy. Thus if you choose to have a partner participate in therapy, either individually or conjointly, do not tell me anything you which kept secret from you partner. I will suggest that we terminate couples therapy if I deem that disclosed secrets have impaired our ability to work together productively.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concern that you may have. The laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, a legal consultation may be advisable. If you request it, I will provide you with relevant portions or summaries of the applicable state laws governing these issues.

Upon reading and understanding these policies, please sign below.

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I have read and understand this Disclosure Statement in its entirety. Fee arrangements and terms of confidentiality have been clearly made. My signature below indicates that I agree to all terms herein, and I have received a copy of this Disclosure, and that I wish to enter treatment on these conditions.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_