PHEBE BRAKO-OWUSU, LMFT

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**State of Washington Required Disclosure**

**Phebe Brako-Owusu, MA, LMFT**

State of Washington License #LF60607100

This disclosure statement provides information about the treatment provider and the treatment offered, to assist you in choosing the treatment and the provider best suited to your needs.

**Educational Credentials**

Masters in Marriage and Family Therapy, Seton Hill University, 2013

Bachelors in Psychology, Salem College, 2011

**Client's Course of Treatment**

If you decide to continue treatment beyond an initial assessment, we will develop an individualized treatment plan with you. This plan will include what is known at the time about your course of treatment and will be amended as appropriate during our work together.

**Confidentiality**

Confidentiality in counseling sessions is protected by law. Unless you grant me written or verbal permission, I will neither inform anyone that you are receiving counseling, nor will I disclose the content of anything communicated in our sessions.

Since the content of what you share is legally confidential, I cannot be forced to disclose anything without your consent. The state of Washington does mandate, however, that confidentiality is waives if one or more of the following situations arise (Chapter 26.44 RCW):

* If you pose a serious physical danger to yourself or another person
* If threats to national security are disclosed
* If you disclose that you or another person have physically or sexually abused or molested a child, an incompetent person or a disabled person
* If you disclose that a child, an incompetent person or a disables person is suffering from neglect
* Subpoenaed testimony in criminal court cases and order s to violate privilege by judges in child-custody and divorce court cases
* Confidentiality does not apply in criminal or delinquency proceedings, or when there is a legal or disciplinary proceeding regarding quality of care, or when services are being reviewed by a professional or legal entity

There may be times when I may need to consult with a colleague, supervisor, or another professional, like an attorney, about issues raised by clients in therapy. Client confidentiality is still protected, or provided for, during consultation by me and the other professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional service to you as a client.

In couple and family counseling, the therapist holds a “no secrets” policy. All members of the therapist that require differential or discriminatory treatment of family members.

**Assessments:** You may be asked to take one or several different kinds of inventories/tests during the course of treatment. These are used under the strictest confidentiality guidelines. These instruments are used as diagnostic tools that can aid the overall treatment of your situation.

**Minors:** In order to provide psychotherapy to a child under 13 years of age, I am required to secure written permission from the custodial parent or legal guardian. In certain cases, you may be asked to provide documented court proof of custody indicating your legal right to sign such permission. In such cases, any legal parent or guardian of the child has the right to information about the therapy of their minor.

**Sessions:** Sessions are 50 minutes in length. Notification of cancellation must be made at least 24 hours in advance (48 hours is preferable to assist scheduling*)* ***to avoid being charged (unless there is a true emergency).*** Missed appointments are also charged. Please be aware of this important policy and utilize the phone number 253-778-6636 to contact me personally, or leave a confidential voice message in my private voice mailbox at this same number.

**Phone Contact/Emergencies:** I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside my scope of practice, I am legally required to refer, terminate, or consult. If, for any reason, you are unable to contact me by telephone, 253-778-6636, and are having a true emergency, you may call the 24-hour Pierce County Mental Health crisis line at 1-800-576-7764 or Suicide Prevention Lifeline 1-800-273-8255. Also you may call 911 or check yourself into the nearest hospital emergency room. Be aware that you may leave a voice mail message in a private and confidential mailbox at the above stated number for non-emergencies as well.

If you have questions or would like additional information, please feel free to ask.

**Billing, Fee and Financial Information**

Your fee will be discussed and written down on the Service Agreement. Procedures regarding additional charges and charges for cancellation will be discussed during the first session as part of the Service Agreement.

**Notice to Clients**

As required under Washington law, therapists practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration or licensure of an individual with the Department of Health does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. It is every client's right to refuse or discontinue treatment at any time. It is the responsibility of clients to choose the provider and treatment modality which best suits their needs and purposes.

In addition, licensed or registered therapists are required to inform clients of the purpose of the Counselor Credentialing Act (the law regulating counselors). The purpose of the Counselor Credentialing Act is (A) to provide protection for public health and safety; and (B) to empower the citizens of the state of Washington by providing a complaint process against those therapists who would commit acts of unprofessional conduct. Clients of licensed or registered therapists in the State of Washington may file a complaint with the Department of Health at any time they believe a therapist has demonstrated unprofessional conduct. To obtain a list of actions considered to be "unprofessional conduct,” or to file a complaint, contact the Department of Health, Business and Professional Administration, P.O. Box 9012, Olympia, WA 98504-8001, (360) 236-4700.

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices and Required Disclosure for Phebe Brako-Owusu, LMFT, LLC and understand the information provided.

Signature of client (or personal representative) Date

Signature of client (or personal representative) Date

Signature of Therapist Date

**If a personal representative on behalf of the client signs this acknowledgment, complete the following:**

Personal Representative’s Name:

Relationship to Client:

**This form will be retained in your medical record.**