Therapist Disclosure Statement and Informed Consent
Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC

I. **THERAPIST DISCLOSURE**

- Credentials: I am a Licensed Mental Health Counselor in Washington State (#LH 60420486) and a Washington Approved Supervisor.
- Education, Training, and Experience: I received a Bachelor of Science in Sociology from Tuskegee University. I completed my Master of Arts in Psychology at Seattle University. I have been a practicing therapist since 2010, specializing in working with marginalized populations, Ethnic and Racial minorities, the LGBTQIA population, older adults, clients who have experienced complex trauma.
- Professional Memberships: I am a member of the Washington Mental Health Counselor Association and American Mental Health Counselor Association.
- Services Provided: I provide psychotherapy for individuals (adults, and adolescents aged 13 and older), couples, families, and groups. I provide supervision to Associate counselors who are working toward licensure in Washington. I provide consultation to other mental health professionals and independent mental health evaluations.

II. **WORKING RELATIONSHIP**

Confidentiality: I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.

Record-keeping: I will keep a confidential file containing your private health information (PHI) on Electronic Health Records. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. Washington State Department of Health requires documentation and retention of records for seven years after last contact.

Sessions conducted via video comply with (PHI) including documentation, privacy rights, and retention.

Emergency, Urgent, or Other Contacts: You may call and leave a voicemail at (206) 354-7971 and I will get back to you as soon as I can. I retrieve all messages daily and whenever possible I will get back to you

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within 24 hours. You may also email your message to Lavonnebryan@fortitudetherapy.com. I do not save any client phone numbers in my phone, so if you text, please include your name. Anything sent over email or text message is not confidential. Do not use email/text to communicate crisis information. I am not able to provide on-call crisis or emergency services.

If you have a life-threatening emergency, call 911. The King County Crisis Clinic has 24-hour availability, community resources, and emergency information and can be reached at (206) 461-3222. If I will be out of town or unavailable for an extended period of time, I will provide you with alternate contact information should you need extra support during my absence.

Therapeutic Relationship and Professional Boundaries: Professional boundaries are essential for the protection of therapeutic relationship and confidentiality. Therefore, I uphold the following practices:

1. I will not provide any services outside my scope of practice.
2. I will only provide appropriate referrals to other health professionals, with your consent.
3. I will uphold confidentiality standards during the course of therapy and thereafter. By law, sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.
4. In public settings, I will not initiate contact with you in order to maintain your confidentiality. If you choose to initiate a visible or audible greeting, I will reciprocate unless it is compromising to the relationship.
5. The clinician has a right to conduct their life separate from the therapeutic relationship. Therefore, if the clinician is in a shared space within the confines of their personal relationship, they reserve the right to conduct and participate in their activities, hobbies and interests, etc. as others would within the continued professional boundary and ethical responsibility of confidentiality, while living their personal freedoms.

Termination: You may choose to end our therapeutic relationship at any time. If you would like to end therapy, if possible, I would like to discuss prior to terminating therapy. We may also come to a mutual decision to end the therapeutic relationship. I reserve the right to terminate services with a client as necessary and support client with referrals if needed.

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III. **Confirmation of Informed Consent**

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Fortitude Therapy and Wellness, PLLC and I understand it and had the opportunity to ask questions.

_____ I agree to follow the terms in the Disclosure Statement and consent to treatment as outlined in this Disclosure statement.

_____ If requested, I have a copy of this Disclosure Statement with my signature.

_____ I understand that my therapeutic relationship with Fortitude Therapy and Wellness, PLLC may be discontinued if the terms in this agreement are not fulfilled by either of us.

Print Name _____

Client Signature_____ Date _____

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