

Bill Bedell MAC LMHC  
Stillwater Counseling P.S.  
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253-334-5147

### Overview

Since counseling is built on particular theoretical foundations in addition to the personal style and experience of the counselor, I believe that it is in your best interest to explain my background, my view on the counseling process and relationship, and to clarify administrative policies to avoid any unnecessary misunderstandings.

### Counseling Orientation, Techniques and Methods

I view the counseling process to be a partnership in which we can begin to look at the nature of your struggles while honoring you as an individual. In using a Biblical foundation in my counseling process, I believe that people are valuable and created to profoundly relate. Therefore, the problems we all encounter are deeply rooted in relational dynamics and within a unique personal narrative. Our relating is an experience of incredible delight as well as the most intense pain we will face. I believe approaching the process in a way that addresses these areas is not only effective in engaging the struggles you now have, but is also helpful in discovering its source. The counseling process can sometimes be disruptive as you deal with different aspects of your life, and it is possible that you might feel worse or symptoms might increase for a time. This can be a normal part of the process and is important to understand as we begin to explore your life, relationships, and the change process.

### Participation

Therapy is an alliance that invites active involvement on your part to be most effective. Your level involvement will depend on your own willingness and curiosity to face what is true within your own life. My hope is to create a relationally safe environment for that process to occur. The length of therapy will vary according to individual concerns and needs. We will together determine the length of time we need to meet and when it is appropriate to terminate.

## Professional Profile

I have a Masters of Arts in Counseling and am a licensed mental health counselor with the state of Washington (license #LH60017477). I have been in private practice since 2003. Areas of training include marriage, family, adolescence and individual as well as group therapy. I am not a physician and cannot prescribe medication. If you are currently under medical treatment, I will work in collaboration with your doctor. If medical treatment is necessary, I will recommend competent personnel and work in cooperation with them towards your best interests.

Washington state law requires the following disclosure: Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The Counseling Credentialing Act regulating counselors was passed for the purpose of protecting public health and safety and empowering the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

## Confidentiality

There is legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, I strive to maintain the strictest ethical standards of confidentiality. There are legal exceptions to confidentiality. The following are those situations in which the information you have shared with me may be shared with others. When possible, we will discuss any exceptions to confidentiality as they arise.

- State law requires suspected child abuse (physical or sexual) to be reported to Child Protective Services or law enforcement officials.
- Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement professionals.
- Case records and testimony may be subpoenaed by court order.
- Periodic professional consultation and/or supervision.
- Written permission provided by the client to share confidential information through signing a release form.

- As required under chapter 26.44 RCW.

In addition, I keep a record of the services I provide you. You may review your own records in my files at any time. You may add to them or correct them, and you may have copies of them. If, as part of our therapy, you create and provide to me records, notes, artwork, or any other documents or materials, I will return the originals to you at your written request but will retain copies.

### **Confidentiality in Consultation**

I sometimes consult other therapists or other professionals about my patients. This helps me in giving you a high level and best quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

### **Billing and Insurance**

The fee for counseling is \$100 per 50-minute session and \$145 for a 75-minute session, due at the time of the session. At this time, I do not take insurance. However, I am willing to provide you the information necessary for you to pursue compensation from the insurance companies. If there are economic difficulties I am open to working out a reasonable arrangement on which we both are comfortable. Payment is due at the beginning of the session (cash or check); other arrangements must be made in advance. The appointment time has been reserved especially for you. In the event that you must change or cancel an appointment, 24 hours advance notice is required or the full fee will be charged (emergencies excepted).

### **In Order to Contact Me**

You may leave me a confidential voice message at my counseling office number (253)334-5147. I regularly check my messages and try to return phone calls within 24 hours.

### **Emergencies**

If an emergency or crisis should occur and I cannot be immediately reached, please call the crisis clinic at 1-800-244-5767 or dial 911 immediately to receive the help or counsel you need.

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you-perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and information of your chosen contact person in the blanks provided.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

### **Ethics and Professional Standards**

I subscribe to the ethical and professional standards of the Washington State Licensing Law. If you have questions about our work together, please talk with me about this so that we can come to an understanding about your specific needs and the direction of our work together. In the event that you feel I have acted in an unethical manner, please discuss the situation with me so we can come to a resolution. If you find our negotiation has not been satisfactory, you may contact directly the Professional Licensing Services in Olympia at (206)753-1761.

### **Other Points**

Although I share this office with other therapists, each of us works independently, and each alone is responsible for the quality of the care he or she provides.

### **Patient Acknowledgement**

I, the patient (or his or her parent or guardian), understand I have the right not to sign this form. I understand I can choose to discuss my concerns with you, the therapist, before I start (or the client starts) formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this form, I can talk with you about them, and you will do your best to answer them.

I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I have read, or have had read to me, the issues and points contained within this form. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this form. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

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Signature of Patient

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Date

I have read and understand that the information disclosed in counseling sessions with my counselor may be discussed with other professionals for the purpose of ongoing consultation. I hereby grant permission for any information that I share in my counseling with Bill Bedell, to be discussed in consultation with other professionals as described above.

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Signature of Patient

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Date

I have been provided with a copy of the Washington State Department of Health brochure, *Counseling or Hypnotherapy Clients: Client and Counselor Responsibilities and Rights*. I have read the brochure and understand the content.

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Signature of Patient

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Date

“Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of public of health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of and treatment.” WAC 246-810-031

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, \_\_\_\_\_, acknowledge that I have received a copy of the Notice of Privacy Practices for Bill Bedell LMHC.

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Signature of Patient

Date

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**Therapist Acknowledgement**

I, the therapist, have met with this patient (and/or his or her parent or guardian) and have informed him or her of the issues and points raised in this form. I have responded to all his or her questions. I believe this person understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the patient, as shown by my signature here.

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Signature of Therapist

Date