DISCLOSURE STATEMENT

Frank L. Robinson, M.Ed.,LMHC
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Washington State License

Licensed Mental Health Counselor (L.M.H.C.) License # LH00004048

Purpose of the Disclosure

This information is offered to assist you in choosing the therapist and the approach that best meets your needs. You have the right to request a change in therapy, referral to another therapist or the right to discontinue treatment at any time for any reason, with or without notice to me (except in certain court ordered situations). It is important that you realize that it is your responsibility to choose the provider and the treatment modality that best fits your needs.

Approach To Treatment

I see my counseling style as caring, direct, intuitive and very interactive. I have a spiritual (not religious) frame of reference. I believe most people have a tremendous ability to grow and constructively work through their own issues. I see my job as assisting you in that process. It is my intention to enhance your own clarity and your freedom to choose.

I teach specific skills in living, such as how to open your heart to yourself, how to recognize and set healthy and appropriate boundaries, and how to soften, breath, and let go of holding on to attachments. I teach people how to listen to hear rather than to react, how to speak with an "open heart", and how to give and receive support in such a way that the other actually feels supported. I also teach a range of meditation and mindfulness techniques.

It is important for you to know that if you are in a relationship and you elect to do personal/ spiritual growth work with me and your partner does not choose to participate, it may have an effect on your relationship. You may experience this as positive or you and your partner may experience this as negative or threatening. In couples counseling the records of our sessions will not be released unless both people sign a release form.

I feel I work well with 13 to 95 year olds. I tend to attract people who want to do personal and spiritual growth work. I work especially well with relationship and boundary issues, anxiety, depression, and pain management issues. I also enjoy helping people with clarifying addiction problems. My clinical orientation is primarily cognitive/emotive and I often exercise creative use of Gestalt, visualization, and meditative techniques. I generally suggest readings and outside homework. I can work in a short term (6 to 12 sessions) or a longer term format, depending on your goals of treatment, our rate of progress, and how you feel you can best use my services

Education and Experience

Bachelor of Arts Degree (BA) Master of Education (M.ED.) Business Administration
Counseling Psychology University of Washington - 1968 University of Washington - 1974

Military: United States Air Force: Captain, 1968 - 1973

1974 to present: Extensive additional continuing education and training in brief solution-oriented and brief psycho-dynamic therapy approaches, Gestalt therapy, cognitive therapy approaches, panic and anxiety disorders, evaluation and treatment of addictions, grief and loss, hypnotherapy approaches, meditation practices, human sexuality, group process, specific communications strategies, EMDR, problem solving and conflict resolution.

UNISPHERE

1980 to present: Originator and operating director of company providing a wide range of services in support of personal/spiritual, organizational and environmental well being. Activities include the following areas: (1) Private counseling practice specializing in short and longer term treatment for relationship issues, anxiety, depression and pain management and for personal and spiritual growth. (2)Consulting practice specializing in executive coaching, team building, communication skills training, burnout, conflict resolution, mission statement clarification and development, reducing employee stress and anxiety, raising productivity and job satisfaction. (3)Training/Education/Public Seminars in areas of relationships, individual and organizational co-dependence, communication skills, conflict resolution and personal/spiritual growth.

Professional Memberships

American Mental Health Counselors Association
Washington Mental Health Counselors Association
Seattle Counselors Association

Client Rights and Confidentiality
(RCW 18.19; 18.130)

1. You have the right to refuse treatment.

2. You have the right to choose the provider and treatment modality which best suits your needs.

3. You have the right to confidentiality to the extent that it is protected by law. Information will not be released without your written consent except in the following exceptions: I am required to report:
    a. (a) A communication that reveals the contemplation or commission of a crime or harmful act.
    b. (b) There is a clear threat to do serious harm to self or others.
    c. (c) Any evidence of abuse or neglect of a child, dependent adult or a developmentally disabled person.

    My testimony may be subpoenaed by a court of law or by the director of the Department of Licensing. Confidentiality is null in the event you bring legal charges against me. Consultation may be done with your permission or in a way that maintains your privacy.

4. You have the right to know my education, training and treatment orientation.

5. You have the right to know the proposed course of your treatment.

6. You have the right to know all financial requirements.

7. You have a right to see a copy of the treatment record which I keep of

    our sessions. You have the right to request me to correct that record. I

    will not disclose your record to others without your written consent

    unless the law authorizes or requires me to do so.

8. You have the right to lodge a grievance with the State of Washington Department of Licensing if you feel your rights have been violated.

Fee Information and Payment Policies

Payment

My fee is $175.00 for the initial fifty minute appointment for individuals and $150 per fifty minute session thereafter. My fee is $175.00 for couples or family sessions. I request the fee be paid at the beginning of each session.

Cancellations and missed appointments

If you must cancel a session, please let me know as far in advance as possible. Sessions that are missed or canceled with less than 24 hours notice will be charged full fee. If I have to cancel a session with less than 24 hours notice to you, I will owe you a session without charge.

** Client's Initials _____

"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 a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment." (WAC 246-810-830 & WAC 246-810-031)

Insurance Policy and Informed consent

Audits of Covered Patients:

"Should you elect to use your insurance benefits to pay for psychotherapy, your diagnosis, symptoms, history and substance abuse issues (if any) will become a part of your permanent medical records. Your insurance company has retained the right to access and copy any and all of the information as well as all clinical documentation of your treatment. You should be aware that in some cases, this information may be submitted to insurance databases and/or to employers when they are the purchasers of your medical/mental health benefits."

Insurance coverage:

I have decided to no longer be covered by medical insurance programs. I have therefore terminated all of my provider contracts with all the insurance companies with whom I have worked in the past. For people who choose to work with me I am doing so only on a private pay basis. I have never refused anyone because of financial constraints. If money is a limiting factor for you, I will be happy to have a conversation to find a way that works for both of us. I accept Zelle payments or checks sent to my mailing address.

_____

(Client Signature) (Date)

Acknowledgment

I have read the complete Disclosure Statement and have had an opportunity to discuss and ask questions about its contents. I have also read and understand the HIPPA Compliance Notice of Privacy Practices accompanying this document.

_____

(Client Address and Phone Number) (Date)

E-Mail _____

_____

(Client Address and Phone Number) (Date)

_____

Frank L. Robinson, M.Ed., Date Washington State License #LH0004048

Please Complete:

Date of birth _____

Whom I may contact in case of emergency.

Name_____ Relationship to you_____
Telephone _____

Are you currently under care of a physician or other health care provider?
____Yes____No

Name(s) and phone number(s) of provider(s):
_____
_____

Medications you are currently taking and their purpose:_____
_____
_____