

**DISCLOSURE STATEMENT
PATRICK C. GERACIE**

**Trinity Counseling
2209 Elm St. Ste# 202
Bellingham, WA. 98225
360-715-3230**

Washington State Law provides that all therapists who provide clinical services present to new clients a disclosure statement with information as an aid to ensure that your needs as an informed client are met.

TRAINING AND PROFESSIONAL BACKGROUND

I am a licensed mental health counselor in the state of Washington (# LH00008435) and a Board Certified Christian Counselor. I received my Bachelor of Arts degree in biblical studies and general education at Oak Hills Christian College in Bemidji, Minnesota. I received my Master of Arts degree in counseling psychology from Western Evangelical Seminary (now George Fox Evangelical Seminary) in Portland, Oregon. I also hold a Master of Divinity degree and a Master of Arts degree in Exegetical Theology from Western Seminary in Portland, Oregon. I have been working as a clinician since 1993 providing individual, marriage, family and group counseling in a variety of settings. I am a member of the American Association of Christian Counselors and abide by its' code of ethics.

THEORETICAL ORIENTATION AND APPROACH TO COUNSELING

As a Christian counselor I believe that real change takes place as people understand and appropriate the grace of God in their lives. I try to facilitate this by promoting a better understanding of God's word and a deeper appreciation for God's community. In doing this I will try to assess and ameliorate those issues that may be standing in the way of progressing Christian maturity. This process will include prayer and Bible study but may also include family systems work, cognitive-behavioral methods and psycho-educational approaches. I stay abreast of the latest Christian and secular counseling research and will use new techniques and approaches if I find them to be Biblically sound and effective in promoting real change.

FEE STRUCTURE

I charge \$140.00 per 60 minute session. Fees may be adjusted for those experiencing financial difficulties. Payment is due prior to the session.

CLIENT RIGHTS & CONFIDENTIALITY

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, and progress. As informed consumers, it is the client's responsibility to choose the counselor and modality that best suits his/her needs. Clients have the right to request a change of counseling approach, a referral to another counselor, or termination at any time.

Confidentiality is an important part of the therapy process. Your identity and ongoing work in therapy will be kept strictly confidential with the following exceptions:

State law requires suspected abuse (physical or sexual) and/or neglect to be reported to the appropriate authorities.

Threat of harm to self or others may be reported to family and/or appropriate mental health or law enforcement professionals.

Case records and testimony may be subpoenaed by court order.

When insurance coverage is requested, a billing form containing the diagnosis, dates of service and type of service is sent to the billing service and the insurer. They may also request information about presenting problems and symptoms, treatment plan, indication of progress and outcome of therapy.

The Uniform Health Care Information Act, Section 501, requires health care providers to present the following statement of information practices: "We keep a record of the services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to."

PERSONS TO NOTIFY OF CONCERNS ABOUT YOUR THERAPY

Department of Health
Health Professions Quality Assurance Division
Counselor Registration/Certification
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4903

IN CASE OF EMERGENCY

In case of a mental health emergency, contact the VOA Care Crisis Line at **1-800-584-3578**.

CONSENT FOR TREATMENT

I have read the above statements and I am requesting to be involved in counseling services at Trinity Counseling and I have the right to cancel services at any time. I understand that I will be responsible to check with my insurance company and that I will be charged any fees that are not covered by insurance.

Signature _____

Date _____

