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**Client Consent and Disclosure Form**  
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206-369-4792

As a Registered Counselor in the State of Washington (RC00046329), I am providing the following disclosure of information, policies, and procedures so you are able to be fully informed about me and offer your consent to treatment.

**Education, Training, and Experience.** I earned my Master of Arts in Counseling Psychology from Mars Hill Graduate School in April of 2005. I earned my Bachelor of Arts degree in Psychology from Seattle Pacific University in 2002. Throughout both my undergraduate and graduate work, I have worked in diverse therapeutic settings including Swedish Medical Center, Providence Campus in their voluntary Psychiatric Unit as a Mental Health Specialist and as a Case Manager at Olive Crest, a foster and adoption agency located in Bellevue. I am currently the Family Advocate at Lake Forest Park Elementary where I work primarily with elementary age students on relational skills and behavior patterns.

**Therapeutic Orientation.** I have come to view the therapeutic process as an intentional time where the client and therapist create together the necessary space needed for positive growth and change to occur. This means that we will work together to explore and uncover those life issues which seem to be hindering your ability to move forward on your unique life journey. This exploration will include but is not limited to biological, psychological, sociological, and spiritual components of one's life. While I cannot guarantee that any specific goal will be achieved, your ability to be open and honest with me will greatly enhance the effectiveness of your therapy. If at any point you have questions or concerns about our relationship or the direction that our time is going, please feel free to address these with me. You are voluntarily agreeing to our counseling and have the right to choose a therapist who best suits you and your needs. You may seek a second opinion from another mental health practitioner and/or terminate therapy at any time. However, upon terminating, it is advisable for the client and therapist to have one final session to debrief and wrap up.

**Confidentiality.** All information you disclose is confidential unless you give me written permission to do so. Our work will remain confidential with a few exceptions: (1) where there is reasonable suspicion of abuse of children, elderly, or dependent persons; (2) where you present a serious danger to another person or yourself; or (3) if the court of law subpoenas your records. I regularly consult with colleagues about my work with utmost mindfulness to protect the privacy and confidentiality of my clients. Communication through cell phones and e-mail has inherent limits of confidentiality. Any written communication may be included in your therapy record.

**Fee and Course of Treatment.** My standard fee per individual is \_\_\_\_\_ and \_\_\_\_\_ per couple for a 50 minute session. Because I wish to remain affordable to any seeking to get help, I sometimes am able to offer a reduced fee. In the event that this pertains to you, this fee can be negotiated during our first session. Payment may be made at the end or beginning of each session, unless we agree to arrangements based upon your circumstances. Checks returned NSF will be charged \$20.00. Scheduled appointments become your financial responsibility; you are responsible for payment of sessions unless cancelled at least 24 hours prior to the session or if due to an emergency. The course of treatment includes risks associated with treatment, number of sessions, frequency of sessions, and ending of therapy will be determined by your needs and progress.

**Emergencies.** I attempt to respond to my messages within 24 hours. If you need help sooner or if there is a life-threatening emergency, call the Crisis Line (206-461-3222), call 911, or go to the nearest hospital emergency room.

**State Laws.** WAC 308-109-040: *Counselors practicing for a fee must be registered or certified within the department of health for protection of 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. SHB 1828: A record of the mental health care provided is kept in this office. You may ask to see a copy of that record. You may also ask this office to correct that record, if you believe the information within your record is in error. A copy of your corrections to the office records will be placed within your record, at your request. This office will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record, or get more information about it, at this office.*

**Consent:** I have read and understand all the information provided in this disclosure statement. I hereby give my consent for treatment and have been provided a copy of this *Client Consent and Disclosure Form*.

Client/s \_\_\_\_\_ Date \_\_\_\_\_

Therapist \_\_\_\_\_ Date \_\_\_\_\_