

DISCLOSURE INFORMATION

Counselor: Robert C. Keller, MA, LMFT, LMHC

Address: 4119 Pilatus Ave SE, Lacey, WA 98503

License: Licensed Marriage and Family Therapist, LF00002599; Licensed Mental Health Counselor, LH00003517

Type of Counseling: Family, Couples and Individual Counseling, Hypnotherapy, EMDR, specializing in trauma work.

Method of Counseling: Help people understand the effects of past and present relationships and how they may be effected by them now. Help people understand the effects of trauma and associated symptoms in their lives and how they may be effected by them now. I use Cognitive Behavior Therapy Techniques, Solution Focused Therapy, Narrative Therapy, Hypnotherapy, and Eye Movement Desensitization and Reprocessing (EMDR).

Experience: I have done extensive work with families at risk of losing their children to the state due to abuse, neglect or serious conflict since 1994. Began providing readjustment counseling to Veterans with Post Traumatic Stress Disorder in 1998. Also work with sexual assault victims since 1998. Entered private practice in 1999 and supervise other counselors in their work with families, couples, individuals and adolescents. Performed a variety of counseling for grief and loss issues, marriage and relationships, family issues, adolescents, depression, anxiety, addictive tendencies, anger, family problems, spiritual issues, and PTSD.

Supervision: I discuss some of my cases with other counselors, but not by name, this is to provide feedback on my counseling.

Costs: \$98 per hour session unless fee is covered by one of my contracting agencies. Fee to be paid in full at completion of each session, unless prior arrangements for payment are made. The fee for hypnosis or EMDR sessions is \$138.00 per session due to the length of such sessions. Also, Cancellation of appointments must be made at least 24 hours prior to appointment time or \$80 fee is assessed.

Confidentiality: Counselors cannot disclose any information you've told them during a counseling session unless: You give written consent, the information contains information about harmful acts, or the counselor has reasonable cause to believe that a child or adult dependent or developmentally disabled person has suffered abuse or neglect; the counselor receives a subpoena to provide information or you bring charges against the counselor. Therapist are required to report incidents of suspected child or elder/disabled persons abuse to authorities. Information that leads the counselor to believe you or others are or could be in danger of harm may be reported to the authorities. Information may be given to any insurance company we bill about your treatment and progress made.

Acts of Unprofessional Conduct: Abuse of a client or sexual contact with a client, incompetence, negligence or malpractice that harms a client or creates an unreasonable risk of harm to a client, willful betrayal of confidentiality, any act involving moral turpitude, dishonesty or corruption relating to the practice of counseling; possession, use or distribution of drugs or habitual use or impairment from the use of alcohol, false advertisement, offering to treat clients by a secret method, procedure or treatment, aiding an unregistered or uncertified individual to practice counseling, rebating laws which includes payment for referral of clients and interference with any investigation against the counselor.

Note: "Counselors practicing counseling for a fee must be registered or licensed with the department of licensing 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 implies the effectiveness of any treatment." The purpose of the law regulating counselors is (A) to provide for public health and safety and (B) to empower the citizens of the State of Washington by providing a compliant process against those counselors who would commit acts of unprofessional conduct.

There is no Guarantee as to the effectiveness of counseling or the amount to which symptoms or problems may be relieved.

I or we the undersigned have read and understand this disclosure information. Copy available upon request.

Client: _____; _____ Date: _____

Counselor: _____ Date: _____