

Bellingham Family Counseling
Kellie Furlan, MS, Professional Disclosure
12 Bellwether Way, Suite 223A, Bellingham, WA 98225

*Kellie Furlan, M.S.
Licensed Marriage and Family Therapist*

Formal Education and Training: I hold a Master's Degree in Marriage and Family Therapy from Seattle Pacific University (2001). I am a Licensed Marriage and Family Therapist in Washington State (MG 60584956), I completed an intensive in Narrative Therapy the fall of 2013 and again the fall of 2016 in Vancouver, BC at the Vancouver School of Narrative Therapy and I am increasing my knowledge and interest in a somatic modalities, which addresses the nervous system distress that is often the result of prolonged stress and traumatic experiences. I work with Individuals Adults, Couples, Families and Teens ages 14+ toward the resolution of difficulties in relationships, anxiety, grief, trauma and premarital education. I do not specialize in treating personality disorders or have the resources required to properly support Client's who are actively suicidal.

Philosophy and Approach: I am honored to accompany you at this juncture as you look to address things in your life that may have been concerning to you for quite some time. In counseling I will be actively involved in working with you, providing information, guidance, and support. I use a combination of approaches in treatment including Narrative, Cognitive Behavioral and Somatic awareness as informed by the Hakomi Method all applied through the lens of Family Systems and the importance of what Murray Bowen described as the "differentiation of the self" towards decreasing both internal and relationship distress. These approaches help to dis-entangle you from Problems that are leading to patterns of living that you want to leave behind while strengthening a positive sense of who you are and where you are headed. You can expect us to explore relationship patterns, how to improve boundaries and how to undermine Problems while using everyday language.

Counseling can have risks *and* benefits. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, over time there is evidence that counseling can have many benefits to one's own wellbeing and the wellbeing of one's relationships.

Some Clients need only a few sessions to achieve their goals, while others may benefit from longer term counseling. It is difficult to provide a clear picture of a timeline for your treatment until after we meet a few times and we get a clearer picture of your needs and goals. This is something that you have a right to know and we will discuss it together.

All sessions will be conducted according to the Code of Ethics for Counselors and Therapists adopted by the State of Washington Department of Health and the American Association of Marriage and Family Therapists. My code of ethics demands that our relationship remain professional therapeutic one, and never a personal one. Furthermore, I am a clinician, and not an Expert Witness. This means that I do not provide evaluations or opinions for the court of law related to mental health, custody, parenting fitness or otherwise.

It is important that you know that if you have a concern that some form of our work together has been unethical or unlawful, please express your concerns with me openly. Otherwise, consumers who believe a health care provider acted unprofessionally are encouraged to call the Washington

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State Department of Health with my License # MG 60584956 at 360-236-4700, to report their complaint.

Session Length and Fees: Sessions last between 55-60 minutes as we attempt to close our time together in graceful fashion. Unless we have made other arrangements each individual and family counseling session is \$150.00. A discount of 30% at a rate of \$105.00 is offered for private pay individuals and couples not utilizing insurance benefits regardless of income or household dependents and a Sliding Scale Application is not required.

A limited number of weekly sessions will be designated at a discounted rate for those clients qualifying for a discount of 50%. Please do not hesitate to inquire regarding your qualification for a reduced fee based upon Bellingham Family Counseling's sliding scale. All requests and supporting financial documentation will be handled with dignity and remain a confidential portion of your record. For consideration please request a copy or download from the website www.bellinghamfamilycounseling.com a copy of the sliding scale application.

Client portion of payment is required at the time of service by cash or check. If you pay by check, please be aware that in the normal course of business my bank may see your name and thus it could be argued that your confidentiality as a client may be compromised in this small way. If you are utilizing insurance, your insurer will also have access to your Protected Health Information.

If you will be unable to attend a scheduled session, you will be charged my full fee for the missed session unless you provide 48 hours notice or your cancellation is the result of an emergency. If you would like to be provided with an autotext or voice reminder call of your appointment time two days prior to your appointment please initial here: _____

Please also be aware that if your insurance company denies payment, you will be responsible for the remaining charges incurred. If more than three sessions remain unpaid, future sessions will not be scheduled.

In an emergency situation, before you are in danger of harming yourself or are a threat to the safety of others immediately contact the Whatcom County Crisis line at (360) 715-1563. You may also call my phone at (360) 325-1717 but this is not a 24 hour crisis line.

Completion of Treatment: You have a right to terminate counseling at any time. We will evaluate together whether you believe you have satisfactorily met your goals and I will offer any recommendations regarding additional support that I may believe would be helpful. If on the other hand it becomes apparent to me that your needs are beyond my scope of practice and therefore you would best be served with a referral to another professional for appropriate care, I will discuss this with you and support you to the best of my ability to locate an appropriate provider. If I do not have contact or communication from you for a period of 2 months, I will assume you no longer intend to remain active in this therapeutic relationship and your case will be closed.

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Mandatory Reporting:

I will make every reasonable effort to safeguard the personal information that you share with me. However, the laws of this state mandate licensed counselors to report to governmental authorities' specific actions or intentions. Failure to do so may result in civil and/or criminal prosecution of the counselor. Confidentiality will be broken in these specific situations:

1. Any known or reasonably suspected cases of *child abuse or neglect*.
2. Any known or suspected *intentions of harming yourself (suicide)*.
3. Any known or suspected *intentions of harming others*.
4. When written *consent is given by the client* to release information.
5. If you file a complaint against me or your records are *subpoenaed by a court of law or administrative agency*.

In an effort to provide you with the best ongoing care I may at times reach out for consultation with colleagues. This is considered best practice in the field of counseling and demonstrates my commitment to 'thinking outside the box of my own head' when necessary to support you on your journey. In these situations I commit to protecting your confidentiality by omitting any identifying information.

_____ (Initials)

_____ (Initials)

I acknowledge that counseling is provided *on the condition* that clients recognize this policy of confidentiality and agree that all licensed/certified or registered counselors will and are free to break confidentiality under any of these specific circumstances.

Email Communication:

Email and cell phone communication is convenient and is an acceptable method for sending copies of therapeutic letters in-between our sessions or confirming appointments. However, please understand that E-mail transmission and cell phone communication cannot be guaranteed to be secured or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. By signing below, you agree to communicate via E-mail and or cell phone with the understanding that I do not accept liability for any errors or omissions in the contents of the documents which arise as a result of e-mail transmission.

Yes, I would like to communicate via email under these conditions

_____ Date _____ EMAIL: _____ CELL

PHONE: _____

Initials

Yes, I would like to communicate via email under these conditions

_____ Date _____ EMAIL: _____ CELL

PHONE: _____

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Use of Spiritual Interventions in therapy:

At times, the inclusion of spiritual interventions in therapy can be reassuring and complimentary to psychotherapeutic treatments. This may be the case if:

- 1) You believe you are dealing with a clinical problem that can be helped by religious or spiritual interventions;**
- 2) Your therapist is not imposing their religious faith and values and you are thus working within your belief system and**
- 3) You have given your express consent to use religious or spiritual resources and interventions as part of therapy.**

If you believe that any of the following spiritual interventions might be helpful at some point in your therapy, please initial below and we will discuss together how to ensure that your spiritual values are honored in your healing process.

(Initials) Use of
religious texts or
references as appropriate

(Initials) Prayer out
outside of session or with
you during sessions

(Initials)
Exploration of your
spiritual beliefs and
practices as a personal
resource

By signing below, each of us confirms this disclosure document to represent the agreement between us. Also, you confirm receiving a copy and you confirm that you understand the information in this document.

Signed: _____ **Date:** _____
(Client)

Signed: _____ **Date:** _____
(Client)

Signed: _____ **Date:** _____

Kellie Furlan, LMFT