Beautiful Autism, LLC

DISCLOSURE STATEMENT

In order to provide accurate and current information and to comply with Washington State Law we at Beautiful Autism, LLC offer the following disclosure to you:

Full Name of Therapist: Jennifer W. Edwards, MA
Office Address: *16404 Smokey Point Blvd, Suite 208, Arlington, WA. 98223*
Therapist Phone: (425) 387-3872 ◆ **Email:** Jen@BeautifulAutism.com
License(s): *MC60590118* ◆ **NPI:** *1417245234*
Degree(s): Bachelors of Science in Education; Masters of Arts in Marriage & Family Therapy
Supervised By: Eddie Eccker, MS, LMFT – Lic#975

This above information represents your primary therapist. This information is available on any psychotherapists and behavioral specialist in the employ of Beautiful Autism, LLC.

The Washington State Department of Health (DOH) regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. The address by which this regulatory body can be accessed is the DOH Customer Services Center, 310 Israel Road S.E., Tumwater, WA. 98501 – Phone: (310) 236-4700

As a client of Beautiful Autism, LLC you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy (if known), and the fee structure. Additionally, you are entitled to seek a second opinion from another therapist or may terminate therapy at any time. As a client of Beautiful Autism, LLC you should be aware that in a professional relationship, sexual intimacy is never appropriate and should be reported to the DOH. As a client of Beautiful Autism, LLC you are entitled to know that information provided by you during therapy sessions is legally confidential in the case of licensed marriage and family therapists, clinical social workers, professional counselors, psychologists, and certified school psychologists, as provided in the Washington Administrative Code (WAC) 246-809-700. There are however certain legal exceptions, which will be identified to you by your therapist, should any such situation arise during therapy. If available, a list of other potential Beautiful Autism, LLC therapists will be provided upon request. I agree to $_____ per session of 45-50min, payable when service is rendered. I agree to 24-hour advance notice of session cancelation. I assume financial responsibility for all sessions including those not covered by insurance regardless of possible reimbursement. I understand that receiving counseling is voluntary. I certify that I have received a copy of this disclosure or have had the opportunity to read the aforementioned information. Everyone fifteen or older must sign a disclosure statement.

_____	_____	_____
Client/Guardian Printed Name	Client/Guardian Signature	Date
_____	_____	_____
Client/Guardian Printed Name	Client/Guardian Signature	Date
_____	_____	_____
Primary Therapist Printed Name	Primary Therapist Signature	Date