# Dragonfly Wellness & Education Center

# Counselor Disclosure Information: Sinay Butler

(Required by WAC 246-809-710)

**Name and credential/license**

Name: Sinay Butler

Title: Marriage and Family Therapist and Mental Health Counselor.

Education: M.Ed. in Adult Education

M.A. in Marriage and Family Therapy.

License: Mental Health Counselor Associate (#MC 60508703)

Marriage and Family Therapist Associate (#MG 60534864)

**Supervisor Information**

As an Associate, I have a supervisor while I complete the requirements for full state licensure. My supervisor is Carmen Green (WA License #LH00009493 and #LF00002255). I will seek input and collaboration with Carmen regarding clients. Clients are usually discussed without personal identifying information but Carmen and I are bound by the same confidentiality standards.

**Education and Experience**

I have two Associate degrees from the University of Alaska and received a Bachelor’s degree in Social Science from California State University, Stanislaus. I hold a Washington State teaching credential and taught at the college level for eleven years. I have a M.Ed. in Adult Education from Eastern Washington University and a M.A. from Whitworth University, where I studied Mental Health Counseling and Marriage and Family Therapy. I completed my internship at Whitworth University Counseling Center and Whitworth Marriage and Family Wellness Center where I worked with individuals experiencing a variety of psychological and emotional issues, including: depression, anxiety, bi polar, PTSD (Post Traumatic Stress Disorder), ADHD (Attention Deficit/Hyperactivity Disorder), OCD (Obsessive Compulsive Disorder), grief and loss and relational issues. I worked with acute and chronically mentally ill clients while employed at NEW Alliance Counseling Services in Colville, WA.

**Methods and Techniques Used**

Treatment is an individualized experience and you will actively participate in goal setting and in implementing interventions. I use evidence-based (shown by research to be effective) methods and techniques in therapy, such as Cognitive Behavioral Therapy (CBT), Solution Focused Therapy (SFT) and Motivational Interviewing (MI). I have completed the level 2 training for the Gottman Method of Couples therapy and use those methods. I am a PREPARE/ENRICH facilitator. Psycho-education is also an important tool in the therapeutic process. At times, individuals may be referred out for other services, such as an evaluation for psychopharmacology treatment.

**Course of Treatment**

Treatment starts with an assessment to determine your needs. Next, you and I will collaborate to develop measurable goals for those identified needs. Treatment interventions may include individual therapy, couples, and/or family therapy. The length of treatment is dependent primarily upon your needs and the presenting problems. Treatment can be as brief as 3-5 sessions, or longer if this is deemed necessary. Treatment comes to an end when treatment goals have been met and/or when you and/or I agree that continuation is no longer desired or indicated. Clients are expected to participate in their treatment and to attend their scheduled appointments.

**Type of Services Provided**

I provide therapy to individuals, couples and families with mental illness and/or other emotional/ behavioral problems. I believe that treatment is a mutual process and encourage active participation of clients and their families. I do not prescribe medications. In the event that it is determined that medications might be an appropriate addition to therapy, you will be referred to your primary physician.

**Billing Practices**

I currently do not accept any insurance. You are responsible to pay for services. You will sign an agreement which states what fee will be paid. I will provide you with a receipt that you can remit to your insurance company, should they agree to reimburse you. I reserve the right to review and amend fees biannually.

**Client’s Rights**

Feel free to ask any questions about my work as a therapist, the approach used, and your progress. You have the right to request a change in treatment, or to refuse treatment. It is critical that we work together to meet your needs as quickly as possible. You have the right to choose a counselor who best suits your needs and purposes. If you believe you are not being helped, please let me know so that we can fix the situation together. If we are unable to do so, I will assist you in finding another counselor.

All sessions are held in strict confidence, and no information can be released about you without your written permission. Washington State Law provides the following exceptions to confidentiality:

1. When a client poses a clear and present danger to self, or to others, or is unable to provide minimal life-sustaining self-care;
2. When a client reveals contemplation of a major crime against a person, or harmful act;
3. When the counselor receives a court order to share information with a judge; or
4. If the counselor has a reasonable suspicion that a person, under the age of 18 or a dependent adult (aged or developmentally delayed), is, or has been, physically or sexually abused, or neglected. This report must occur within 48 hours of the counselor receiving such information.

I do confer with other colleagues in order to gain a better understanding of how I can work with my clients more effectively. In these consultations, your identity will be protected, as will unique indentifying information. The other professionals with whom I meet are bound to the same standards of confidentiality as I am.

If you believe that I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that negotiation has not worked, you may contact one of the following:

Washington State Department of Health

Health Systems Quality Assurance (360) 236-4700

*or*

Washington State Department of Health

Health Systems Quality Assurance

Complaint Intake

P.O. Box 47857

Olympia WA 98504-7857

**Client Consent to Treatment**

I have read Sinay Butler’s Counselor Disclosure Information above, and I understand it. I have asked any questions that I had about this statement. I consent to counseling under the terms described above. I understand that I have the right to terminate counseling at any time I desire. My signature indicates that I have received a copy of this agreement.

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|  | Client Name (please print) |  |
|  | Client Signature | Date |
|  | Therapist Signature | Date |