Rebuilding Hope! Sexual Assault Center for Pierce County
Therapist Disclosure Statement

Sara Wendler, MA, LMHC
Washington State Mental Health License Number: LH60526900

Education/Training/Experience:
MA in Psychology from Chapman University; BA in Psychology and BA in Sociology from the University of Portland. Completed 33-hour Basic Sexual Assault Awareness Training and 23-hour Therapist Core Training with the Washington Coalition of Sexual Assault Programs. Member of the Pierce County Counselors Association.

Philosophy & Techniques:
Every person is unique and your life experiences will influence your views and beliefs. The therapeutic relationship is a collaboration between the client and therapist in which our experiences and skills will combine to meet your needs. My goal is to create a supportive environment for growth and healing to occur.

Course of Treatment:
I believe that the client has the right and the ability to direct the course of his or her therapy. We will discuss your personal goals and expectations for treatment and work together to determine what course of treatment will be best for you. I will maintain an open, honest, and supportive environment in which you will be able to express any questions or concerns you may have at any time during the process.

In accordance with the Washington State Department of Health, "Counselors practicing counseling for a fee must be registered or Certified (Licensed) with the Department of Health for the protection of 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 treatment. The purpose of the Counseling Credentialing Act (chapter 18, 19 RCW) is (A) to provide protection for public health and safety; and (B) to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct."

Supervision:
I will be supervised and receive consultation in my work with you by my agency supervisor, Stephanie Sacks, LMHC. I will be sharing information of our sessions with my supervisor to assist me in understanding your needs and to help me develop possible directions for our sessions. My supervisor and I will treat all information in the strictest confidence.

By signing below, you are acknowledging the receipt of this disclosure statement and you agree to the process of supervision.

______________________________	______________________________
Client Name (please print)	Therapist Signature
______________________________	______________________________
Client Signature	Agency Supervisor Signature
______________________________	
Date	