JENNIFER STOWELL, LPC

360.908.4099 FAX: 360.824.6825

www.jennifer-stowell-lpc.com

Client Disclosure Statement

Therapeutic Approach and Treatment Orientation: I use several therapeutic approaches in my treatment, depending on the personality and needs of the client. These include (but are not limited to): behavioral, cognitive, family of origin, systemic and developmental modalities. I often employ more than one method at a time. If you have a preference, please tell me. Because of the inexact science of psychology where complex and different responses to situations are the norm, I cannot guarantee that specific changes will occur or exact time limits for change.

Education and Training: Bachelor of Arts from Seattle University. Masters Degree in Counseling Psychology from Antioch University Seattle.

Fee: My fee is $140 per 50-minute session. I accept Visa and MasterCard. There is a $25.00 service charge on all returned checks and a fee for balances that go unpaid for 60 days or longer.

I am covered by most insurances and will bill them for you. The co-pay is due at each session. If your insurance company fails to provide reimbursement, you will be responsible for the full cost of the services provided. If you do not have insurance or choose not to use it the full fee is due at each session unless you negotiate a payment plan with me.

It is your responsibility to get pre-authorization for mental health services if so required by your insurance carrier. If you do not get this and the insurance does not pay you will be responsible for the bill.

Reports, evaluations, assessments, consultations and court appearances are services that are sometimes needed in addition to counseling and will be billed on a time-used basis. Your insurance company may not pay for these services.

_____ (please initial)

Cancellation Policy: Twenty-four (24) hour notice is required for cancellations and you will be charged full fee. Insurance will not pay for missed appointments. Emergency situations may be discussed with your therapist.

_____ (please initial)

Emergencies: I can be reached through my phone at 360.908.4099. At times I will be available to take your call. At other times, it will be necessary to leave a message with my voice mail, which is operational 24 hours per day.

The nature of my practice does not allow me to provide continuous emergency services. If you have an **emergency**, call the Crisis Line at 520.622.6000. In case of a **life-threatening emergency, call 911**

or present at your hospital's Emergency Room.

_____ (please initial)

Confidentiality is extremely important to the psychotherapeutic process. I am legally and ethically bound to protect your confidence. If you want me to release information about your participation in therapy to anyone, I will require your signed 'Release of Information' document. This confidentiality has the following exceptions as provided by law:

1) In case of medical emergency, emergency personnel or services may be given necessary information.

2) In case of a threat to harm oneself or another person the proper individuals may be notified, including the person against whom the threat is made.

3) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.

4) If ordered by a judge or other judicial officer information regarding treatment must be disclosed.

5) If the client brings a complaint against the therapist with the Department of Health, information will be released.

7) As part of using health insurance the client's name and some information about diagnosis or treatment are usually required. Some managed health care policies require regular detailed progress reports to the primary care physician.

8) If the client does not pay the bill and the account is turned over to a collection agency some identifying confidential information will be released.

9) In case of a client's death or disability the information may be released to the patient's personal representative or the beneficiary of an insurance policy after that person has signed a release authorizing disclosure.

10) The therapist may seek consultation with other mental health professionals but the client's identity will be protected. The laws pertaining to confidentiality will also strictly bind any consultant or supervisor utilized.

_____ (please initial)

Records: 'Progress notes' are recorded at almost every session. You have a right to see your records and to request that any inaccuracies be corrected. You also may request that I keep no records, other than the dates of service. You may request a copy of your records. I may charge a fee for photocopying any portion of the record.

Your Rights: You have the right and the responsibility to choose the type of therapy and therapist which best fits your needs. You have the right to:

1. Request a change of therapy
2. Request a referral to another therapist

3. Discontinue treatment at any time, for any reason, with or without notice to the therapist (except in some court-ordered situations).

I urge you to discuss any concerns about your care with me directly. If this course of action fails to satisfy those concerns and you believe that your care has been handled in an unethical manner, you have the right to file a complaint with the State of Washington.

Please be informed that clients of licensed counselors may file a complaint with the Department of Health at any time they believe a counselor has demonstrated unprofessional conduct. Counselors practicing counseling for fee must be registered or licensed with the Department of Health for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. Questions or complaints may be directed to:

Arizona Board of Health Examiners

1740 W. Adams Street, Suite 3600

Phoenix, Arizona 85007

Consent: I have read the above information and have received clarification as needed. I agree to the terms as stated and acknowledge receipt of a copy of this disclosure.

Date:_____

Signature of Patient or Legal Representative:_____

Relationship to Patient:_____

Therapist:_____

Jennifer Stowell, LPC

License number LPC-17275