DISCLOSURE STATEMENT

Conditions of psychotherapy differ from professional to professional. I like to be as clear and direct as possible about our relationship. As a therapist, I recognize that each person is biologically, psychologically and sociologically unique. As a treatment model I blend systems theory with a psychodynamic approach. I will discuss therapy goals and the proposed course of therapy with you periodically. If you have any concerns or questions, please bring them to my attention. You have the option at any time to refuse therapy, change therapists, or request a change in treatment protocol.

Clinical Background

I am a Licensed Mental Health Counselor in the State of Washington and have a Master of Science (M.S.) Degree in Counseling Psychology from Eastern Washington University.

My office policies and fees are listed below. Please consider them carefully and ask me to clarify anything you do not understand. Do not sign the agreement until all your questions are answered.

Fees for individual counseling

My fees are:

$155= Intake evaluation

$100= 1 hour

$150= 1 ½ hour

Fees for couples counseling

My fees are:

$155= Intake evaluation

$120= 1 hour

$180= 1 ½ hour

$240= 2 hours

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As a rule fees are paid at the time of appointment. Any other financial arrangements must be made prior to entering into the therapeutic process. You must reschedule or cancel 24 hours in advance to avoid paying full fee for time reserved. Your insurance company is not responsible for these charges. I may use a collection service for unpaid accounts.

We will assist you in the proper billing of your insurance provider. My account manager, Sandy Sollie, will check your insurance coverage. Please contact her at (509) 443-9086 prior to your first visit.

I am available for telephone consultation when appropriate.

Emergencies

My voice mail operates 24 hours a day and I check my messages frequently. If I am on vacation I will have another mental health professional available for emergencies. If you need assistance before I can be reached, you can call the crisis line (838-4428) or , go to your nearest hospital emergency room.

Confidentiality

Your communications with me are privileged under Washington State law. This means that with some exceptions, anything you disclose in therapy, and any information I obtain about you from other sources is confidential and can be disclosed to others only with your written consent, even when you are no longer a client.

However, once you have signed an Authorization for Release, and your records have been released pursuant to your wishes, I no longer have control over those records and/or their possible re-release.

In some situations, disclosure without your authorization can be made if the disclosure is:

- To a current health care provider;
- To a former or future health care provider, unless you request in writing that I not do so;
- To public health authorities when required, or when needed to protect the public;
- To proper authorities if I have reason to believe that a child, a disabled adult, or an

elderly person has been abused or neglected, or if I feel you are a danger to yourself or others;

- To the courts if under a valid court order;
- To my licensing board if I should ever be under disciplinary investigation.

- If disclosure without your authorization is needed, I will first, if possible, discuss options and alternate solutions with you.
- You should be aware that most insurance agreements require that I provide a clinical diagnosis, and additional information such as a treatment plan or treatment summary.

As a result of new regulations adopted by the Washington State Department of Health, I am required to report unprofessional conduct by another licensed provider. I will also have to report a client who is a health care provider if I believe they pose a clear and present danger to their patients/clients.

In the case of children less than 13 years of age, the parent(s) or legal guardian holds the communication privilege. This means that the parent or legal guardian is entitled to treatment information about the child and may authorize the release of such information.

During couple's therapy, I hold the couple as the client and records will not be released without the written authorization of each party. In addition, upon receiving a request for records, it will be necessary to release only portions relevant to the individual covered by the request.

When counseling with a couple I assume confidentiality to be waived among the participants unless prior arrangements have been made. I may occasionally consult with other professionals. When doing so I will make every effort to avoid revealing your identity. The consultant is also ethically bound to keep the information confidential.

Email and fax

For purposes of treatment or billing, your name and information about you may be sent by electronic means.

You may communicate with me via email at melissa@melissavanbeck.com. Although I do maintain and frequently update my firewall and antiviral software, my address is not encrypted. For your protection, please do not email your personal health information.

My web address is www.melissavanbeck.com.

Concerns and complaints

If for any reason you should have a concern or complaint about the services I deliver, please let me know. You also have the right to contact my licensing board.

Counselors: Department of Licensing, Business and Professions Administration, P.O. Box 9012, Olympia, WA 98504, (360) 236-4902.

Client acceptance

I have read and understand and agree to the above-stated policies. I give my informed consent for services. (If you have any questions, please ask before signing.)

______________________________ _______________

Client's Signature Date

I authorize Melissa VanBeck or her designee to bill my insurance provider for services rendered and to disclose required information to them. I agree to be financially responsible for the services provided. I HAVE READ AND UNDERSTAND THE ABOVE.

______________________________ _______________

Client's Signature Date

I have discussed this disclosure with the client:

______________________________ _______________

Therapist's Signature Date