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DISCLOSURE AND CONFIDENTIALITY STATEMENT – Jeanne L. Meyer, LMHC, MAC, LPC

Washington State law requires that all mental health professionals present to new clients a disclosure statement that specifies the therapist's background, experience, theoretical orientation, and approach to services. This disclosure statement is intended to help you become a more informed consumer about these aspects of my clinical practice. The Washington State Dept. of Health oversees mental health care and can be contacted at (360) 236 4901.

Washington State License: Licensed Mental Health Counselor LH00008054
NAADAC Certificate: Master Addiction Counselor 502037
Oregon State License: Licensed Professional Counselor C0938

I have a Bachelors of Arts (1984) and a Master of Science (1988) from the University of Oregon. Subsequently, I have had numerous trainings about a variety of topics. I have completed the trainings necessary to employ EMDR Therapy. I am a clinical member of The American Counseling Association and the National Association for Addiction Professionals. My practice involves working with individuals, couples and groups.

PHILOSOPHY:

I believe each person has a drive to make their lives better. We all do the best we can with the information and resources that we have. Unfortunately, sometimes we have not learned correct information, have adequate skills to manage the complications of life, or know what to do when. Working with me provides you an opportunity to gain from my information, experience, skills and insight in a way that will improve your life.

METHOD:

I provide therapy based on your goals, and history. I provide mental health assessments, DSM V diagnosis, and referral for medication evaluation and management if necessary. In addition, we will look carefully at any addictive behavior since it directly impacts people's ability to achieve their dreams. I help people clarify their goals and see any discrepancies between those goals and behavior. I help you identify and experience feelings, so you can manage emotions rather than having emotions manage you. My counseling style, while empathetic, tends to be very direct. I use various tools to help clients be aware of their own behaviors, thoughts, beliefs, feelings and relationship dynamics. I teach a variety of skills that come from Dialectical Behavioral Therapy (DBT). I use Eye Movement Desensitization and Reprocessing (EMDR) Therapy to assist people overcome past hurts and trauma. In couples counseling I focus primarily on learning and using healthy communication skills as I find that the majority of problems that couples face are based on not understanding what the other person is really saying.

AREAS OF EXPERTISE:

Mental health and substance abuse (co-occurring), addiction recovery, sexual abuse, childhood abuse, trauma, depression, anxiety, post-traumatic stress disorder (PTSD), Bipolar Disorders, Personality Disorders, relationship problems, recovery process, relapse prevention, issues of the GLBT community.

LENGTH OF TREATMENT:

Length of treatment will vary according to the nature of your challenges. Some treatment is very brief (several sessions) and some lasts for an extended period of time. Average length of treatment is generally 6 to 12 sessions. By the end of our second session we will develop an initial treatment plan outlining the steps we take for you to reach your goals.

CONFIDENTIALITY AND CLIENT RIGHTS:

As a client, you can raise questions about my therapeutic approach or request a referral if you believe you might make more progress with another therapist. I will be glad to discuss these matters with you and refer you to another therapist at your request. You have the right to confidentiality. I am ethically bound not to release any information to anyone without your written permission. The only exceptions are consultations with other clinicians, or as required by Washington state or Federal law i.e. if I suspect you are involved in child or elder abuse, you are a danger to yourself or others, are unable to meet your own basic needs in taking care of yourself, or a medical emergency. In addition, if your records are subpoenaed, there is a specific procedure that

legally must be followed, but I can be compelled to release records and/or testify in court. As of April 14, 2003 HIPPA laws allow the Dept. of Health and Human Services to have access to all medical records. If information is authorized to be released by you to any other person or professional, please be aware that this information becomes part of the permanent file and may be then be shared with others according to their policies and procedures.

Confidentiality is also somewhat at risk during telephone contact, e-mail, text message and correspondence. If I have occasion to contact you in that manner, I give minimal identifying information. If you wish to restrict the ways in which I may contact you during the normal course of business please be sure to inform me in contact notes below.

CONTACT NOTES: _____

EMERGENCIES:

If you have a Mental Health emergency I will schedule any appointment with you within 1 business day. I check my voice mail daily on non business days and will return emergency calls. Non emergency calls will be returned during the business week. If you cannot reach me call the Clark County Crisis Line at (360) 696-9560 or (800) 626-8137 or 911.

SCHEDULING & FEES:

Individual sessions are 60-80 minutes long. Payment is due at the beginning of the session. Since regularly keeping appointments is essential to effective therapy, I emphasize the importance of attending all scheduled sessions. If for some reason you are unable to keep a scheduled appointment, **I REQUIRE 24 HOURS ADVANCE NOTICE TO AVOID BEING CHARGED THE FULL (\$120) FEE FOR THE SESSION**. If you schedule an appointment with me you are, in essence, purchasing this block of time, whether or not you choose to use it. Without adequate notice I do not have time to schedule this time slot to anyone else. Therefore, I must charge the fee to you. If for any reason there is occasion to bill for services, a charge of \$15/month will accrue for any late payments. Refusal to pay for services will result in accounts being turned over to an agency for collection.

ELECTRONIC COMMUNICATION: With the increasing frequency of email and text message as a method of communication issues of confidentiality are often raised. I treat any electronic communication you may send with the same care I use for any other type of records. Because text messages are not secure, I DO NOT receive or send TEXTs. All of my e-mail communication is encrypted, just as cell phone signals are. Since I use a wireless network however, I cannot guarantee security beyond that of the servers they pass through. My policy is to use e-mail only as a response to your inquiry. I interpret your initiation as consent to communicate with you in this way. Please keep security in mind when communicating sensitive information electronically.

USE OF INSURANCE BENEFITS:

If you choose to use benefits with an insurance company with which I have a contract, you are responsible for your copay. I will ask you to complete a Release of Information giving me permission to bill for the remainder of my fee. For those insurance companies for whom I am "out of network," you are responsible for paying my full fee each session. I will, of course, provide a receipt and any other documentation you need to file for insurance reimbursement. Be aware that insurance companies will keep records of any information they are given. If you wish to find out more about what is reported in your medical history you can contact the Medical Information Board at (617) 426-3660 POB 105 Essex Station, Boston, MA, 02112.

This document is subject to revision. Current copies may be obtained by request. Last revised 7/16/15.

ACKNOWLEDGMENT OF DISCLOSURE:

FULL FEE: \$120 Insurance Company Co-Pay Insurance Reimbursement

I have read, understand, and agree to the terms of this disclosure statement. My therapist has verbally explained my rights of confidentiality to me. I agree to pay the above stated fee.

Client Signature Date

Client Signature Date

NAME (PRINTED)

NAME (PRINTED)

Witness Signature Date

NAME (PRINTED) NAME (PRINTED)