Dianah Jackson, LMFT LF 60872112
Couples and Family Therapy; Therapy for Teens and Their Adults
4699 Woodson LN SUITE 319C, Bainbridge Island, WA 98110
www.bainbridgefamilycounseling.com – jackson.dianah@gmail.com – 206.953.2810

Disclosure and Consent

Education, Training, Experience: I hold a Masters of Psychology degree with a specialization in systems counseling from LIOS Graduate College of Saybrook University. I have been in private practice on Bainbridge Island since January of 2013. I also hold a doctoral degree in French Studies and prior to my practice as a psychotherapist, I worked as literature teacher, cademic researcher and writer at the graduate, university and high school levels. I am a fully Licensed Marriage and Family (LMFT) in the State of Washington.

Therapeutic Orientation: I believe that you hold expertise regarding your experiences, feelings, thoughts and relationships. My role is to facilitate your access to that expertise. When working with families, my job is to help families increase healthy patterns of relationship while reducing distress and suffering. My strengths lie in two areas. I am able to identify the existing resources that bring family members together, and I am able to discover alongside you new resources and to cultivate the ones that need growth. My work is primarily oriented towards narrative therapy and the general principles of family systems. I am a member of the American Association of Marriage and Family Therapists (AAMFT) and abide by its Code of Ethics. Accordingly, I do not perform forensic evaluations for custody, residence, or visitation of minors who engage in therapy with me.

Confidentiality: All information that you disclose during your session is confidential. Please note that children over the age of 13 have the right to full confidentiality, if they so choose. This means that the therapeutic process and files are privy to them alone. I participate in ongoing consultation with other mental health professionals. Such consultation allows me to stay current with professional standards and new developments in the field. It also allows me to receive valuable input on my work. When discussing cases, I do not disclose any identifying information about you, using the utmost care to protect your confidentiality.

Exceptions to Confidentiality: When working with couples or families, it is in the best interest of the therapeutic process that I do not keep secrets between individuals. There are legally mandated exceptions to confidentiality as well: (1) if I have reason to believe there is abuse of children, the elderly, or dependent persons; (2) if you present a life-threatening danger to yourself or others; (3) if you take legal action against me; (4) if your records are subpoenaed by a court of law; (5) if an involuntary commitment for mental assessment appears necessary.

Privilege: If you become involved in legal proceedings, you may be entitled to obtain a judicial ruling that my records and recollections pertaining to you are privileged and should be excluded from admission into evidence. You are responsible for claiming privilege in a timely and acceptable manner. You should seek you own legal counsel for a full explanation of privilege and for assistance in asserting a privilege claim.

Fees: My fee is $120 for a 50-minute session in person or by phone, Skype or Facetime (charged in 10-minute increments). Payment should be made at the end of each session. I do not bill insurance but can provide a receipt with necessary information for reimbursement from your insurance company.

Cancellation policy: Please provide 24 hour notice for cancellations to avoid paying your regular fee for a missed session.

Course of treatment: After the first two or three sessions, we will decide if I am the best person to provide the services you need, then determine a regular meeting day and time reserved for you. I may request your permission to contact and collaborate with your former and current medical and/or mental health providers. You have the option of discontinuing therapy at any time.

Emergencies: If there is a life-threatening emergency, please call 911. You may call the Crisis line at 206.461.3222, or Kitsap County 24-hour telephone crisis services at 360.479.3033 or 800.843.4793 if you are unable to reach me.

State Laws: WAC 308-109-040: *Counselors practicing for a fee must be registered or certified within the department of health for protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment*. SHB 1828: *A record of the mental health care provided is kept in this office. You may ask to see a copy of that record. You may also ask this office to correct that record, if you believe the information within your record is in error. A copy of your corrections to the office records will be placed within your record, at your request. This office will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record, or get more information about it, at this office. The Counseling Credentialing Act empowers the citizens of the State of Washington by providing a complaint process against those who would commit acts of unprofessional conduct.*

I have read and understand all the information provided in this disclosure statement.

Client/Parent/Guardian Signature(s) and date

______________________________ ______________________________

______________________________ ______________________________

After two or three sessions we will formalize our agreement to work together. Soon after I will provide a treatment plan, detailing the goals and strategies for therapy. Your signature below formalizes our mutual commitment to work together.

NOTE: Please leave the section below blank until we have met for two or three sessions to determine mutually if we will work together.

I hereby give my consent for treatment.

Client/Parent/Guardian Signature(s) and date

______________________________ ______________________________

______________________________ ______________________________

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Patient In-take

CONTACT INFORMATION

Name: ____________________________________
Date ____________________________________

Home phone: ______________________________
May I leave a message at this number? _____ *yes* _____ *no*

Cell phone: ______________________________
May I leave a message at this number? _____ *yes* _____ *no*

Email address: ____________________________
May I communicate non-confidential emails with you? _____ *yes* _____ *no*

Home address: ____________________________

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Alternative address, if any: ____________________________

____

Emergency Contact:
Name ____________________________

Phone number ____________________________

Below please provide the names and ages of everyone in your household.

NAME	AGE	RELATIONSHIP

PATIENT PROFILE (please complete for each family member)

What is your age? When is your birthday?

What is your race or ethnicity?

Do you take part in religious activities or have a spiritual practice?

What is your profession? Do you work full-time or part-time?

REASONS FOR PSYCHOTHERAPY

For what reasons are you seeking therapy at this time? *Please circle all that apply.*

marital or partner issues	loss of employment or home	alcohol abuse	depression
issues between parent(s) and child or children	financial struggles	drug abuse	anxiety
marital separation	housing problems	pornography habit or addiction	grief
divorce	educational struggles	cannabis ("pot") abuse	mania
geographic move	legal problems	nicotine addiction	learning disorders

Have you ever sought counseling/psychotherapy in the past? For what reasons? When and for how long did you seek therapy?

Do you or have you ever experienced suicidal thoughts? When and for how long?

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Brief Health Profile

NAME:

DATE:

What is your sleep schedule?

Do you eat three meals a day? Are you on any special diet or do you have dietary restrictions?

How much caffeine do you consume per day?

How much water do you consume per day?

Do you have any pets or farm animals?

If you use alcohol, how much do you consume and how often per day or per week?

If you use pot, how much do you smoke or ingest and how often per day or per week?

If you use other recreational drugs, how much do you use and how often per day or per week?

What prescription medications and/or health supplements do you take and for what conditions?

How often do you exercise and what are your exercises of choice?

May I contact your physician to collaborate care? If you agree, I will provide you with a release of information form.

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This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

As of April 14, 2003, the Health Information Portability and Accountability Act of 1996 (HIPAA) requires that I provide you with information about how I use and protect the information you provide to me in the course of treatment. This Notice is a statement of my privacy policies and your rights under HIPAA.
Information that is included in your file:
Your file of "protected health information" includes all of the data I collect from you (add ress, telephone number, insurance information, history, medications and so forth) and the progress notes I create after each session. The file also contains notes of any contacts with other persons, such as your doctor, and a log of all such "collateral" contacts.
How your information is stored: All of your protected health information is stored in a locked file cabinet in my office, in a folder identified by your name. Only I have access to the keys to that file cabinet.
How your information will be used: It is my policy to hold your information in strict confidentiality, and to use it only for purposes of your treatment. This means that I will not disclose any personal information, including the fact that you are receiving treatment, to anyone without your written permission: the written permission of anyone over the age of 13 and the written permission of legal guardians of children under the age of 13. There are certain legally required exceptions to this policy:
1. I am required by Washington law to report to the appropriate authorities incidents of abuse of a child, elder, or vulnerable adult of which I become aware. It is my policy to discuss the necessity of disclosure with my client if at all possible before reporting. **2**. If you are suicidal or in danger of hurting yourself, I am ethically obligated to notify the appropriate authorities in order to protect your safety. **3**. If you threaten to harm another person, I have a duty to break confidentiality, warn that person, and warn the appropriate authorities. **4**. In certain legal proceedings I may be required to reveal information in response to a court or administrative agency order, and in certain cases in response to a subpoena, discovery request or other lawful process. **5**. Please be aware that both custodial and noncustodial parents may have access to the treatment records of their minor children (children under 18). **6**. I have the right to disclose necessary protected client information in any legal proceedings involving my license. **7**. I may have to disclose certain protected client information in the course of an investigation by the Secretary of the Department of Health and Human Services regarding compliance with HIPAA. **8**. I may be required to disclose certain protected client information for public health purposes, or in regard to communicable diseases.
In addition, I participate in consultation with other professionals. Any individual case information revealed in consultation is disguised to prevent identification of the client involved, and of course your name will never be used.
Clinician's duties: I have the duty to protect the privacy of your client information as discussed above, and to provide you with this written description of my privacy practices and policies.
I must abide by my written privacy policies then in effect.
I may change my privacy practices or policies, but I must also revise the Notice and inform you of any change. Revised policies are effective for all protected client information, whether or not you are still

in treatment with me. You may request a copy of my revised policies at any time, by providing your name and address.

Your rights under HIPAA: You have the right to request that I restrict the use and disclosure of your protected health information for treatment, payment and health care operations. I am not required to agree to your restrictions, but I am bound by any agreements I do make with you in this regard. (Under Washington law, you have a right to request that I not keep notes of our sessions, other than a record that the session occurred. Please discuss this with me if you are interested in exercising this option.)

You have the right to request that I contact you by alternative methods and locations, instead of the standard practice of telephoning you at your home or office. You have the right to inspect and obtain a copy of your official client record. You have the right to amend information in your client record which you believe is erroneous. You have a right to an accounting of disclosures of your private health information. You have a right to receive a copy of this notice upon request. You have a right to file a complaint with me, the Secretary of Health and Human Services, or both in regard to my HIPAA practices. I will not retaliate against you should you file such a complaint.

Privacy Acknowledgement:

By my signature on this page I acknowledge that I have received a copy of Dianah Jackson's Privacy Policies, and that I have had an opportunity to review and ask questions about those policies.

Client signature(s) and date

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