

PRISCILLA GILBERT, M.A., LMHC
Lacamas Counseling
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LACAMAS
COUNSELING

DISCLOSURE STATEMENT

THEORETICAL ORIENTATION AND TRAINING

I, Priscilla Gilbert, have specialized in working with people who are suffering from depression, anxiety, Post-Traumatic Stress Disorder (PTSD), perinatal and postpartum mood disorders, grief and loss, adjustment to life transitions, trauma and abuse, parenting transitions and struggles, and interpersonal conflict. I have worked cross-culturally, with both males and females, and with children, teens, adults, and the elderly.

My theoretical training and orientation is Supportive Therapy, Cognitive Behavioral Therapy, and Solution-Focused Therapy. My goal is to discover what you are already doing well and then attempt new skills in safety that can be applied to your life to lead to whole-hearted living and healthy well-being.

I have a Masters Degree in Counseling with a Child & Youth Specialization from Western Seminary in Portland, Oregon; and a Bachelors of Science in Human Development and Family Science from Oregon State University in Corvallis, Oregon. I am a Licensed Mental Health Counselor (#LH60463811) who abides by the ethical guidelines of the Washington State Department of Health. As a professional, I continue my education through classes, workshops, and conferences; relevant books, articles, and magazines; and consultation with other professional counselors.

CONFIDENTIALITY

Therapy is confidential, including what you say, your records, and your attendance. Exceptions to this confidentiality include when you sign an authorization for me to disclose information, when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (e.g. suspected child/elder/developmentally disabled person abuse or neglect, extreme danger to self or others), and other exceptions outlined in the *Notice of Privacy Practices*.

I may use outside professional businesses for billing, administrative assistance, communication, record management, and collection purposes. If you choose to use insurance, then treatment notes, summaries, and diagnosis may be used to process claims, determine medical necessity, or to request additional sessions.

In keeping with generally accepted standards of practice, periodic supervision and consultation is made regarding the best practices and procedures with other mental health professionals who are bound by the same rules of confidentiality as previously stated herein.

In the event of my death or sudden incapacitation, I have designated a colleague who is a licensed counselor as my professional executor. My professional executor will be given access to all of my client records. She may contact you directly to inform you of my death or incapacity, as well as provide direction in how to access your records.

RIGHTS OF CLIENTS

You have the right to choose the treatment that is best for you. Other treatment options may include other therapists or psychologists, support groups, self-help resources, medications, and other modes of treatment. Some clients may experience a worsening in symptoms as therapy begins; I will work collaboratively with you to promote progress, change, and relief. Some clients may only need a few sessions to achieve their goals, while others may require months or even years of counseling. It is impossible to guarantee your course of treatment. You have the right to request a change in approach or to terminate therapy at any time for any reason. Premature termination, however, may result in the return or worsening of the initial problems and symptoms.

Therapy sessions between a counselor and client may be very intimate emotionally and psychologically. This therapeutic relationship is a context that promotes self-understanding, healing, and growth. The counseling relationship will also remain on a professional level. Therefore, I will limit contact to the office or phone. I will not engage in physical contact, socialize, give or accept gifts, nor establish any relationship other than the professional counseling relationship. Counseling sessions should focus exclusively on your concerns.

I encourage you to ask questions and engage with me about my training and specializations, fee arrangements, your diagnosis, and your course of treatment. All communication is considered to be part of the clinical record, which is accessible to you upon written request to view or to obtain copies. Records are maintained for a period of five years from date of termination.

Priscilla Gilbert, LMHC is not a participating provider with any insurance plan. By agreeing to treatment you are agreeing to self-pay for your sessions. You are encouraged to explore your insurance benefits with your insurance company and consider accessing treatment with other participating providers if you would like to use your in-network insurance. Superbills (a receipt of counseling services provided) may be requested if you would like to pursue use of your out-of-network insurance benefits.

I encourage you to speak with me directly if you are dissatisfied with the service you received. You may also file a complaint with the Department of Health, Health Professions Quality Assurance Division, PO Box 47869, Olympia, WA 98504-7869, (360) 236-4902.

ELECTRONIC COMMUNICATION

I offer electronic communication via email and text messages for purposes of scheduling, finances, or resources. I cannot ensure the confidentiality through electronic communication and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. While I may try to return messages in a timely manner, I cannot guarantee immediate response. Agreeing to communicate electronically releases Priscilla Gilbert, LMHC from any liability due to unforeseen errors in electronic transmission that do not provide total privacy and security of information. Electronic messages may also become a part of your mental health record.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

EMERGENCIES

In an emergency call **911**, call the crisis line at **360-696-9560**, or go directly to a hospital emergency department.

FEES

Session fees will be paid in full at the time of service.

- **Counseling sessions** are \$130.00 and are 60 minutes in duration; approximately 10 minutes of that time will be spent doing case conceptualization, progress notes, treatment planning, case consultation, billing, and related correspondence.
- **Missed appointments** will be billed \$75.00 unless cancellation is made at least 24 hours in advance of the scheduled appointment.
- **Additional services** will be billed at hourly rate of \$130.00, for services such as phone calls longer than five minutes, letter writing, completion of forms, file audits, and record requests.
- **Service fee** of \$20.00 will be charged for any checks returned for special handling or insufficient funds.

You have the option to provide credit/debit card information which will be kept on file to be used as a form of payment for fees incurred.

ENDING THERAPY

Therapy ends when you have completed your treatment goals. I encourage you to have at least one final session upon completion of your treatment goals in order to acknowledge all aspects of your progress, reinforce your skills and resources, identify any potential relapse or risk factors, and provide any other closing recommendations.

I may end therapy for ethical reasons such as when your needs are outside the scope of my practice, if there are other immediate needs that need to be addressed prior to counseling, or if you are not participating or benefiting from treatment.

Your case will be closed after 45 days if no contact or prior arrangements have been made.

PRIVACY POLICY

By signing below, you acknowledge receipt of my *Notices of Privacy Practices*. This document provides information about how I may use and disclose your private health information. I encourage you to read it in full.

My signature on this document indicates that I have read and understood these policies, that I agree to adhere to these policies, and that I have been given a copy of them.

Client /Guardian Signature

Date

Priscilla Gilbert, LMHC

Date