Jamelyn Keatts, MA LMHC (Lic#: LH60498732)
Jamelyn Keatts Psychotherapy LLC
2900 Eastlake Ave E., Suite 220 Seattle, WA 98102
Jamelyn@JamelynKeatts.com
408.836.2896

STATE OF WASHINGTON REQUIRED DISCLOSURE AND CONSENT FOR SERVICE

This disclosure statement provides information about the treatment provider and the treatment offered, to assist you in choosing the treatment and the provider best suited to your needs.

My Approach to Treatment
I believe the counseling process to be forming a mutual alliance with you to explore the nature of your struggles. It is my belief that we are relational beings, and are meant to have deep, satisfying relationships with others and with ourselves. Often these significant relationships include dynamics that are the source of our greatest joys as well as our deepest hurts. In working together, we will explore the nature of your relationships and how your relational style impacts your ability to engage life in the manner you desire. My hope would be that by dealing with the source of the problem, we will address the constellation of symptomologies as well. Ultimately, I believe that healing occurs in relationship and believe the therapeutic relationship to be a place for such transformation. The outcome of such transformation is relief from issues that stir one to seek out therapy, and hopefully the ability to more freely enjoy life. This theoretical orientation is influenced by my theological and psychological trainings in relational psychoanalysis, attachment theory, and interpersonal and feminist psychologies.

My Education, Training and Experience
I hold a Bachelor of Arts in Secondary Education, with an emphasis in Mathematics from Pacific Lutheran University, and a Masters of Arts in Counseling Psychology from The Seattle School of Theology and Psychology. Prior to pursuing my graduate degree, I spent 6+ years working in a non-profit ministry, directly working as a mentor for adolescents and young adults. I have been working as a therapist with adolescents and adults since 2010. I am Licensed Mental Health Counselor (LH60498732). I have taught courses in Psychodynamic Psychotherapy at The Seattle School of Theology & Psychology and The Center for Object Relations, in Seattle. I am currently supervised by Sue Carlson.

Client's Course of Treatment
If you decide to continue treatment beyond an initial assessment, we will develop an individualized treatment plan with you. This plan will include what is known at the time about your course of treatment and will be amended as appropriate during our work together.

Participation
The therapy experience is created both by the therapist and client. Both participants are encouraged to be honest, open and curious. Your freedom to be honest about your thoughts and feelings regarding the therapeutic process is a posture I invite in our time together. You have the freedom to stop therapy at any point, refuse to do a particular activity, or request a referral to another therapist. Most important is your experience as a client. Together we will work to ensure a positive therapeutic experience.

Confidentiality
Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

Supervision and Consultation
I seek ongoing consultation from colleagues in order to provide you with the best services possible. I may disclose information about you in consultation with colleagues, in which case I will limit the information I disclose to the minimum

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amount necessary. I have an agreement with Susan Kim to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to Susan Kim accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

Working with Minors
If you are the parent or guardian of a minor who is seeking treatment, please know that under Washington State law, any child age 13 or older can independently consent to mental health treatment without your permission. In addition, parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission. If you are 13 years of age or older, you have the legal right to seek mental health treatment without obtaining permission from a parent or guardian.

I am not able to provide a recommendation, evaluation, or opinion, in any legal forum relating to separation, divorce, child custody, visitation, or parenting plans. I will need to be provided with a copy of any parenting plan, custody orders, or any other similar documents, including any changes or revisions made during the course of treatment. Also, it is generally necessary that both parents or legal guardians consent to treatment of their minor child.

Electronic Communications and Social Media Policy
In the regular conduct of my practice, I may make use of a cellular phone, or other portable communication device, to communicate with clients. In such cases, I will limit the information I store in any portable communication device to the least necessary. Please be aware that such forms of communication do have inherent risks to client confidentiality. If you would prefer that I do not store you name and telephone number in a portable communication device, or if you would prefer that I do not communicate with you via cellular phone, please inform me so that we can make alternative arrangements.

In order to best protect your confidentiality, I typically will communicate with clients via email or text for the purposes of scheduling or canceling appointments only. I cannot guarantee the security or confidentially of information sent via email or text. If you need to communicate with me via email for any other purpose, please discuss that with me in person.

Professional ethics standards do not permit me to communicate with clients via personal social media. For this reason, I cannot accept any client requests to connect on Facebook, or other similar social media platforms

Billing, Fee and Financial Information

<u>Fees</u>
My fee for appointments is $_____/53 minute session. By signing this agreement, you agree to pay for all services at this rate for all non-insurance covered services provided to you. I reserve the right to change my fees.

You will be charged for any additional services you request of me outside of your appointment time. Any time spent testifying in court will be charged at $110/hr including travel time

<u>Payments</u>
Payment is due at the time of service. However, there may be circumstance including insurance billings that may modify that timing. Please discuss any questions you have about this with me, and a reasonable payment schedule will be determined. We will also discuss and determine the method of payment. If a check is returned because of nsufficient funds, you will be charged the actual cost for handling

<u>Appointments</u>
You and I will set your appointment time. Once established, your appointment is reserved just for you. A missed or cancelled appointment will be charged at the full-session fee. If you are more than 15 minutes late and have not notified me that you are still coming, I may not still be in my office and it will be considered a missed session. Cancellations must be made at least 48 hours in advance or the session will be billed at the full-session fee. Please note: insurance does not pay for missed appointments.

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Insurance

Your insurance may cover a part of the cost of therapy. If you wish to use your insurance, I will bill your insurance company directly. If I am not in-network with your insurance company, you will be responsible for any difference between what I charge and what your insurance company pays for the service. Please complete the Insurance Information below if you wish to use insurance.

Insurance Provider:_______________________________________

Policy Number: _______________________________________

Group Number: _______________________________________

Policy Holder Address: _______________________________________

Termination

If, without having made prior arrangements, I have not heard from you in 30 days I will assume that you would like me to terminate our current episode of care and close your active clinical file. In such cases, we may re-open the file and initiate a new episode of care once we meet in person.

Emergencies

If you are experiencing an emergency or crisis, please call 911 or the Crisis Connection at (206) 461-3222, or (800) 244-5767. In such situations, you may also go to the nearest hospital Emergency Room.

Notice to Clients

It is every client's right to refuse or discontinue treatment at any time. It is the responsibility of clients to choose the provider and treatment modality which best suits their needs and purposes.

If you have any concerns or complaints about your therapy, you may always address the issue directly with me.
A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

Consent for Treatment

By my signature below, I acknowledge that I have received, read, fully understand and consent to the disclosures, terms, and conditions above, and that I have received a copy of the HIPAA Notice of Privacy Practices and I have read and fully understand these rights, and have been given the opportunity to ask questions.

By my signature below, I am attesting to my consent to participation in counseling services provided by Jamelyn Keatts, MA, LMHC.

_______________________________ _______________________
Client Signature Date

_______________________________ _______________________
Client Signature Date

_______________________________ _______________________
Therapist Signature Date

If a personal representative on behalf of the client signs this acknowledgment, complete the following:
Personal Representative’s Name:_______________________________________
Relationship to Client:_______________________________________

This form will be retained in your medical record.

SEE OVER