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 **DISCLOSURE STATEMENT**

**WELCOME!**

The following information is intended to answer any questions you might have concerning therapy, my credentials and experience, financial obligations, appointment lengths, insurance, and informed consent. If you have additional questions, I would be happy to discuss these with you personally.

**NON AFFILIATION WITH OTHER PROFESSIONALS AT EVERGREEN HEALTH AND WELLNESS OFFICES:**

All the practitioners at Evergreen Health and Wellness Offices are independent non-affiliated practitioners with no legal or professional affiliation with or to each other. We simply rent office space within the same suite. Other professionals located within the same suite are not liable for any legal recourse taken against me, and so forth.

**ABOUT THERAPY:**

Therapy is a process of learning about yourself and how you interact with those around you. It will, at times, be difficult, emotional work which nonetheless has many rewards. You will be encouraged to try new behaviors and to review old ideas. At times I will suggest homework or exercises to do in between the sessions. I encourage you to keep a journal of questions which may come up in between sessions. I encourage you to let me know if you have concerns regarding your progress in therapy or if you are unhappy with me as a therapist. You have the right to terminate counseling at any time.

**CONFIDENTIALITY:**

All information discussed with me is kept confidential except in the following circumstances:

 a. When you request in writing that information is released.

 b. When maintaining confidentiality would violate the law (such as child abuse).

 c. When maintaining confidentiality would endanger you or someone else.

 d. When, to facilitate services to you, I consult with other professional(s).

 e. When there is a judge signed subpoena requesting a specific record.

**INFORMED CONSENT AND CLIENT RIGHTS AND RESPONSIBILITIES:**

You, as a client, have the right to receive the best treatment possible. This means you are responsible to choose your mental health provider and the modality of treatment. It is your right and responsibility to be involved in your treatment planning. Counseling is a choice. It is also your right to refuse treatment. Counseling has been shown to have great benefits and some clients need only a few sessions to solve specific problems and have significant reduction in emotional distress. Other clients may benefit from more long term treatment depending on the diagnosis and the severity of symptoms. Duration of counseling may also depend on client preference, meeting medical necessity and the amount of overall symptom reduction needed to function appropriately in all domains.

**APPOINTMENTS/FINANCIAL OBLIGATIONS:**

Appointments are for 45 minutes unless approved by your insurance company for 60 minutes. My fees are $100 for a 45 minute session and $120 for a 60 minute session unless you are applying for a sliding fee. Telephone therapy is billed at the same rate. All payments including co-pays and the amount of your deductable that you are responsible for are due at the start of the session unless you are a EAP client. I accept cash, checks, or charge cards. If your insurance company denies a claim because you have not met your deductable you are responsible for that payment and payment must be made before your next session. Any claims denied by your insurance company are your responsibility. I am a network provider for many insurance companies and an out of network provider for most of the others. Please verify coverage with your insurance company before making an appointment with me. If you are applying for a sliding fee you must provide a copy of your last year’s 1040 form or your last pay stub at your first appointment. Sliding fees begin at $60. If you are unable to keep your appointment, please give 24 hours notice so that someone else may use your time. No charge will be made if adequate notice is given. **Appointments canceled the day of the appointment or missed appointments will be charged a $50 fee.** Phone calls are charged in 15 minute increments of $30 unless the phone call is appointment related. Refunds are given only for overpayments made to your account. Clients are not financially liable for any services rendered prior to receipt of Disclosure Form. Overpayments of deductible, co-insurance, and co-pays will be paid directly to the client within 1 week of notice of overpayment to the Practice. Insurance will be billed monthly by the Practice.

**ABOUT INSURANCE:**

Should you elect to use your insurance benefits to pay for psychotherapy, your diagnosis, symptoms, substance abuse issues (if any) and history will become part of your permanent medical records. These records are often accessible by other insurance companies and on occasion can be accessed by employers and private investigators.

It is your responsibility to check with your insurance company before your first appointment to find out what your policy covers and your reimbursement rate. I do file insurance claims for clients but please remember, it is your responsibility to be prepared to pay your co-pay or the amount of your deductable not covered at the beginning of each session. We can discuss what you can accomplish with the insurance benefits available to you and what will happen when benefits run out before you are ready to end your sessions.

**MESSAGES AND EMERGENCIES:**

Please leave a message on my confidential voice mail and I will return your call as soon as possible during the hours of 9 a.m. and 8 p.m. Monday through Saturday. If you need immediate assistance and your call is an emergency, **please call** **911 or call the** **CRISIS CLINIC** **at (206) 461-3222 or 1-(800)244-5767. I provide a back up counselor for my clients when I am on vacation or out of town-this will be discussed with you any time I am intending on leaving town.**

**EDUCATION, CREDENTIALS AND EXPERIENCE:**

I received by Bachelor of Arts Degree in Humanities from Brigham Young University in Provo, Utah in 1998. I earned my Masters of Science Degree in Marriage and Family Therapy from Southern Christian University in Montgomery, Alabama in 2002. I am licensed by the State of Washington as a Marriage and Family Therapist (# LF00002652). I am a Certified Child Specialist and a Certified Attachment Specialist. I am a clinical member of the AAMFT. I have 10 years of experience in the mental health field as a counselor, psychotherapist, educator, trainer, and coach. My work experience is in a variety of clinical and educational settings including private practice, social service agencies and both public and private schools.

My clinical experience is in working with children, adolescents, adults, couples, and families. I have special skills in working with problems related to depression, anxiety, stress management as well as relationships, communication and co-dependency issues. I have expertise in working with substance abuse and co-occurring disorders, ADHD, Asperger’s issues, social skills deficits, teenage social problems, seriously behavioral disturbed children, Attachment Disorder, adoption issues, grief, loss and trauma resolution, including adult survivors of childhood abuse.

**METHODS AND COMMITMENT TO QUALITY THERAPY:**

I have training in a variety of methods of treatment and can choose from these techniques the approaches that can most benefit you. My clinical training is in the areas of Family Systems, Brief Therapy, Solution Focused Therapy, Cognitive and Behavioral Therapy, Nurturing Attachments, Marriage Counseling, Psychodrama, Family Structural, Child Development, Social Skills Training, Anger Management Training, Self Differentiation, and Co-occurring Disorders. I work from an assets based Recovery Model. I also use stress management and relaxation techniques, guided imagery, coaching, training, art therapy, grounding techniques, talk therapy, and play therapy for children.

**YOUR FILE:**

A record of the mental health care provided to you is kept by this office. You may ask to see that record. You may also request a copy of the record or a portion of the record. You will be charged a reasonable cost-based fee for this service. 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.

**THE COUNSELING CREDENTIALING ACT:**

Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of the 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.

**COMPLAINTS:**

The purpose of the law regulating counselors is to provide protection for public health and safety; and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. The Department of Licensing publishes a brochure for the education and assistance of the public regarding counseling. You may contact the Department of Health to obtain a list of acts of unprofessional conduct: DOH Health Professions Quality Assurance, Counselor Section, PO Box 47869, Olympia, WA 98504 or call (360) 236-4700.

**RELEASE OF INFORMATION:**

I am not able to release information to any third party without your written authorization. If you wish for me to consult with another professional I must have your written authorization specifying exactly what information would be released, obtained or exchanged.

**MINORS AND PARENTS:**

I am unable to disclose what a child 13 and over discusses with me in therapy sessions due to the law. However, they can tell you or they can invite you into a session if they so choose. Clients under the age of 18 who have not been emancipated, and their parents, should be aware that the law allows parents to examine their child’s records. I will only provide general information to parents about attendance and progress in treatment, any other communication will require the child’s authorization if they are over 13, unless I feel the child is in danger of hurting themselves or someone else.

**ACKNOWLEDGEMENT AND AGREEMENT:**

By signing this form below, each of us confirms this Disclosure Statement to represent an agreement between us, and you confirm receiving and reading a copy of this agreement and agreeing to the provisions of the agreement. If you refuse to sign the Disclosure Statement or the Notice of Privacy Practices I will be unable to provide mental health outpatient treatment to you at this time.

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Client/Parent/Guardian Signature Date Debra Gibbons M.S., LMFT Date