DJ (Dathan)Lane MS LMHC NCC CCMHC CMHS

Disclosure Statement

Practice Location: Develop Minded Therapies

4040 S. Tyler St. #9 Tacoma, WA. 98409

Office Phone: 253-750-2664

Thank you for considering my counseling services. To help you make an informed decision, I have prepared this statement for you to read. Please review this statement in its entirety and sign it in the space provided. If you have any questions or concerns, please feel free to ask.

As the client, you have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs;

Types of Counseling Provided and Course of Treatment
The types of counseling services I provide are for: adults, adolescents, and families. Issues including but not limited to mental health disorders, self-esteem, behavioral difficulties in school and/or home, divorce or separation, bereavement, and difficulties in family communication are among the range of situations with which I typically work. My sessions usually start out at weekly but can taper off in intensity as our work progresses. We will work together to develop a treatment plan and course of treatment that works for you.

Education, Training, and Experience
My Education: M.S. in Mental Health Counseling from Walden University.
Bachelor's degree in psychology from Walden University.
I currently am a: Licensed Mental Health Counselor (#LH60531446)
Nationally Certified Counselor
Certified Clinical Mental Health Counselor
Dialectical Behavioral Therapy Certified
Child Mental Health Specialist

I have been working with children and families in various capacities since 1999. I have served as a counselor/therapist for public and private sector organizations. I have experience in doing therapy with people of all ages, lifestyles, faiths, ethnicities and cultural backgrounds.

Methods of Counseling
My approach to counseling is to utilize the approach/modality that best suits you. I employ techniques of CBT, Solution focused therapy, and Dialectical Behavioral Therapy.

Billing and Cost of Treatment
Cost per session $130 per 50-minute session (Individual, Couples, or Family). Advance payments are accepted via cash or credit/debit card. No Checks accepted. Sliding scale fee is available on a case-by-case basis. I accept most major health insurances. We will verify any coverage before our first session. Any co-pays will be collected prior to the session.

If your therapist is subpoenaed or otherwise required to appear at a deposition, trial, or other legal proceeding, you will be charged an hourly rate of $250 for all professional time spent by your therapist preparing for testimony, writing reports, and traveling to and attending the proceeding. Because of the difficulty of legal involvement, our rate is higher for this work.

I am licensed by the Washington State Department of health, for any complaints regarding unprofessional conduct (as defined by RCW 18.130.180) you can call 360-236-4700. You can also mail the information request form to:

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

Complaint forms are also available online at:

http://www.doh.wa.gov/

Client Rights:

As a client, you have the following rights guaranteed by law:

A. The right to choose appropriate care and treatment which best suits the needs of you, your child, or family in the least restrictive manner possible.

B. The right to be treated with respect and dignity, and be free of any sexual exploitation or harassment.

C. The right to receive treatment which is nondiscriminatory and sensitive to differences of race, culture, language, sex, age, status, national origin, disability, creed, socioeconomic status, marital status, sexual orientation, and ability to pay.

D. The right to an individualized treatment plan reflecting problems and/or needs identified for or with you and an explanation of all medications prescribed, including expected effects and possible side effects.

E. The right to know the qualifications of your therapist including education, degree, special training, and method of providing therapy.

F. The right to be fully informed regarding fees to be charged and methods of payment. The right to confidentiality as specified by law. Please refer to the policy on confidentiality.

G. The right to refuse any proposed treatment unless treatment is court ordered (consistent with Chapter 71.05 RCW), also refuse to participate in research, untested, and experimental procedures involving known or potential hazards.

H. The right to review treatment records in consultation with your therapist, provided that information confidential to other individuals shall not be reviewed.

I. The right to receive information on local advocacy organizations.

J. The right to lodge a grievance, if you have reason to believe your rights have been violated.

_____ I acknowledge that I have read and received a copy of my client rights.

Client Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the Clients Rights and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by Therapist DJ Lane. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received (If applicable) I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment (If applicable).

Confidentiality & Privacy Policies

_____ I acknowledge that I have read and received a copy of the Confidentiality & Privacy Policies.

Appointments, No Shows & Recording Policies

_____ I acknowledge that I have read and received a copy of Appointments, No Shows & Recording Policies.

Please check one box below:

☐ I/We grant permission for DMT to undertake video and/or audio recording of myself or child for the specific purposes and/or indications described above.

☐ I/We DO NOT grant permission for DMT to undertake video and/or audio recording of myself or child for the specific purposes and/or indications described above.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

I, DJ Lane LMHC NCC, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.