Jarred Lathrop-Weber

Informed Consent For Treatment, Disclosures, Payment Information, & Privacy Rights

Jarred Lathrop-Weber MA, LMHCA, MHP
Washington State License # MC60166564
1812 E Madison St #101Seattle WA, 98122.
LGBTQ Counseling Services

The information contained on this sheet is offered to ensure that you are given all the necessary information to make an informed decision in regards to counseling and/or consultation services. Do not hesitate to mention if you have any questions, need clarification, or if anything is unacceptable to you.

Confidentiality
Your counseling or consultation sessions are confidential, meaning that no one (including your partner, physician, or parent unless you are a minor) will be able to obtain information about you from me. This includes others that may pay for you to receive services from me. If you would like someone else to speak with me, I will be unable to communicate with him or her until you sign a release of information form. One exception to this is if you are participating in an assessment paid for and mandated by a third party. You should note that the other mandating party may have rights to this information. If you have asked me to help you get reimbursement from your insurance for our sessions, I will disclose to the company a diagnosis for your treatment and number of sessions attended. Occasionally insurers request additional information. I will discuss such requests with you prior to responding to them. There are particular situations in which I would need to, and in most cases legally mandated, break confidentiality. These include if you are planning to harm yourself or someone else, if you are fully unable to take care of yourself, if you are aware of current sexual or physical abuse of a child, or under direct order of a court judge. Specific to child therapy, I will not testify in court in regards to my therapy with your child, unless mandated by the court, such as part of a child custody dispute.

Emergencies
I am available until 10pm on most office days by calling my cell number for brief phone calls. My email address is not a crisis resource, is not checked regularly, and is only to be used for in 24 hours. If you need immediate assistance or emergency care, please call the area 24-hour crisis line at 866.427.4747. Also, in case of emergency you may call 911 or walk into the nearest Emergency Room or your local Urgent Care Center. When on vacation or otherwise unavailable for extended periods of time, I will arrange for another mental health provider to cover client emergencies. In such a case, referral information will be available on my office voicemail.

Fees
Our payment agreement is determined during our initial phone consultation. My standard fee is $90.00 per 50 Minute Session. Sliding fee scale is available; and can be discussed prior to our first session. I do not charge for brief phone calls to discuss scheduling, cancellations or other topics. Other arrangements can be made if a phone session is needed beyond 15 minutes. If you have coverage through a health insurance plan, you may try and get reimbursement directly through your insurance company. However, I currently to do not work with any insurance boards and I will not submit insurance claims on your behalf. I require full payment before each session begins. I currently accept cash and checks for method of payment. I will charge a $25 check return fee should your check not clear. If you want to try and get reimbursement through your insurance plan, please let me know and I will give you all the necessary paperwork; this includes: an invoice from me detailing the dates of service, a diagnostic code, and my counseling credentials number (see fees, payment & insurance document). You will be responsible for filing the claim directly with your insurance provider. Cancellations must be made within 24 hours of your next appointment so that your scheduled time can be used by others seeking services.

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Treatment

Therapy should be a safe place to explore the depths of your humanity. Counseling is in essence a relationship between two people, which is safe from judgment, oppression, and harmful messages. It is an opportunity to raise your level of awareness, and connect the unconscious mind to the present moment. Self-discovery through counseling can be very challenging; it takes enormous strength to delve into the depths of your pain and struggles. Failing to do so, however, can lead to living from a place of fear, regret and resentment. We rarely grow as human beings in isolation; the presence of an empathetic ear facilitates understanding, acceptance and forgiveness.

Each therapist brings his or her own philosophy to counseling. As an individual, I have a unique set of societal experiences and moral compass, which shapes how I view myself and the client-counselor relationship. I approach therapy from a belief that every human being has suffered pain in their life. While much of this pain presents itself in our day-to-day lives, other wounds go unspoken and unrecognized. It is my role to be present with you as we explore your history and identify needs, which may have gone unfulfilled. Revisiting injurious wounds from the past, while meaningfully connecting them to the present, allows us to lead more authentic, joyful lives. Adopting a truly respectful self-image is an essential element in countering a lifetime of negative messages. Therapy should be a safe place to explore the depths of your humanity, celebrate your culture and identity, and allow your most positive, beautiful self to surface.

I agree to participate in counseling sessions with Jarred Lathrop-Weber on an open-ended, as needed basis for a fee of $_____ per hour. I understand Jarred Lathrop-Weber is under the Supervision of Jerry Saltzman, LMFT. I also understand I can contact Jerry Saltzman with any questions or concerns at (206) 859-9249.

Washington State Law allows the client to choose whether or not they want written records of their sessions to be documented by their therapist. If you should chose to NOT have the therapist keep a record please inform your therapist now and Initial below. I, Jarred Lathrop-Weber do reserve the right to document sessions that I believe to be high risk or concerning; such as suicidal thoughts and attempts, any type of abuse including substance abuse, etc.
In accordance with WAC 246-810-035, I request that no records be kept of my treatment other than a fee arrangement for services rendered, a record of dates of service were rendered and payments for these services. Initial_____

Signature of Client _____Date_____

Clinician's Signature_____Date_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact Jarred Lathrop-Weber at 253.906.8738.

WHO WILL FOLLOW THIS NOTICE.
This notice describes the information privacy practices followed by my employees, staff and other office personnel. Your privacy is protected by law. I serve as my own Privacy Officer.

YOUR HEALTH INFORMATION:
This notice applies to the information and records I have about your health, health status, and the health care and service you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I am required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.
I may use and disclose health information for the following purposes:

For Treatment: I may use health information about you to provide you with clinical treatment or services. I may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For Health Care Operations, consultation, and supervision: I may use and disclose health information about you in order to run my office more efficiently and to make sure that you and our other patients receive quality care. For example, I may use your health information to evaluate my performance in caring for you through consolation and supervision. I may also disclose your health information to health plans that provide you insurance coverage (should you try and seek reimbursement) and other health care providers that care for you. My disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Appointment Reminders: I may contact you as a reminder that you have an appointment for treatment or clinical care at this office. Treatment Alternatives: I may tell you about or recommend possible treatment options or alternatives that may be of interest to you. Health-Related Products and Services: I may tell you about health-related products or services that may be of interest to you. Please notify me if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise me in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, I will not use or disclose your information for these purposes.

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SPECIAL SITUATIONS

I may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

Child Abuse: I am required to report all suspected cases of physical and/or sexual abuse or neglect of children to the Department of Human Services (DHS).

Elder Abuse: I am required to report suspected cases of elder abuse or neglect to the Senior & Disabled Services Division.

Serious Threat to Health or Safety: I may use and disclose health information about you when necessary to prevent a clear and substantial risk of harm being inflicted by you on yourself or another person. When there is a clear and substantial risk of harm to another individual I am required to warn law enforcement officials and the intended victim.

Workers' Compensation: If you file a worker's compensation claim, this constitutes authorization for me to release relevant mental health records to involved parties and officials.

Health Oversight Activities: I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, I may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose health information about you in response to a subpoena.

Law Enforcement: I may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable: I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Research: If you were to sign a consent form to participate in a research study, I might use and disclose health information about you for research projects that are subject to the approval process specified in the consent form. This does not apply to you if you have not been asked to participate in a research study.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

I will not obtain, use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give me Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, I will no longer obtain, use or disclose information about you for the reasons covered by your written Authorization, but I cannot take back any uses or disclosures already made with your permission.

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YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy:
You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Jarred Lathrop-Weber LMHCA in order to inspect and/or copy records of your health information. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review. Right to Amend: If you believe health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a CLINICAL RECORD AMENDMENT/ CORRECTION FORM to Jarred Lathrop-Weber LMHCA.

I may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that I did not create.

Right to an Accounting of Disclosures:
You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures I have made based on your written authorization. To obtain this list, you must submit your request in writing to Jarred Lathrop-Weber LMHCA. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free.

For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions:
You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION to Jarred Lathrop-Weber LMHCA.

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Right to Request Confidential Communications:
You have the right to request that I communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Jarred Lathrop-Weber LMHCA. I will not ask you the reason for your request. I will a commodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice:
You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

Changes to this Notice
I reserve the right to change this notice, and to make the revised or changed notice effective for clinical information I already have about you as well as any information I receive in the future. I will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with my office, contact Jarred Lathrop-Weber LMHCA, 253.906.8738, 1812 E Madison St #101 Seattle WA 98122. If you request assistance filling out the complaint forms, someone will be assigned to help you. You will not be penalized for filing a complaint. You will be asked to state that these policies have been explained to you and that you have been offered a copy of this policy before you consent to treatment. If you have any questions about my privacy practices, please ask for clarification. If you require further clarification at any time please contact me.