

Professional Disclosure Statement

Philosophy and Approach: My approach to counseling is best described as integrative, utilizing psychodynamic theories, Cognitive Behavioral Therapy (CBT), Narrative Therapy and Eye Movement Desensitization Reprocessing (EMDR). I believe people are capable of reaching their best potential given the right support and tools for change. When appropriate, I use creative and expressive approaches including play therapy. The goals of counseling will be based on each client individually according to their specific concerns and reasons for entering into counseling.

Formal Training and Education: I hold a Masters Degree in Social Work from Portland State University. My coursework and practice focus emphasized counseling with children and adolescents, individual adult and couples counseling. I am a Licensed Clinical Social Worker with the state of Oregon. I am a certified EMDR therapist.

Confidentiality: I will not release any information about you to any person or agency without your written consent, except as noted in the Bill of Rights as follows.

As a Licensed Clinical Social Worker of the Oregon State Board of Licensed Social Workers, I will abide by its Code of Ethics. As part of the process to gain licensure, I participate in professional supervision in order to support my work with clients. I am happy to explain this process to you.

You have the following rights as a client of an Oregon Licensed Clinical Social Work:

- ◆To expect that the licensed clinical social worker has met the minimal qualifications of training and experience required by state law;
- ◆To examine public records maintained by the Board and to have the Board confirm credentials of an associate
- ◆To obtain a copy of the Code of Ethics;
- ◆To report any complaints to the Board;
- ◆To be informed of the cost of professional services before receiving the services;
- ◆ To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
 - 1) Reporting suspected child abuse and elder abuse;
 - 2) Reporting imminent danger to client or others;
 - 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
 - 4) Providing information concerning licensee consultation or supervision; and
 - 5) Defending claims brought by client against licensee
- ◆ To be free from being the object of discrimination on the basis of race, religion, gender, sexual orientation, ability or other unlawful category while receiving services.

You may contact the Oregon State Board of Licensed Social Workers at 3218 Pringle Rd SE #240, Salem, OR 97302-6312. Telephone: (503) 378-5735 or 1-866-355-7050 Email: oregon.blsw@state.or.us Website: www.oregon.gov/BLSW

Authorization for Treatment

Confidentiality: *Counseling is most effective when people feel they can talk openly in an environment that is private. I am committed to the confidentiality and privileged communications of all clients. I will not share your personal information unless you sign a release that gives me permission to talk with a specific party. However, the following limitations and exceptions exist:*

- 1.) *You provide me with your consent to release information;*
- 2.) *I have reason to believe that you are a danger to yourself or to someone else;*
- 3.) *You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;*
- 4.) *I am ordered by a court to disclose information; or*
- 5.) *I need to release specific information to your insurance provider in order to receive payment for services.*

Additional billing and payment issues: Full payment for the session is the client’s responsibility and is requested at the beginning of each session. Any other payment agreements must be made and agreed to in advance.

Cancellation: *Your session is reserved for you. If you are unable to make your appointment, please notify me at least 24 hours in advance. You will be responsible for payment for the missed session in the absence of advanced notification.*

Emergency Procedures: If there is an emergency, please contact your physician, the emergency room at the hospital nearest you, or the Multnomah County mental health crisis line at (503) 988-4888 or the crisis line closest to you. I do not provide emergency services.

Additional Issues: I appreciate the time you have taken to read this. It is important to be aware that sometimes people experience emotional discomfort or changes in relationships as a result of working toward goals of treatment. Please discuss any concerns you notice so that we can work together to help you cope with these changes and create a more positive outcome. One of the most important rights you have as a client is that you are always free to ask questions and communicate concerns as they arise for you now or at any point during you or your child’s treatment. Please feel free to let me know directly how I can be of assistance to you.

I very much look forward to working with you.

Authorization for Treatment: I have read this form and have had the chance to discuss it with the therapist who is working with me. I understand the information stated, and I agree to participate in treatment under the conditions described. I give permission for L. M. Loewenthal, LCSW, to provide necessary treatment or to make an appropriate referral for me and/or my child.

Printed Name of Client or Child

Date

Signature of Client or Parent/Legal Guardian

Signature of Licensed Clinical Social Worker