Phone: 425-256-2125
Fax: 425-310-8166
www.insidehealthinstitute.org
info@insidehealthinstitute.org

CLINICIAN DISCLOSURE STATEMENT

Eileen Bowen, MA, LMHC, GMHS License #: LH60273538

EDUCATION/TRAINING/EXPERIENCE Master's in Counseling Psychology Bachelor's of Science is Human Services/Management Experience and training in child, adolescent, and children in care issues Experience and training in issues of Geriatric mental Health Developed and delivered curriculum for working with families with disabled children Developed and delivered curriculum around grief and loss issues in the foster care system Developed and delivered curriculum around issues of working with individuals with Fetal Alcohol Spectrum Disorder 30 years group facilitation

DESCRIPTION OF METHODS AND TECHNIQUES USED IN COUNSELING
Philosophy of treatment consists of client centered approach using rapport building and Active Listening as an opportunity for client and therapist to become comfortable and well acquainted with each other. Modalities utilized in treatment consist of a combination of client centered approach; Cognitive Behavioral (addresses thought distortions). Solution focused centering on strengths and positive coping skills as well as Client expertise combine to form a collaborative approach towards change.

Confidentiality: Client confidentiality is a foundation for the trusting relationship. As a rule, all client information is considered confidential. There are few exceptions to this rule. These exceptions will be discussed at the beginning of our first session

I consent to treatment:.

Name_____ Birth date_____

Address_____

Phone_____

E-Mail (optional)_____

What is/are your goal(s) for counseling?_____

_____

_____

_____

_____

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How will you know when this goal(s) is/are met?_____

_____

_____

_____

_____

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Eileen Bowen regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Signature_____ Date_____

Relationship to patient is not patient (i.e. parent or guardian)_____

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Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to an insurance company for payment.

• Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

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• The right to reasonable requests on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosure of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies or procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note “Attention Privacy Officer.”

Or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Ave. S.W. Washington D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

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Eileen Bowen, MA, LMHC, GMHS License #: LH60273538

Licensed Mental Health Counselor & Geriatric Mental Health Counselor

Eileen Bowen, LMHC, GMHS is required to provide you with a copy of her "Notice of Privacy Practices" document, and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:

• Provide and coordinate my treatment among health care providers

• Obtain payment from third-party payers for my health care services.

• Conduct normal health care operations such as quality assessment and improvement activities.

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy at any time.

My signature below acknowledges that I have: (please check one box)

☐ Been offered a copy of the "Notice of Privacy Practices" document and have accepted that copy.

☐ Been offered a copy of the "Notice of Privacy Practices" document and have declined to take a copy. I understand that I may request a copy at any time in the future, and will be granted a current copy upon request.

_____ _____

Patient Signature Date

_____ _____

Guardian / Representative's Signature Date

OFFICE USE ONLY:

I hereby affirm that Bothell Natural Health Center has made a good faith effort to provide a copy of the Notice of Privacy Practices document to the above named patient, and to obtain written acknowledgement of such.

Staff Initials_____

☐ Patient was offered form but refused to sign

☐ Patient was physically unable to sign acknowledgement

☐ Communication barriers

☐ Other _____