Mayne|Mental|Health

COUNSELOR DISCLOSURE STATEMENT OF GARY MAYNE, M.A. LMHCA

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EXPERIENCE AND METHODS: Master of Arts-Clinical Mental Health Counseling, Trinity Washington University, Washington, DC 2015; Bachelor of Education – Music Education, The University of Northern Colorado 2007; Specialties: Serving all ages of individuals, families, and couples; Psychodynamic, cognitive structural/behavioral, solution-focused, narrative, existential. Existential Therapy, CBT (Cognitive Behavioral Therapy), attachment issues, stress management and trauma, military life issues, depression, anxiety, anger management

LICENSES: Licensed Mental Health Counselor Associate: MC60601854
Mayne Mental Health Tacoma Business License:000500106168

CLIENT RIGHTS: Per State law, to 1) be treated with respect and dignity, 2) develop a plan of care and service which meets your unique needs, 3) refuse any proposed treatment, consistent with the Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW, 4) receive care which does not discriminate against you and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation, 5) be free of any sexual exploitation or harassment, 6) review your case record, 7) confidentiality, as described in relevant statutes (chapters 70.02, 71.05, 71.34 RCW) and regulations (chapters 275-54 and 275-55 WAC and this chapter), and the Notice of Privacy Practices (see those pages separate from this document), and see paragraph below on confidentiality, and 8) file a grievance or lodge a complaint with the Department of Health (360-753-1761) or an ombudsman (800-531-0508)

CONFIDENTIALITY: See Notice of Privacy Practices. None of your health care information from counseling here is released to anyone without your written consent, exceptions being when child abuse or neglect or dependent adult abuse is suspected, when you threaten harm to yourself or another, or when records are subpoenaed by a court of law. Other parties you wish me to consult with about your case or to share your record with require a Release of Information to be signed by you.

Email Communication is a confidentiality risk if private health information is transferred. Although Gary Mayne uses an encrypted email service, it is not completely confidential if the client's email is not also encrypted (i.e. Gmail or similar). Telephone and Fax are confidential.

I do not accept or confirm clients as friends on social networking sites at this time in an effort to maintain confidentiality as far as possible.

APPOINTMENTS: Are 50 MINUTES long and together we will determine frequency. I require a 24 hour minimum notice for cancellation. Call 202-792-8817 to cancel. **You will be charged the full fee for showing up too late, a too-late cancel, or a no-show**. If you are ill or there was a legitimate emergency there is no charge. Please call if at all possible in the case of illness.

RATES: Intake $100, Sessions $100 In-Home $80 In-Office Individuals, $110 Couples. Telephonic Sessions $80. Court testimony, driving time, waiting time, and preparation, including letters or evaluations for court are at a higher rate. Other (non-legal) letters are at the rate of $100/hour. Payment is due at the time of service, prior to the start of the session.

I accept cash or check payable to Gary Mayne. You are responsible for the total charges and any unpaid balance that insurance will not pay (provided no contract is breached). There is a $25 fee for all NSF checks. **Unpaid accounts will be turned over to bill collection after two attempts**.

As I am a Licensed Mental Health Counselor Associate, I am under the supervision of Patty Swanson, M.A., LMFT-LMHC-NCC. A signature on this form acknowledges your consent to my supervisor being aware of and reviewing your case.

I UNDERSTAND THAT NON-PAYMENT WILL RESULT IN BILL COLLECTION AND MAY ADVERSELY AFFECT MY CREDIT RATING.

I REALIZE THAT LATE CANCELLATIONS OR NO-SHOWS WILL INCUR A FEE EQUAL TO THE FULL AMOUNT CHARGED FOR THAT SERVICE AS EXPLAINED HEREIN.

I HAVE RECEIVED NOTICE OF AND UNDERSTAND MY RIGHTS AS A CLIENT AND THIS DISCLOSURE STATEMENT.

I CONSENT TO COUNSELING.

Client (printed name) _____

Client Signature _____ Date_____

Gary Mayne Signature _____

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