

Clients of Jeffrey Larson, Ph.D.

CONSUMER RIGHTS

You have a right to:

1. **Be treated with respect, dignity and privacy;**
2. **Develop a plan of care and services which meets your unique needs;**
3. Receive services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability, see Title VI of the Civil Rights Act;
4. **Refuse any proposed treatment, consistent with the requirements in Chapter 71.05 and 71.34 RCW;**
5. **Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;**
6. **Be free of any sexual exploitation or harassment;**
7. **Review your clinical record and be given an opportunity to make amendments or corrections;**
8. **Receive an explanation of all medications prescribed, including expected effect and possible side effects;**
9. **Have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential;**
10. All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;
11. Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
12. Enrollees have the right to receive direct access to mental health specialists for beneficiaries, with long-term or chronic care needs (e.g. severely and persistently mentally ill adults or severely emotionally disturbed children);
13. If you are Medicaid eligible, receive all services that are medically necessary to meet your care needs. In the event that there is disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary;
14. **Lodge a complaint with the Mental Health Ombuds Service of King County regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you shall be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is: (206) 205-5329 or 1-800-790-8049;**
15. Disenroll from his/her mental health prepaid health plan when the client has "good cause" for disenrollment. Clients must utilize the regional support network grievance process prior to requesting disenrollment;
16. Allow clients, parents of clients under the age of 13, and guardians of clients of all ages to select a primary health care provider from the available primary care provider staff within the mental health prepaid health plan to comply with WAC 388-865-0345, or any successor, and in accordance with the approved Medicaid waiver or any successor;
17. Change primary care providers in the first 90 days of enrollment with the mental health prepaid health plan and once during a twelve month period for any reason;
18. Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;
19. File an administrative hearing with DSHS without first accessing the contractor's grievance process. Use the DSHS pre-hearing and administrative hearing process as described in chapter 388-02 WAC.

Client Name(s) (please print)

Client Signature(s)

Date

CONSENT TO TREATMENT

for Counseling Clients of Jeffrey Larson, Ph.D.

As an employee of Vashon Lutheran Church, Dr. Jeff Larson provides professional counseling to families, couples, and individuals. Thank you for choosing our services. Please read the following information and discuss any concerns with your therapist.

CONFIDENTIALITY. My policy is that no information about you is released to anyone without your written consent. However, in cases of **suspected child abuse and neglect or dependent adult abuse**, the therapist is **required by law to make a report** to the appropriate authorities. In addition, in instances where there is **evidence of planned acts of violence toward oneself or others**, the therapist is required to take steps necessary to secure the safety of the client or others. It is also possible for records to be subpoenaed by a court of law. Another exception to confidentiality includes exchange of information for reimbursement by third party payors.

URGENT CARE. In the event of an emergency please contact the Crisis Clinic at 1-800-621-6040 or call 911.

GRIEVANCE. If you have any reason to be concerned with my service, I recommend that you address the issue directly with myself. If the issue is not resolved to your satisfaction, you also have the right to lodge a complaint or grievance with the Ombuds person at 1-800-790-8049. If you lodge a complaint or grievance, you shall be free of any act of retaliation. The Ombuds persons may, at your request, assist you in filing a grievance. Other options include the State Dept. of Licensing at (360) 753-1761 or WAMI at (206) 783-9264 or 1-800-782-9264.

CONSENT TO TREATMENT.

I, by my signature below, hereby request and consent to mental health services such as psychotherapy, psychiatric evaluation, community support services, and therapeutic activities or services as may be rendered under the general and specific instructions of the Dr. Larson. I understand the practice of mental health treatment is not an exact science and state that no one has made guarantees or promises as to the results that I may receive. **Various modalities may be part of your treatment plan. These may include case management, medication management, chemical dependency treatment, vocational services, individual or group therapy, and family therapy. You have the right to participate in decisions regarding your care, including the right to refuse treatment. There are risk, benefits and consequences to treatment decisions.** If I use private insurance or governmental financial assistance in payment for my mental health services, I understand my name and other statistical information must be released to my insurance company or the State to which I hereby consent. If the client(s) is my child(ren), I consent for my child(ren) to receive mental health services from Dr. Larson.

I have received instructions and understand how to access emergency/after hours services. I have received a copy of Consumer Rights pertaining to mental health services rendered by Dr. Larson. I understand my rights as a psychotherapy client including grievance procedures, access to records and limits to confidentiality. I have received a notice of Dr. Larson's Privacy Policy. I have received and understand the disclosure statement provided by Dr. Larson.

Client(s):(please print) _____ / _____
Date: _____

Signature(s): _____ / _____

Therapist/Counselor: Jeff Larson, Ph.D. Signature:  Date: _____

** "Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the Department does not include a recognition of any practice standards, nor necessarily implies effectiveness of any treatment." (State of Washington, Department of Licensing).