

## **Mineko Takada-Dill, MA, LMHC, ATR**

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Studio Mene

Seattle, WA 98125

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Tel: (206) 276-4915, License: #LH00004693

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## **Information for Clients and Disclosure Statement**

### **Background and Experience**

I am a Licensed Mental Health Counselor and Registered Art Therapist. I have been certified in Washington State since 1997 and licensed since 2001. I gained an M.A. in Art Therapy from New York University in 1992, and frequently attend continuing Education Seminars, including Ethnic Minority Certification Program. I have worked at Outpatient Substance/Alcohol Program in Brooklyn, NY, at the Community Mental Health Center of King County in Seattle, WA, and at Highline School District. I have been in private practice since 2001 and have held several school district contracts for student counseling.

### **How I practice**

I have two different places to practice counseling and art therapy. In the counseling office I use art therapy with limited art supplies and use both psychodynamic and cognitive behavior therapies depending on my clients' needs. In the studio, I primarily use art therapy and sand tray therapy.

I believe art therapy is a powerful medium to express ourselves. Our creative processes and final art works reflect our mind and help us to recognize our inner conflicts and/or problems and bring creative solutions. More detailed information is available on my web site at [www.studiomene.com](http://www.studiomene.com). Feel free to discuss my approach and your treatment goals and progress.

### **Appointments**

My counseling and art therapy sessions are 60 minutes long. It is important that you be on time for your appointment, as it is not possible to extend your sessions beyond your scheduled appointment time.

Your session time is reserved for you. **If you are unable to keep your appointment for any reason, please give me 24-hour advance notice of cancelation, excluding weekends and holidays.** If I don't answer the phone, please leave a message on the voice mail. I don't accept cancelation by e-mail even if you have signed the consent to allow us to have limited communication through e-mail. Appointments cancelled without 24 hours' notice will result in a full fee charge for the session. (the amount is indicated in the Fee section)

### **Fees**

I am a network provider for Premera, Regence, First Health, Life Wise and MHN. Frequently the insurance companies subcontract out with other insurance companies for Behavior Health (counseling) coverage, so please contact your insurance company prior to the intake session.

Insurance coverage for mental health services varies depending on your insurance company and its policy.

You will need to sign the **Authorization for Treatment Form** which includes your consent to release your PHI to your insurance company prior to me contacting your insurance company or sending billing to them. Until I receive verification from your insurance company, you will be responsible for full payment at each session. If your insurance policy has a co-pay requirement, you will be responsible for your co-pay at each visit.

If you pay privately, your full fee is: \_\_\_\_\_ (intake) and \_\_\_\_\_ (60minutes session)

**Emergencies**

In case of an emergency during office hours, Mondays to Saturdays between 9 am and 5 pm, you may reach me through my office number (206) 276-4915. I check for voice mails several times a day but I am not able to attend you immediately if I am with other clients. The 24-hour Crisis Line is available at **(206) 461-3222.**

**Confidentiality**

As I discussed in Notice of Privacy Practice, I am dedicated to maintaining the privacy of your Protected Health Information (PHI). All information from sessions will remain confidential. The only way information may be released to any other party is through a specific **Consent for Disclosure and/or Exchange of Protected Health Information (PHI) Form.** If you choose to use third party coverage (medical insurance), your PHI will be released to your insurance company after you sign the **Treatment Agreement Form.** The law requires the release of confidential information without consent in certain select circumstances. Please read **Notice of Privacy Practices**

**Record Keeping**

As a licensed Mental Health Counselor, I am required to keep treatment records. If you would like NOT to keep treatment records, with the exception of you or your child's name, payment method and date of services and disclosure form (this form) signed by you and Mineko Takada-Dill, MA,LMHC, please notify me in writing.

**Understanding**

I declare that I have read and understood the content of the policies and the disclosure statement and have discussed any questions and have had my concerns addressed with Mineko Takada-Dill.

I have also received the following documents.

1. Copy of this disclosure statement
2. The Washington State Department of Licensing brochure
3. The copy of Notice of Privacy Practice

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_