PROFESSIONAL DISCLOSURE

I am a clinical social worker licensed by the Wyoming Mental Health Professions Licensing Board. My license number is WY-742. I received a Bachelor of Arts in Psychology and Communications from Denison University in 1998. I received a Master of Social Work from Portland State University in 2004.

The Wyoming Mental Health Professions Licensing Board regulates the practice of licensed persons in the field of social work and other mental health professions in the State of Wyoming. Concerns or complaints regarding the practice of social work may be directed to the licensing board or the State of Wyoming Behavioral Health Division. Their contact information is provided below:

Wyoming Mental Health Professions Licensing Board
2001 Capitol Ave, Room 104
Cheyenne WY 82002
Phone: (307) 777-3628
Fax: (307) 777-3508

State of Wyoming Behavioral Health Division
6101 N. Yellowstone Rd., Suite 220
Cheyenne WY 82002
Phone: (307) 777-6494
Fax: (307) 777-5849

You have the right to confidentiality. In most situations, personal information will not be released without your written consent, unless:

a) Suspected abuse or neglect of children, the elderly, disabled or incompetent.

b) Information related to treatment is necessary to defend against a malpractice action brought by a client.

c) An immediate threat of physical violence against a readily identifiable victim is disclosed to the clinician.

d) In the context of civil commitment proceedings, where and immediate threat of self-inflicted harm is disclosed to the clinician.

e) The client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation. In this circumstance, a judge may order my testimony if he/she determines that the issues demand it.

f) In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.

I strive to maintain the highest quality of service. Therapeutic relationships are professional in nature; therefore, sexual intimacies or friendships between client and clinician are not appropriate. I follow ethical guidelines established by the National Association of Social Workers.

I have read the above disclosure statement, understand what I have read, and voluntarily and knowingly execute this document subject to the above provision.

Client/Parent/Legal Guardian Signature	Printed Name	Date

CONSENT FOR TREATMENT

Therapy is a dynamic, fluid process between therapist and client. There are many different therapy methods I may use to deal with the problems that you hope to address. Therapy requires a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and between our sessions.

Therapy can have benefits and risks. There are no guarantees of what you will experience. You may accept or reject any suggested clinical intervention. You have the right to ask for a referral to a different clinician or to terminate treatment at any time. If you would like to terminate for any reason, I will support you in your decision. Our first couple of sessions will involve an evaluation of your needs. By the end of the evaluation, we will develop a treatment plan together. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

CONTACTING ME

I check my voicemail frequently and make every effort to return phone calls within 24 hours, with the exception of weekends and holidays. I do not have an after hours emergency service. If you cannot reach me and need to talk with someone, there is a local crisis hotline, which you can call at (307) 733-2046. In emergencies, you can go to your local emergency room and ask for the mental health provider on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague or agency to contact, if necessary.

PROFESSIONAL RECORDS

You are entitled to receive a copy of your records or a prepared summary. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern.

EMAIL

I prefer using email only to arrange or modify appointments. **Please be aware that if you email me content related to your therapy sessions, email is not completely secure or confidential**. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CONSENT FOR TREATMENT

I voluntarily consent to mental health and/or consultative services with Leah Black, LCSW. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client/Parent/Legal Guardian Signature	Printed Name	Date
Leah Black, LCSW	Printed Name	Date