



Northwest Psychological Center

Professional Disclosure Statement
Jason Blei LMFT, CMHS
License # LF 60140895, WA; T0932, OR

Northwest Psychological Center, P.C.
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Email: jason@nwpcpc.com

Philosophy and Approach: Our brains are by far the most complex organs in our bodies, yet when we lack the skill to heal our own emotional pains, how quick we are to torture ourselves while avoiding specialized assistance. I am a licensed Couples and Family Therapist with more than 10 years of experience helping individuals and families. Our office provides the safety and support, the therapy provides the tools for growth, the healing and change are your own. As a facilitator of your process, I honor the time people devote towards growth, enhancing relationships, and introspection. I look forward to working with you.

Formal Education and Training: I received my Master's degree in Marriage and Family Therapy at the University of Oregon. After receiving my Master's degree, I spent two years in Connecticut conducting the evidence-based model of Functional Family Therapy (FFT). I have three years experience providing Family Preservation Services (FPS) in the Vancouver area. I have extensive background utilizing motivational interviewing to engage treatment resistant, at-risk youth struggling with family, school, peers, and difficulties finding their own identity. I am a licensed Couples and Family Therapist with more than 10 years of experience helping individuals and families accustomed to mediation, family and group processing, and Gottman Couples therapeutic approaches. I provide a respectful, nonjudgmental, confidential space to process interpersonal difficulties, grief & loss, depression & anxiety, anger issues, past trauma and current adjustment challenges. As a supervisor and trainer of crisis intervention I am well accustomed suicide intervention, assessment and the treatment of mental health.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

Fees: \$120 per 50 minute session, \$150 for intake.
On many insurance panels. Will also bill for out of network benefits if client has benefits available.
Sliding scale: Case-by-case basis (limited)

As a client of an Oregon licensee, you have the following rights: To expect that a licensee has met the qualifications of training and experience required by state law; to examine public records maintained by the Board and to have the Board confirm credentials of a licensee; to obtain a copy of the Code of

Ethics (Oregon Administrative Rules 833-100); to report complaints to the Board; to be informed of the cost of professional services before receiving the services; to be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status; to be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions:

1) Reporting suspected child abuse; 2) Reporting imminent danger to you or others; 3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me; you may contact the Board of Licensed Professional Counselors and Therapists at (503) 470-5499.

3218 Pringle Rd SE, #250, Salem, OR 97302-6312

Telephone: (503) 378-5499 Email: lpct.board@state.or.us

Website: www.oregon.gov/OBLPCT

For additional information about this counselor or therapist, consult the Board's website.

Cancellation Policy: I reserve your appointment time for you specifically. Therefore, I require a 24-hour notice to cancel your appointment. If we receive less than the 24-hour notice, we will bill you a "No Show" or "Late Cancellation" fee of \$100.00, which cannot be billed to your insurance. You will be responsible for payment of this fee.

I have read and understand this statement and discussed any questions I have at this time about services offered. My signature indicates that I am comfortable with and accept the terms and conditions of therapy as outlined above; receipt of this form was witnessed.

Client

Signature _____ Date _____

Printed name _____

Parent/Guardian Signature (if applicable) _____

Date _____

Printed Name of Parent/Guardian _____

Counselor

Signature _____ Date _____

Printed name _____