Dr. Beth Kaplan Westbrook
(503) 860-0614
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PsyD, Clinical Psychology (Pacific University), 1991
Clinical Psychologist, Oregon License #1051, 1993 - present
Registered Dance/Movement Therapist, #1984-ADTR-38 (1984-2005)
Certified, Child & Adolescent Psychotherapy (Washington School of Psychiatry, Wash, DC)
Certified, Group Work, St. Elizabeth's Hospital (Washington, DC),

Professional Disclosure Statement

I abide by all rules and standards for training, experience and ethics required by the Board of Psychologists Examiners (378-4154, Salem, OR). I am a member of the Oregon Psychological Association (Portland, OR), and the American Psychological Association (Washington, DC).

- In addition to private practice, I consult to the Oregon Wellness Program (OWP) and Health Professionals Service Program (HPSP), State of Oregon (formerly Diversion Program for Health Professionals). My theoretical orientation is psychodynamic in individual, group and couples psychotherapy. I provide professional supervision and consultation.

- You have a right to privacy as defined by rule and law, including the exception to confidentiality of information obtained in the course of services that include the following: reporting suspected child abuse, reporting imminent danger to client or others, reporting to relevant agencies, licensee consultation or supervision, defense of claims brought by client against licensees, to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful, category while receiving service.

Fees:

- $260 per initial session
- $220per 45 minute session,
- Fee charged for all missed sessions with the exception of vacations.

I keep a regular time open for you. If you know ahead of time that you need to miss an appointment I will attempt to reschedule with you within the same week whenever possible.

- Insurance accepted out of network,.
- Insurance will not cover missed appointments.
- Please verify your insurance coverage including any pre-authorized requirements, claims addresses and co-pay responsibility. Initial below that you are fully responsible for all fees incurred regardless of any insurance coverage for the services provided under this agreement.
- _____(initial here please)

All information in private sessions is confidential except if danger to self or others is present. Please review the Notice of Privacy Practices on my website, your signature below indicates that you have been provided with this information.

Consent to treatment:

Please sign..... Date.....