DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT

You have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You also have the right to terminate your treatment at any time for any reason. The following information is provided to help you determine if Lakewood Child and Family Counseling PLLC (LCFC) meets your needs as a client. This document contains important information about therapeutic approaches, education, fees, and your rights as a client. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services. We are not able to propose an appropriate course of treatment for you until we have spent some time together. As soon as we are able to identify an appropriate course of treatment it will be discussed with you.

Your Right to Confidentiality: Your participation in therapy, the content of our sessions, and any information you provide to LCFC during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which LCFC may choose to, or be required to, disclose this information:

- If you give written consent to have the information released to another party;
- In the case of your death or disability LCFC may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against your therapist;
- In response to a valid subpoena from a court or from the Secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If LCFC reasonably believes that disclosure of confidential information will avoid or minimize an imminent danger to your health, your safety or the health or safety of any other individual;
- If, without prior written agreement, payment for services has not been received after 60 days, the account name and amount may be submitted to a collection agency;
- If the contemplation of a crime or other harmful act is revealed;
- If we have any other legal duty, obligation, or right to report.

LCFC may also be required by law to disclose certain confidential information including suspected abuse of children under RCW 26.44 and RCW 18.19.180(3), suspected abuse of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05. If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let us know. LCFC will be happy to discuss this with you further. For additional information regarding your confidentiality rights, please carefully review the HIPAA Notice of Rights and Privacy Practices.

Insurance Companies: Insurance companies and other third-party payers may require that LCFC provide them with information regarding the services LCFC provides to you. This information may include the type of service provided, the dates and times of service, your diagnosis, treatment plan, a description of impairment, progress of therapy, case notes and summaries. If you do not want me to provide your confidential information to your insurance company, let me know so that we can discuss alternatives.

Group Family, Couples and Marriage Counseling: If you are seeking group, family, couples, or marriage counseling, it is important you understand LCFC adheres to the ethical and legal requirements of confidentiality as stated above, however, LCFC cannot ensure that you or the other participants in group, family, couples, or marriage counseling will maintain confidentiality about your therapeutic experience including content discussed within the counseling session. In addition, in the case of family, couple, or marriage counseling the entire treatment record will be available to any and all participants in the family, couples, or marriage counseling and all participants must consent to any authorized third-party disclosure.

OUR PROVIDERS:

Michelle Klekota-Chisholm, MA, LMHC, Owner's Education and Training:

Licensed Mental Health Counselor (LMHC) regulated by Washington State (Credential Number LH 60231172)
My formal education: Associates Degree in Human Services, Bachelor of Arts in Psychology and Gerontology from Nazareth College in Rochester, New York. Master's Degree from Bastyr University/LIOS in Kenmore, Washington in Applied Behavioral Science and Systems Counseling. My professional therapeutic experience includes working with children, teens, couples, individuals, and families. Formal training in Emotion Focused Therapy for couples and individuals, Trauma Focused Cognitive Behavioral Therapy treating child sexual assault victims, Domestic Violence, and Autism Spectrum Disorders as well as ADHD. Prior experience: six years working in the non-profit arena with people with disabilities on vocational or independent living goals, four years for-profit customer service/ office management, and time as a General Manager for a non-medical in-home care company for the elderly and disabled. Additionally, I have volunteer experience with at risk youth, domestic violence, foster care, and those facing homelessness.

Michelle's Approach to Therapy/Modalities: My approach to therapy is quite eclectic including; Emotion Focused Therapy, Family Systems Theory, Trauma-Focused Cognitive Behavioral Therapy, Narrative Therapy, Structural, Strategic, and Solution Focused work. My journey in becoming a therapist has included a great deal of self discovery, experiential life learning and formal professional education. I have come to see that this human experience, with all its complexities, is a growth process based on choices and can be full of challenges and credits. Every person's process is unique. This basic premise allows me to be quite diverse in my work and allows me to pull in many of my own life experiences

Please note that your therapy services may be provided by an employee of Lakewood Child and Family Counseling, and not by the owner. All therapist employees are WA state licensed and or associate licensed to provide mental health services to you. Read more about them below.

Stephanie Perceful, MA, MHP, LMHCA, MC60696091(Associates License) & Spanish Speaking
Stephanie's Education: Master's degree Counseling Psychology at Saint Martins University, Lacey WA. Bachelor's Degree in Art of Psychology at University of Washington, Seattle WA. Bachelor's Degree in Arts at The Evergreen State College, Olympia WA. Associate Degree in Arts at Lane Community College, Eugene OR. Stephanie's therapeutic modalities consist of a combination of sand tray, expressive therapy, play therapy with children, Psychoeducation about Neurobiology, Cognitive Restructuring, mindfulness techniques, and much more.
Stephanie also speaks Spanish.

Paul Henry M.ed., LMHC, LH60300442
Paul's Education: Master of Education with an emphasis in Counseling Psychology from the University of Puget Sound. His Counseling orientation is Cognitive Behavioral with an integrative approach. His training has included, among other therapeutic orientations, Motivational Interviewing (MI) and Rational-Emotional Behavioral Therapy (REBT).

Matthew Cruvant, MA, LMHC, LH60305802
Matthews's Education: Master's degree in Art of Psychology at Seattle University, Seattle WA. Bachelor's Degree in Art of Psychology at University of Washington, Seattle WA. Bachelor's Degree in Art of Philosophy at University of Washington, Seattle WA. Matthew's therapeutic modalities consist of a combination of Motivational Interviewing, Existential Phenomenology (EP), Cognitive/Behavioral psychology, Psychodynamic, and Psychoanalytical theories.

Sayaka Ashe, MA, LMHC, MHP, LH60686024 & Japanese Speaking
Sayaka's Education: Master's degree in Art of Clinical Psychology from Argosy in Seattle WA. Bachelor's degree in the Art of Psychology from the University of Washington, Seattle. Associate's degree in Art with emphasis in Psychology, and Associate's degree in Applied Science in Human Services- both in Washington State. Sayaka's modalities and theoretical approaches consist of a combination of Mindfulness Based Behavioral Therapy, Anger Management techniques, Social Skills Training, CBT, and DBT. Sayaka is skilled at Group Therapy in addition to her typical modalities.
Sayaka also speaks Japanese.

Clinical Consultation: LCFC seeks ongoing supervision and consultation from colleagues to provide you with the best services possible. We may disclose information about your counseling session in consultation with colleagues, in which case we will withhold your name and other easily identifiable information.

Financial Requirements: Under Washington State Law, you are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement.

Appointments are usually scheduled once per week or once every other week. The session typically lasts for 45-55 minutes. The scheduled time for your session is set aside for you. **If you miss a session without notice or if you cancel with less than 24-hours notice, you will be billed in full for that time up to $140**. Insurance or other third-party payers will not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate.

Our Standard Rate is $160 per intake session.
Each additional session, for family or individual, is billed at $140.
A discounted *Cash Payment Rate* of: $110 per session will be given to those who pay in full, out of pocket, at the time of service.
All other therapist's time: billed at the full rate of $140 including: phone calls, documentation, or any other direct contact with therapist.

Payment is due at the time of service. Returned checks, for any reason will result in an additional $35.00 processing fee, in addition to the face value of the check. This fee must be paid prior to scheduling your next appointment. Your portion of the full fee is determined based on your medical coverage, unless we specifically agree on another method of payment. Once your insurance company has determined your coinsurance or portion of the fee due, you will be billed. (Your insurance can take up to 90 days to pay us for services rendered. If you would like information prior to 90 days, it is your responsibility to communicate with your insurance carrier about what portion, if any, they will cover towards your counseling services). Payment is due immediately upon receipt of that bill. A collections agency is utilized for past due balances. You are responsible to pay the full fee or your portion of the full fee.

Electronic Communications and Social Media: In the regular conduct of this practice, LCFC may make use of a cellular phone, or other portable communication device, to communicate with clients. In such cases, LCFC will limit the information LCFC stores in any portable communication device to the least necessary. Please be aware that such forms of communication do have inherent risks to client confidentiality. If you would prefer that LCFC does not store you name and telephone number in a portable communication device, or if you would prefer that LCFC does not communicate with you via cellular phone, please inform us so that we can make alternative arrangements. We will also send text and email reminders of appointments to you from non-monitored no replies accounts, i.e.: one-way communication accounts.

To best protect your confidentiality, LCFC typically will communicate with clients via email for the purposes of scheduling/rescheduling appointments, client satisfaction surveys, and holiday or promotional greetings/information. If you need to communicate with us via email for any other purpose, please discuss that with us in person. LCFC may communicate via text for scheduling or rescheduling appointments only. Any other communication should take place in person or over the phone and will be billed at our full rate of $140 per hour. Current professional ethics standards do not permit us to have personal relationships with clients via social media. We do maintain professional social media pages for this practice. We will not post any client information via social media unless, we are responding to your direct online communication to or about us in which you reveal your identity, then we will respond accordingly. We would be happy to discuss our electronic communication and social media policy in more detail if you would like.

Emergencies: If you are experiencing an emergency or crisis, please call 911 or the Crisis Line at (206) 461-3222, (253) 396-5180, or (800) 244-5767. In such situations, you may also go to the nearest hospital Emergency Room or call 911.
The National Suicide Hotline is 800-273-8255.

State of Washington Disclosures: The State of Washington requires that we provide you with the following information:
You have the right both to receive appropriate care and treatment, and to refuse any treatment you do not want. You have the right to choose a Counselor who best suits your needs and purposes. Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of public health and safety. Credentialing of an individual with the Department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

We maintain a referral list of other Counselors with a wide range of specialties. LCFC will provide you with a referral to another Counselor if LCFC feels your needs are beyond the scope of our expertise, or if you request such referral information.

Client Consent to Treatment:

By signing below, I attest that I have read or have had satisfactorily explained to me Lakewood Child and Family Counseling's Disclosure of Information, Policies, Client Agreement, and HIPPA Notice of Privacy Practice and I fully understand these policies. I have asked any questions that I had about this statement, and about statements regarding fees and payment policies. (For clients under the age of 13, consent must be given via this form being signed by a parent/legal guardian. A copy of the current parenting plan including medical decision-making section is required.) I understand and agree to the description of confidentiality and its exceptions as stated above.

I consent to counseling with **Lakewood Child and Family Counseling PLLC**, under the terms described above and I understand that I have the right to terminate counseling at any time. I also understand that notice of termination is requested at the beginning of a regularly scheduled session so that the reasons for termination may be discussed.

My signature below indicates that I have received a copy of this agreement and the HIPPA Notice of Privacy Practice.

Client 1 Signature: _____Date: _____
(Clients 13 years and older must sign here)

Client 2 Signature: _____ Date:_____
(Parent/Legal Guardian signs here)

Therapist Signature: _____ Date: _____

CONFIDENTIAL CLIENT INFORMATION Today's Date_____

Client Name_____ Age_____ Birth date_____

Email_____ Cell Ph#_____

Address_____ Apt#_____ Home Ph#_____

City_____ Zip_____ Work Ph #_____

Employer_____ Social Security #:_____

Employer Address City Zip_____

❑Single ❑Coupled, Not Married ❑Separated ❑Widowed

❑Married: How long?_____ ❑Divorced: How long?_____❑Previous Marriages #_____

(If client above is a child, list parent's full names below):

Residential Custodial Parent/Guardian: _____

Non-Residential Non-Custodial Parent/Guardian:_____

Shared/Joint Custodial Parent/Guardian A:_____

Shared/Joint Custodial Parent/Guardian B:_____

Spouse/Partner (if client above is adult)_____Age_____

Birthdate_____ Email_____ Cell Ph#_____

Address_____ Apt#_____ Home Ph#_____

City_____ Zip_____ Work Ph #_____

Employer_____ Social Security #:_____

CLIENT'S CHILDREN (write 'none' if client is a child):

Name_____ Birthdate: _____M/F Social Security #_____

Name_____ Birthdate: _____M/F Social Security #_____

Name_____ Birthdate: _____M/F Social Security #_____

Responsible Party If Other than Yourself _____Relationship to Client:_____

INSURANCE INFORMATION:*(Insurance card must be present at intake session to use your benefits-otherwise you may pay out of pocket for intake $160.00)* **IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING DEDUCTIBLE, COINSURANCES, COPAY AMOUNTS AND AUTHORIZATION REQUIREMENTS**.

PRIMARY INSURANCE: *(We cannot guarantee in network status with any insurance, you are liable for your copays/coinsurances/deductibles/insurance denials, etc…)*

Insured's Name _____ Relationship to Client: _____

Insurance Company_____ Policy/Group No._____

Insurance Billing Address _____ Insured's Member ID No._____

Insured's Birth Date:_____

Subscriber Address if Different than home address:_____

SECONDARY INSURANCE:*We do not bill Medicaid or state insurance as secondary insurance

Insured's Name _____ Relationship to Client:_____

Insurance Company_____ Policy/Group No._____

Insurance Billing Address _____ Insured's Member ID No._____

Insured's Birth Date:_____

Subscriber Address if Different than home address: _____

FINANCIAL RESPONSIBILITY: I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED, APPOINTMENT FEES, & BALANCES DUE, REGARDLESS OF INSURANCE COVERAGE.

X_____

(Signature of Person Financially Responsible for Paying for All Service Fees, Missed Appointment Fees, & Balances due.)

*For shared custody- will bill ONLY one parent, the one signing here. We can give you a statement of payments you have made upon request.

Please describe any prior therapy you have received, include dates, name(s) of Therapist(s) and nature of:

_____
_____
_____
_____

Please describe the concerns that bring you in today:

_____
_____
_____
_____

What do you hope to accomplish through therapy here?

_____
_____
_____
_____

Please describe any current health conditions or worries:

_____
_____
_____
_____

Do you smoke:___Yes___ No Does your Spouse/Partner:___Yes___ No
Do you drink alcohol?:___Yes___ No Does your Spouse/Partner:___Yes___ No
What kind/How much/How often? _____

Do you use any other substances?:___Yes___ No Does your Spouse/Partner:___Yes___ No
What kind/How much/How often? (i.e. Marijuana, Cocaine, Etc.) _____

Are you taking any medication?:___Yes___ No Does your Spouse/Partner:___Yes___ No
Describe_____

Do you have any trouble sleeping? :___Yes___ No Does your Spouse/Partner:___Yes___ No
Describe_____

Recently gained___OR lost___ Weight? How much/Over how long? _____ / _____

Are you currently being treated for any physical or psychological illness?:___Yes___ No
Describe_____

Name of Client's Primary Care Physician (PCP or PCM):_____
Date of last exam/visit_____Reason:_____

Past Suicide Attempts ___Yes___ No When? _____
Recent Thoughts of Suicide ___Yes___ No When? _____
Do you have a Suicide Plan today?___Yes__No Explain _____

How did you find out about Lakewood Child and Family Counseling? Who referred you? From where?

_____
_____

Financial Policy

The scheduled time for your session is set aside for you and only you. This is your time. Given that, payment for your time and services provided is due on the date of service. **If you miss a session or if you cancel with less than 24-hours notice, you will be billed in full for that time regardless of the reason. The full fee for one counseling session is $160-$140 per hour.** Insurances will not pay for missed appointments.

Once your insurance company has determined your coinsurance or portion of the fee due, you will be informed. Payment is due upon receipt of that information. You are responsible to pay the full fee or your portion of the full fee. Checks returned for any reason will result in an additional $35.00 processing fee, in addition to the face value of the check.

Authorization to Bill Credit Card

You will be asked to create a customer account in our software program, leaving your credit card on file. By doing this you authorize Lakewood Child and Family Counseling Pllc to bill all portions of your bill for counseling in full to this card.

This includes any portions of your bill not paid in full at time of service.
Meaning: insurance denials, copayments, deductibles, patient responsibilities, cost shares, coinsurance, all other 'you pay' wording from your insurance company.
As well as, missed appointment fees incurred for canceling appointments with less than 24hrs notice and/or no-show appointments and returned/bounced check fees.

*****If for some reason your credit card is declined, a collections agency is utilized for all past due balances*****

I agree that I am responsible for the charges for services provided by LCFC to me and my family, and for missed appointment fees or no-show fees; although other persons or insurance companies may make payments on my account and/or my family's account. I agree to pay for services and fees until my full balance is paid.

I understand that I must keep my contact information up to date with LCFC. If I fail to respond for any reason: to phone, text, email or mail attempts made by LCFC to collect on my balance due/owed, that this balance will be sent into collections with Puget Sound Collections and all further communication will then be with this collections agency.

Signature of Understanding & Authorization:

X_____**Date:**_____

Authorization to Use and Disclose Protected Health Information (PHI) to INSURANCE

It is required by law to obtain a client's authorization to disclose PHI to Insurance. Please fill this form out completely.

Client Name: _____

Address:_____

City, State, Zip:_____

Date of Birth:_____

Social Security #:_____

I authorize Lakewood Child and Family Counseling PLLC. to send & receive information TO & FROM:

Insurance Company:_____

Subscriber ID:_____

Group/Policy #:_____

Subscriber Date of Birth:_____

Subscriber:_____

Subscriber Address (if Different then Client) :_____

The purpose of this disclosure is to bill insurance for the client mentioned above.
The information to be released is: Treatment Plan, Course of Treatment, Diagnosis, Psychological History, etc.
Other:_____

Required Statements:

I understand that the information used or disclosed may be subject to re-disclosure and no longer protected under law. It is not required that you sign this authorization. Refusal will not negatively affect your ability to receive mental health treatment from Lakewood Child and Family Counseling PLLC. If you do not sign this form, your health insurance will not be billed. Clients then are required to pay with cash, check, or credit card at the regular rate (which can be discounted in cases of need). You may revoke this authorization at any time in writing. At that point, the information may no longer be disclosed. Any use or disclosure already made cannot be undone. To revoke this authorization, please put all your above information as well as your reason for revocation in writing and return it to Lakewood Child and Family Counseling PLLC.

This release of information will expire 6 months from the last day of treatment with Lakewood Child and Family Counseling PLLC, to allow for all billing to be completed.

Client Signature:_____Date:_____
(Client 13 or older sign here)

Client Signature:_____Date:_____
(If Client is under 13, Parent sign here)