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. **Please read this document carefully as all clients must know and follow the items listed below.** Please 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 can 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 in which LCFC may choose to, or be required to, disclose 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. Please carefully review the HIPAA Notice of Rights and Privacy Practices.

Insurance Companies: Insurance companies and third-party payers require that LCFC provide them with information regarding the services provided. This information may include; type of service provided, dates and times of service, your diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries. If you do not want us to provide your confidential information to your insurance company, let us 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, the entire treatment record will be available to any/all participants in the family, couples, or marriage counseling and all participants must consent to any authorized third-party disclosure.

OUR PROVIDERS:

Please note that your therapy services may be provided by an employee of Lakewood Child and Family Counseling. All therapist employees are WA state licensed or associate licensed to provide mental health services to you.

Michelle Klekota-Chisholm, MA, LMHC, LH60231172: 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. Michelle's Therapeutic Modalities is quite eclectic including; Emotion Focused Therapy, Family Systems Theory, Trauma-Focused Cognitive Behavioral Therapy, Narrative Therapy, Structural, Strategic, and Solution Focused work.

Elva Flannery MA, LMFTA, MG60903120 (Associate License): Education: Master's degree in counseling psychology at Saint Martin's University Lacey Washington. Bachelor of science in psychology at Washington State University, Pullman Washington. Elva's therapeutic modalities include Family Systems Theory such as; structural, and intergenerational. As well as Social Learning Theory such as cognitive behavioral therapy (CBT), trauma focused cognitive behavioral therapy (TFCBT) in addition to, narrative therapy, emotion focused therapy, & mindfulness approaches.

Paul Henry, M.ed., LMHC, LH60300442: 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: 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.

Vanessa Groff, MA, LMFTA, MG61003299 (Associate License): Education: Master's degree in Marriage, Couple, and Family Counseling from George Fox University, Portland OR. Bachelor's degree in Psychology from Portland State University, Portland OR. Vanessa's therapeutic modalities

and techniques are an integrative approach that consist of Family Systems Therapy, Cognitive Behavioral Therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TFCBT), and Attachment Theory.

Annaliese Jacobsson, MSW, LSWAA SA61078619 (Associates License): Education: Master of Social Work from Boise State University and Bachelor of Arts in Social Work and Minor in Refugee Studies from Boise State University, in Boise, Idaho. Annaliese's therapeutic modalities include Attachment Theory, Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy , trauma and body-based therapies, mindfulness, Internal Family Systems (IFS) and more.

Patricia (Trish) Mason, MA, LMFTA, MG60923117 (Associate License): Education: Master's degree in Marriage and Family Therapy from Pacific Lutheran University, Tacoma, WA. Bachelor's degree in Liberal Art's with an emphasis on Women and Family Studies from Evergreen State College, Tacoma, WA. Patricia's therapeutic approach stems from a family systems based framework of Cognitive Behavioral Therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TFCBT), Narrative Therapy, and Experiential/Emotional Focused Therapy.

*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.

Electronic Communications & Social Media: In the regular conduct of this practice, LCFC will use cell phones, and other portable communication device, to communicate with clients. In such, LCFC limits the information stored in portable devices to the least necessary. Such forms of communication do have inherent risks to client confidentiality. If you would prefer that LCFC does not store you name and number in a portable device, or if you would prefer that LCFC does not communicate with you via cell phone, please inform us prior to beginning services. As *a courtesy only*, we *may* send text & email reminders from no reply accounts, i.e.: one-way communication accounts. To best protect your confidentiality, LCFC typically will only communicate with clients via email for the purposes of; scheduling/rescheduling, client surveys, holiday & promotional greetings/information. If you need to communicate with us via email for any other purpose, please discuss that in person. LCFC may communicate via text for scheduling/rescheduling only. Any other communication should be in person or via phone and will be billed at our full cash 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 online media **unless, we are responding to your direct online communication to or about us, then we will respond accordingly.**

All Letters & Documentation Requests (Employment, Disability, Custody, etc):
LCFC does NOT write or sign documentation, certification, letters, or any other paperwork of any kind. LCFC does not provide opinions for legal, parenting, child placement/custody, employment, ability to work, disability, etc. We will support and empower you to sort out and advocate for these needs independently.

Emotional Support Animals, Service Dogs, & OFFICE DOGS:
LCFC does NOT write or sign documentation, certification, letters, or any other paperwork related to/for emotional support animals. We refer all requests to local animal trainers. LCFC has free roaming, small, loving, human-friendly **office dogs on our premises** for all to enjoy while here. Dogs can be territorial with other animals. FOR SAFETY, we require all *certified service dogs* to receive prior written approval before entering our building. If you have a *certified service dog* needing to attend with you, please schedule a separate appointment with management prior to beginning services and obtain written approval with a plan. We would like to accommodate your trained working dog safely, while keeping our lobby guests safe and comfortable as well. All animals without prior written approval will be asked to leave for safety reasons.

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. 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 Counselors with a wide range of specialties. LCFC will provide you a referral to another Counselor if we feel your needs are beyond the scope of our expertise.

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 1x per week. Session typically last 45-53 minutes. The scheduled session time is set aside just for you. **If you miss a session without notice or cancel/reschedule with less than 24 hours' notice, for ANY REASON, you will be billed in full for that time up to $140**. Insurance/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. **Payment is due at the time of service. Our Standard Rate is $160 per intake session. Each additional session is billed at $140. A discounted *Cash Rate* of: $110 per session may be given to those who do not use insurance and pay in full at the time of service. All other therapist's time: billed at the full rate of $140 including: phone calls, documentation requests, or any other direct contact with therapist.** 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.

Payment is due at the time of service. You are responsible to pay the full fee or your portion of the full fee. Your portion of the full fee is determined based on your medical coverage. We may know your approximate portion due based on contracted rates with insurance. You are required to pay your portion before each session. Once your insurance company has processed your claims, you will be billed for any remaining balances not paid at the time of service. Payment for any unpaid portion of your account is due immediately upon receipt of that bill. (Your insurance can take up to 90 days or more to pay us for services rendered. It is your responsibility to communicate with your insurance carrier about what portion, if any, they will cover towards counseling services). A collections agency is utilized for past due balances. **In a shared custody agreement, we will schedule with and bill to only 1 parent, the parent signing this agreement as well as the financial agreement below.**

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 (Please complete in full even if you have written it elsewhere): ***(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, Apple Health, 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, MISSED 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 schedule with & bill to ONLY one parent, the one signing here.

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 use tobacco products?: ___Yes___ No Does your Spouse/Partner:___Yes___ No
Do you drink alcohol?: ___Yes___ No Does your Spouse/Partner:___Yes___ No
Do you use marijuana?: ___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, cocaine, pain pills, 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 (Please read carefully)

Your scheduled time for your session is set aside just for you and only you. This is your time. Given that, payment for your time and/or services provided is due on the date of service.

When you miss an appointment without 24hrs notice, for any reason, this prevents you from receiving help but also prevents another client who is waiting, from getting help as well.
If you miss your session time or if you cancel with less than 24-hours (clock hours) notice, FOR ANY REASON, you will be billed in full for that missed time.

The full fee for one counseling session is $140.
Insurance will not pay for appointments you do not attend.

In shared custody & blended families we will schedule with and bill to ONLY one parent, the one signing these forms.

Payment is due at the time of service. Once insurance has processed your claims, you will be informed of any portion that was left unpaid at the time of service. That 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 Card on File

Together, we will 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 unpaid portions of your bill in full to this card.
This includes all portions not paid in full. Including: insurance denials/rejections, copayments, deductibles, patient responsibilities, cost shares, coinsurance, missed appointment accountability fees, bounced check fees, all other 'you pay' wording.
If for some reason this card is declined, a collections agency is utilized for all unpaid balances

I have read and fully understand this policy and the processes above.
I understand that payment is due at the time of service.
I understand the 24 clock hours reschedule/cancelation, for any reason, policy.
I agree that I am responsible for all fees/charges from LCFC for services provided to me or my family and for fees incurred for missing appointments, late cancelations/reschedules, and no-shows, bounced payments, etc. for any reason.

I agree to pay for services and fees in full. I understand that if I do not pay my balance in full, my card on file will be used for all remaining balances owed. I understand that I must keep my contact information up to date with LCFC. I understand that if I do not respond immediately (for any reason) to attempts made to contact me via phone, text, email, or mail to collect on my balance due, that this balance will be sent into collections with Puget Sound Collections. All further communication will then be with this collection's agency and no further services will be provided to me or my family by LCFC.
Signature of Authorization and Understanding:

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 even if you have written it elsewhere. Without this page we cannot bill insurance for you.

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)