

Barbara Robinette, M.Ed., LMHC

955 Officer's Row
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(360) 694-3017 Fax

DISCLOSURE AND CONSENT FOR TREATMENT FEE AGREEMENT

WELCOME

I am pleased you have selected me as your mental health provider. This document is designed to inform you about my practice and to ensure that you understand our professional relationship.

In our first session you will have an opportunity to see if I am a “good fit” for you. You will want to ask yourself if you feel comfortable working with me. Your questions about therapy or anything in this form are welcome.

CREDENTIALS

I am licensed by the State of Washington as a mental health counselor (#LH00004039) and by the State of Oregon as a licensed professional counselor (#C1133). My practice is directed to counseling of individual adults and couples. I specialize in working with relationship or marital issues, depression, stress and anxiety problems, pain management, self esteem, and women's issues.

I hold a Master's degree in Education (M.Ed.) and a Specialist's degree in Counseling (Ed.S.) from the University of Florida in Gainesville, Florida. Prior to entering private practice I worked in public and private agencies with adult individuals, groups, families, and couples. I also provided crisis intervention and critical incident stress debriefings. Today, in addition to my private clinical work, I am a consultant for various businesses where I provide training in areas such as communication skills, conflict management, team building, diversity training, sexual harassment, violence in the workplace, leadership and management training, and stress management.

In order to maintain my credentials I am required to obtain continuing education credits in the mental health field. This is important as it keeps me up-to-date on the latest research in the treatment of mental health problems and relationship issues.

CLINICAL ORIENTATION

My clinical orientation is a psychodynamic, systems approach which often includes a cognitive-behavioral focus and experiential or Gestalt techniques. In order to get the most out therapy, I suggest that you follow suggestions made for work between sessions such as writing or working with new behaviors outside of the session. The success of our work together depends much on your own motivation and efforts.

CONFIDENTIALITY

I will keep confidential anything you say to me with the following *exceptions*: 1) you direct me to tell someone else and sign such a release, 2) I determine you are a danger to yourself or someone else, 3) you report child or elder abuse to me, and/or 4) I am ordered by a judge to disclose information.

I consult with a supervising therapist on a regular basis. These consultations are an opportunity to ensure I am providing the best possible treatment for my clients. I never use client's names in these consultations.

CANCELATIONS

In the event you are unable to keep an appointment you will need to notify me 24 hours in advance. If I do not receive such advance notice, you will be billed for the session. Insurance does not pay for missed appointments.

Turn over ⇨

EAP

If you have been referred to me through your company's EAP you have a certain number of sessions that are completely free to you. These sessions are meant to be for assessment purposes only. If you need further sessions beyond the number pre-paid by your employer I will be happy to provide you with other provider's name(s) and other resources to help you resolve the issue which has brought you in.

FINANCIAL RESPONSIBILITIES

My fee is \$120.00 per session. Sessions are 50 minutes in duration. This is standard practice for most therapists. (Sometimes I recommend 90 minute sessions for couples. But we would discuss this together.) The fee is due at the time of service. Cash, personal checks, VISA or MASTERCARD are accepted.

Some insurance carriers may cover therapeutic services. You are responsible for obtaining prior authorization for treatment from your insurance carrier. I will bill your insurance company; however, you are responsible for co-payments and deductibles as set by your benefit plan.

If you are not using insurance for services or become ineligible for insurance coverage, you are responsible to pay the session rate due on the day of service.

CLIENT RESPONSIBILITIES

It is your responsibility to make and keep appointments, to arrive on time, to do any homework assignments to the best of your ability, to be honest and open to communicate difficulties, and to let the therapist know if our work together is not producing the results you had hoped for.

Your signature below also gives permission for: 1) THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR SERVICES RENDERED and 2) DIRECT PAYMENT OF MEDICAL BENEFITS FOR SERVICES RENDERED BY BARBARA ROBINETTE, M.ED., L.M.H.C.

I agree, understand, and will comply with the above statements.:

Clients(s) signature

Date

Barbara Robinette, M.Ed., LMHC

Date

Barbara Robinette, M.Ed., LMHC

955 Officer's Row Vancouver, WA 98661

CLIENT INFORMATION FORM

Today's Date: _____ Who referred you? _____

NAME: _____

MAILING ADDRESS: _____

City State Zip

CELL PHONE: _____

Is it ok to leave a message? Yes No

WORK PHONE: _____

Is it ok to call you at work? Yes No

HOME PHONE: _____ Message ok?

Social Security Number: _____ Age: _____ Birth date: _____

Marital status: _____ Number of children: _____ Ages: _____

Who lives with you?

Table with 3 columns: Name, Relationship to you, Age. Rows 1-6.

Your occupation: _____ Employed by: _____

Highest education level: _____

Spouse/partner's occupation: _____ Employed by: _____

Health Insurance Carrier: _____

Insurance I.D. Number: _____ Under whose name? _____

List current medications and dosage: _____

Who prescribes these medications? _____

Who is your primary physician? _____

Have you participated in counseling before? Yes No If so, with whom? -----

• For what reason? _____

• Has anyone ever complained about your use of drugs or alcohol? Yes No

Have you ever been treated for alcohol or drug abuse? Yes No

If so when?----- Where?-----

Please briefly describe what brought you here today:

Please check the following behaviors and symptoms that occur more often than you would like:

- | | |
|--|--|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Major health problems | <input type="checkbox"/> Loss of interest in life |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Less sexual interest |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Increased alcohol consumption |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Use of non-prescription drugs |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Excessive fear of the future |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Feeling others are out to get you |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Panic | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Eldercare issues |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Grief or loss |
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Anger problems |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Employer's request |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Distractibility |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Self harm | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Overspending | <input type="checkbox"/> Isolating yourself |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Other |

NOTICE OF PRIVACY PRACTICES

For Barbara Robinette, M.Ed., LMHC, LPC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My Legal Duty: I am required by HIPAA law (Health Insurance Portability and Accountability Act, 1997) to give you this notice when my service to you begins. This notice will tell you about the ways I may use and disclose health information about you, and about your rights regarding the use and disclosure of that information.

Your Health Information: This notice applies to the information and records I have about your health including all clinical records, billing information and both written and oral communications about you.

Who Will Follow the Practices Described in this Notice: This notice is about the health information privacy practices followed by Barbara Robinette, M.Ed., LMHC, any contracted professionals who assist me in health care operations, and “on call” professionals.

Questions and Complaints: If you believe your privacy rights have been violated or have other questions or complaints, you may contact Barbara Robinette, M.Ed., LMHC (designated privacy contact) at (360) 694-5820. You may also file a complaint with the U.S. Secretary of the Department of Health and Human Services (address to be provided upon request). *There will be no retaliation or penalty against you for filing a complaint.*

Changes to This Notice: I reserve the right to change my privacy practices and this notice any time, and to make such changes effective for health information already received/created as well as health information received/created after the change. Before a significant change goes into effect, this notice will be revised and new version made available upon request. You may request a copy of this notice any time.

HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED

By State law and ethics of my profession, I must have your informed written authorization to use and disclose health information for the following purposes:

Treatment: I use health information about you to provide you with clinical services. I may use and disclose health information about you to a physician, other healthcare provider, or other mental health professional involved in taking care of you and your health in the past, present or future.

For Payment: I may use and disclose health information about you to obtain payment for services I provide you. **It is my policy to release only diagnoses, date and type of service when you have consented to billing third party payers (usually health insurance companies).** I will ask you to sign a more detailed written authorization for disclosure if more information is requested by a third party payer.

For Healthcare Operations: I may use and disclose health information about you in order to run my practice and make sure you receive quality care. For example, I may contact you to respond to a question or message you have left, or to change an appointment time. Please notify me if you do not wish to be contacted or if there are restrictions you want to make about such contact.

Your Authorization: In addition to the uses and disclosures of your health information described above, you may give me informed written consent to use or disclose your health information to anyone for any purpose. For example, you may wish for me to receive or communicate information about you to a family member, close friend, or employer and therefore would sign a written authorization specifically for that purpose.

Revocation of Consent: You may revoke your authorization any time by written or verbal notice. Your revocation will be effective when I receive it but will not apply to any uses and disclosures that occurred before that time.

EXCEPTIONS AND SPECIAL SITUATIONS

Health information about you may be used or disclosed without your permission in the following circumstances according to applicable State and Federal laws:

To Avert a Serious Danger to Self and/or Others: Health information about you may be used and disclosed when it is necessary to prevent serious harm to your health, safety or that of other persons.

Required by Law: I may use and disclose health information about you when required by law to do so. I am obligated to report to authorities any suspected abuse and neglect of a child or elder, and exposure of a child to domestic violence (unless already reported by you or someone else). Disclosures may be compelled by the U.S. Department of Health and Human Services for compliance and enforcement purposes. Constitutional rights in regard to search and seizure have been compromised under the Patriot Act allowing for the possibility of secret searches without a citizen's knowledge until after the fact.

Lawsuits and Disputes: Health information about you may be used or disclosed in response to a legal *court* order or subpoena. Disclosure will only be made with your informed written consent or if it cannot be avoided because of a court order/subpoena.

Family and Friends: In situations that you are not capable of giving authorization because you are not present or due to incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest according to my professional judgment. Only the health information relevant to the person's involvement in your care would be disclosed. For example if you were in a mental health crisis, I might involve a family member or friend in helping you get to an appropriate care facility.

Additional disclosures are permitted under HIPAA regulations but will not be made by this practice without your authorization. They may be contrary to state law. However, once information leaves this practice and becomes part of any data resource outside my control, HIPAA permits disclosure in the following circumstances:

Research: Health information about you can be used for research projects. You may be asked for your permission if the researcher will have access to identifying information.

Military, Veterans, National Security and Intelligence: If you are or were a member of the military or other national security/intelligence agency, release of health information about you may be required by military command or other government authority. HIPAA also permits release of information about foreign military personnel to appropriate foreign military authority.

Workers' Compensation: Health information about you may be used to determine or deny benefits for work-related injuries or illness.

Public Health: Health information about you may be disclosed for a variety of public health reasons; for example: to prevent or control disease.

Health Oversight Activities: Health information about you may be disclosed to a governmental or private health oversight agency for audits, investigations, inspections or licensing. These disclosures may be necessary for certain federal and state agencies to monitor the health care system, government programs or compliance with civil rights laws. Information Not Personally Identifiable: Health information about you may be disclosed in a way that does not identify or reveal who you are. *Again, note that this practice will not use or disclose your health information without your specific, written authorization except as per the "Exceptions and Special Situations" described above. The HIPAA law allows for broader disclosures that may apply to your health information once it leaves this practice if you have authorized me to release it.*

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to inspect and copy your health information such as clinical and billing records, but not psychotherapy notes or information compiled in reasonable anticipation of, or for use in a legal proceeding. To inspect or copy your health information, you must submit a written request to Barbara Robinette, M.Ed., LMHC, at 955 Officer's Row, Vancouver, WA 98661. A reasonable fee may be charged for the costs of copying, mailing or other associated supplies.

Your request to inspect and or copy may be denied in certain circumstances and you may ask that a denial be reviewed.

Right to Amend: You may ask me to amend health information that you believe is incomplete or incorrect. To request an amendment, simply provide me with a clear written statement of the amendment you request.

Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. Additionally, your request may be denied if you ask to amend information that: Was not generated by me within my practice; Is not part of the health information I keep; Is not permissible for you to inspect or copy; And/or is complete and accurate.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures made of health information about you other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to me (the designated privacy contact). Your request must state a time period not longer than six years or prior to April 14, 2003. More than one request in a year may be subject to a charge of the costs associated with providing the list.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you to someone who is involved in your care or the payment for it, like a family member or a friend. For example, you could ask that I not communicate with a certain family member no matter what the circumstance. To request restrictions, simply advise me of the details either verbally or in writing.

Although I am not required to comply with your request for restrictions, I will honor any reasonable requests unless the information is needed to provide you with emergency services or the law requires otherwise.

Right to Request Confidential Communications: Care is always used in my practice to protect the confidentiality of your health information in communications. Additionally, you have the right to request that I communicate with you about your health information in a certain way or at certain locations. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you may simply tell me verbally or in writing of the details of your request.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice and may ask for a copy any time. Simply ask to receive a copy.

Acknowledgment of Receipt of:

Notice of Privacy Practices for Barbara Robinette, M.Ed., LMHC

****You may decline to sign this acknowledgment****

I, _____ have received a copy of
The "Notice of Privacy Practices for Barbara Robinette, M.Ed., LMHC

Signed: _____ Date: _____

For Office Use Only:

Acknowledgment of receipt of notice not obtained because:

____ Client or guardian declined to sign

____ Communication barriers

____ Emergency situation

____ Other: _____
