NEW VISION COUNSELING

Client Name: _____Date: _____

Parent/Legal Guardian (under 18): _____

Client Address: _____

City: _____Zip: _____

May we have permission to send mail to this address? Yes No

Client Phone: _____Can voice mail be left at these numbers? Yes No

Email: _____Authorized email correspondence? Yes No

Date of Birth:_____Employer: _____

Occupation: _____ Marital Status: _____

Primary Care Physician: _____ Phone:_____

What are you seeking counseling for?_____

On a scale of 1-10 with 10, being the worst, rate this problem: _____

Medications and their reasons for use:

_____

Name of financially responsible person/policy holder: _____

Relationship to Client: _____Insurance Carrier: _____

EAP Authorization# if application: _____Number of sessions: _____

Date of Birth of Policy Holder:_____ Employer: _____

Insurance Identification #: _____Group #: _____

How many alcoholic drinks per week _____Do you think you have a problem with alcohol? Y N

Do you use marijuana Y N Other drugs _____Do you think you have a problem? Y N

How did you find us? _____

Emergency Information

Person to contact: _____ Relationship: _____

Phone: _____

NEW VISION COUNSELING

Service Agreement/Treatment Consent

Welcome to our practice. The decision to begin counseling services can be a difficult one. By making this decision you have made a commitment to your well-being and to the improvement in your relationships with yourself and others. We look forward to working with you!

The following materials will provide you with important information about our professional services and business policies. Please read it carefully and feel free to ask us any questions you might have. When you sign this document, it will represent an agreement between us. You will receive a copy of this form to take home with you for future reference. Please bring this form to your first session.

Professional Services

The clinical staff at New Vision Counseling are licensed and experienced mental health providers. Our clinicians are trained to provide assessment and counseling services to adolescents, adults, couples and families that are struggling with a wide range of mental health concerns. Your first appointment is considered to be an intake assessment during which time your clinician will ask you to complete some paperwork and answer questions pertaining to (but not limited to) your current problem, past psychiatric history, any prior treatment, family history and desired goals for the future. If following this appointment, mutually agreed upon treatment goals are identified then your clinician will continue to work with you in subsequent sessions. Your therapist may feel at any time during your treatment that it may be best to refer you to another provider and you are free to terminate therapy at any time.

Your therapist has the responsibility to ask you questions about you and your family's history, as well as your thoughts, feelings and actions. We also have the responsibility to provide you with direct information about treatment as well as clinical recommendations.

Therapy sessions are typically 45 or 55 minutes in length. The length and frequency of sessions depends on clinical need and can be discussed with your clinician at any time during your treatment. The best outcome is achieved through a collaborative effort between you and your clinician.

We do not provide forensic services such as custody evaluations, ability to stand trial, etc. We do not attend court hearings, depositions, etc. We also do not provide prescriptive letters for emotional support/therapy animals and we do not do disability and/or FMLA paperwork.

Financial Policies

Co-payments, deductibles and ALL out-of-pocket session fees are due at the time of service. It is your responsibility to know what your specific insurance plan covers and what your responsibility is as the subscriber. Many of the newer plans now have large deductibles/co-insurance. Some plans may not reimburse for specific procedural codes and/or diagnostic codes. Please review your benefits carefully. You are responsible for any and all denials from your insurer regardless of the reason for the denial. Our office manager will pre-verify your benefits for you, provided we have this information prior to your first

appointment. Please note that we do not always get accurate information from insurance representatives so it is crucial that you are aware of your specific benefits and policy limitations.

Insurance and EAP coverage depends on the provider you see. If the provider is not contracted with your insurance plan you will be provided (upon request) with a receipt for payment (superbill) that you may use to file a claim for out-of-network benefits. We do not file claims for out-of-network plans and we do not accept payment from insurers that we are out-of-network with.

New Vision Counseling accepts cash, checks, all major credit cards as well as HSA cards. Per policy, a credit card MUST be kept on file for all privately insured and self-pay clients for missed appointments (see Missed Appointment Policy). We encourage all clients to also leave a credit card or HSA card on file for copayments and deductibles as this streamlines the payment procedure and reduces the need for remembering payment at each session.

Returned checks will be assessed a $25 administrative fee as well as any bank charges. All accounts become overdue after 30 days if no payment arrangements have been made. We will make every effort to cooperate with you if you have special financial concerns. Severely past due accounts may be sent to a collection agency and any collection costs will be added to what is owed.

Professional Fees

Self-pay/out-of-network fees for therapeutic services range from $75-$150/session. All other services such as (but not limited to) extended treatment summaries, complex forms/letters, and phone calls in excess of 15 minutes are charged at $100/hour. These are considered out-of-pocket expenses and are not covered by insurance.

Missed Appointment/No-Contact Policy

If you need to cancel an appointment, it must be done within 24 hours advanced notice. If this does not occur, a cancellation/"no show" fee of $100.00 will be billed to you personally. Please review and sign our Missed Session Policy Agreement.

Please note that if you late cancel or miss 3 or more appointments, your therapist may decide to terminate treatment. You will be provided with outside referrals for continued care.

If we do not receive any contact from you in a 30 -day period, we will assume you are no longer interested in services and your case will be closed.

Court Related Services

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

• We charge $250/hour to prepare for and/or attend any legal proceeding and for all court related services.

• Charges for court related services are not covered by insurance.

• Court related services include (but are not limited to): talking with attorneys, preparing documents, traveling to court, depositions and court appearances.

• If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters.

• You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

Limits of Confidentiality

The confidentiality of your records is highly valued. The law protects the privacy of communications between a client and therapist, although, some situations are excluded by law. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or other Federal or State law.

Limits to preserving confidentiality include the following:

• If you have a managed health insurance policy, it will usually provide some coverage for mental health treatment or assessment. If you choose to use this mental health coverage your insurance company, external gatekeeper and quality assurance committee may review your records for quality and/or appropriateness of care. Required information will also be released to your insurance company upon the start of care to facilitate payment.

• If we know or have reason to suspect, that a child under 18 years of age is or has been abused, abandoned or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law mandates that we file a verbal and written report with the Department of Children and Families (DCF). Once a report is filed, we may be required to provide additional information.

• If we believe that there is a clear and immediate probability of physical harm to the client, other individuals or to society we may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member and/or the police.

• If such situations arise, we will make a reasonable effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Complaints/Questions

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully. If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment

communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at audrey@newvisioncounseling.net.

• Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

• Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

• Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

• Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate

reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

• Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

• Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 40 Lake Bellevue, Suite 100, Bellevue, WA 98005 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is February 28, 2018

CONSENT AND ACKNOWLEDGEMENT FORM OF PRIVACY PRACTICES

By signing below, I understand and acknowledge that I have read this consent and have been given the Notice of Privacy Practices.

_____

Print Name of Individual or Personal Representative

_____ _____

Signature of Individual and/or Personal Representative Date

If signed by the Personal Representative, describe the legal authority you have over the individual (i.e., parent, guardian, etc) and print the name of the individual.

_____

CONSENT AND ACKNOWLEDGMENT FORM OF SERVICES AND TREATMENT CONSENT

I HAVE THE READ AND UNDERSTAND THE ABOVE INFORMATION AND BY SIGNING THIS FORM I ACCEPT AND FULLY AGREE TO BE TREATED ACCORDING TO THE ABOVE CONDITIONS AND CLIENT/THERAPIST RESPONSIBILITIES.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date Signature of Witness Date

(Mandatory for clients under the age of 18)

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, I hereby request that New Vision Counseling communicate with me regarding my treatment via email. I understand that this means New Vision Counseling will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications (texting is appointment scheduling only).

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted but reasonable efforts will always be made to keep protected health information encrypted/private. New Vision Counseling utilizes the Paubox platform for secure and encrypted email messaging. Per policy, New Vision Counseling does not transmit any protected health information (PHI) through text messaging. **Please do not contact us through text** messages. If you need to contact your therapist between sessions, please call 425-209-1212 or utilize our secure email service. As the electronic transmission of information can never be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, New Vision Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by New Vision Counseling.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept or respond to friend or contact requests from current of former clients on any social networking sites including; Twitter, Facebook, LinkedIn, etc. We will not solicit testimonials, ratings or grades from clients on websites or through any means. After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize New Vision Counseling to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from New Vision Counseling, I may revoke this authorization by providing written notice to New Vision Counseling, 40 Lake Bellevue, Suite 100, Bellevue, WA 98005.

I agree that New Vision Counseling may communicate with me electronically unless and until I revoke this authorization by submitting notice to new Vision Counseling in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties. I hereby authorize the transmission of my protected health information electronically as described above.

_____

Printed Client Name

_____ _____

Client Signature Date

MISSED SESSION POLICY

A cancelled appointment hurts three…you, your therapist and another client. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. In addition, we are unable to bill your insurance company for sessions that are not kept.

A fee of $100.00 will be charged when you miss or cancel an appointment without giving 24 hours advanced notice. This means that if an appointment is scheduled for 3pm on a Tuesday, notice must be given by 3pm on Monday. You can cancel your appointment by calling or emailing your specific therapist.

The only time we will waive this fee is in the event of serious or contagious illness or extreme weather. Missed appointment fees will be automatically charged to the credit card on file, following a 3-day grace period from the date of the scheduled appointment. This 3-day grace period allows you to be able to get in touch with your therapist to reschedule and/or discuss the reason for missing the appointment. During this grace period, you can choose to pay the fee with another form of payment other than the credit card on file and/or ask for a payment plan. If you do not contact us to reschedule or make other payment arrangements within 3 days, the credit card on file will be charged.

Our agreement with EAP companies is that we are not able to bill for missed appointments, therefore it is very important that you provide us with advance notice if you are not able to attend your session.

Treatment may be reevaluated and/or terminated when any client misses 3 or more consecutive appointments or is frequently missing appointments over the course of treatment.

Thank you for your understanding.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

CREDIT CARD AUTHORIZATION/BILLING FORM

Credit Card Type (please check one):

VISA MASTERCARD AMEX DISCOVER

I authorize New Vision Counseling to:

Bill this credit card for my copayment/coinsurance and/or deductible responsibilities.

Bill this credit card for missed session fees and any out-of-pocket payments and/or denials not covered by my insurance.

Credit Card Number: _____

Exp. Date: _____

3-4 Digit CCV Code: _____

Name of Cardholder (as it appears on the card): _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event the indicated person, company or association fails to pay for any part or the full amount of these charges. I am an authorized user of the credit card and I will not dispute the payment with the credit card company so long as the transaction meets the terms of the authorization.

CARD HOLDER SIGNATURE: _____ DATE: _____

If not using a credit card for copayment/deductible fees, please indicate how you wish to make payment (all session fees are due at the time of service).

Cash Check