

HARBOR VALLEY COUNSELING

Kathy Pregnall, MA, LMHC, CMHS, CCTP

Client Name: _____ DOB: _____ Age: ____ Sex: F ☐ M ☐ SSN# of Guarantor: _____

Marital Status: Single ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed ☐ Separated ☐

Person filling out form if not client: _____ Relationship to Client: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer/School: _____ Phone: _____

Home Phone: _____ Can a message be left? Yes ☐ No ☐

Cell Phone: _____ Can a message be left? Yes ☐ No ☐

Email: _____ Can a message be left? Yes ☐ No ☐

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

FAMILY INFORMATION (Others in household)

DOB

Relationship to Client

FAMILY INFORMATION (Others in household)	DOB	Relationship to Client
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

If client is a child, is he/she the subject of custody proceedings? Yes ☐ No ☐

Referred by: _____

INSURANCE INFORMATION

Primary Insured _____ Subscriber Name: _____ Relation: _____

DOB: _____ SSN: _____ Employer: _____

Policy Number: _____ Group number: _____

SECONDARY INSURANCE _____ Subscriber Name: _____ Relation: _____

DOB: _____ SSN: _____ Employer: _____

Policy Number: _____ Group number: _____

By completing this form, my signature indicates that the information provided is true and accurate. If the client is a minor child, I certify that I have the legal authority to authorize treatment.

Form Completed by: _____ Date: _____

Signature: _____

HEALTH INSURANCE CONSENT

Your health insurance may pay for part or all of your therapy, but the benefits cannot be paid until your health insurance authorizes this. If you choose to use your health insurance to pay for therapy, you must allow your therapist to communicate with your health insurance company about your treatment recommendations, progress during therapy, and about how you are doing in many areas of your life. This information is considered Protected Health Information (PHI). All of this information will become part of the health insurance records.

Your health insurance may set limits on the kinds of therapy your therapist can provide to you and can refuse to pay for services. You or your therapist can appeal the health insurance's decisions on payment and number of sessions. The health insurance will approve therapy aimed at improving the specific symptoms that brought you to therapy. If your health insurance authorizes your therapy, it may limit the number of therapy sessions within a calendar year. It may not agree to more sessions, even if your therapist feels they are needed to fully relieve your presenting issues. The health insurance company in charge of your medical and mental health benefits can change during the course of therapy. If this happens your therapist may have to go through the authorization process again. It is possible that the benefits or coverage for your therapy may change and your part of the costs may change as a result. **It is your responsibility to let your therapist know when your benefits change. In the event that your claims for services is denied, or payment is retracted, then payment for services rendered becomes the patients/guardians responsibility.**

In some cases, your therapist is required by your health insurance to contact your physician. This PHI is allowed to be shared under HIPAA and state regulations without consent (RCW 70.02 Medical Records).

By signing this form, you give your therapist permission to submit PHI in order to secure payment for mental health services. You agree to have payment from the health insurance be sent directly to your therapist. You are aware that this may include faxing; sending encrypted PHI through Office Ally, our billing software vendor; and possibly exchanging information with your health insurance through HIPAA compliant emails. **In the future we may change how we use and share your PHI and we may change our Notice of Privacy Practices. If we change it, you can get a copy from our website, www.harborvalleycounseling.com or by calling us at 360-362-6219.**

If, after reading this consent information and discussing with your therapist, you are concerned with any of the above, you have the option to pay your therapist directly and not use your mental health benefits. A separate document for "Opting Out" of your insurance benefits will be required. This means your PHI will not be shared with your health insurance. By signing below, you indicate that you understand the issues described above and willingly enter therapy accepting these limits.

INFORMED CONSENT

We are pleased to offer you therapy services and look forward to working with you. As with any treatment, there are some risks as well as many benefits with therapy. You should think about the benefits and risks when making any decisions. You should understand that developing a treatment plan with your therapist and regularly reviewing your progress toward meeting the treatment goals are in your best interests. You agree to play an active role in this process. You understand that no promises have been made as to the results of treatment or of any procedures provided by your therapist. You are aware that you may stop your treatment with your therapist at any time. You will still be responsible for is paying for the services that you have already received.

APPOINTMENTS: The usual sessions are 45-55 minutes. Appointments can be made or rescheduled with the office staff. When office staff is not available, you may be able to schedule directly with your therapist. Please leave any messages regarding scheduling in the receptionist voice mail when possible. If your therapist is unable to start on time you will receive the full time agreed to. If you are late, we will be unable to meet for the full time because it is likely that your therapist will have another appointment after yours. Twenty-four (24) hour notice is required for cancellations. **Failure to provide such notice will result in you being charged for the appointment. You will be responsible for the contractual payment to your therapist.**

FEES: Initial session will be \$325. Continuing sessions will be \$275 to \$300 depending on time utilized and type of treatment. If you would like us to bill your insurance company or other third party, you are responsible for providing information, referral forms, etc., needed for reimbursement. You are responsible for any deductible and co-payment amounts, which are to be paid at the time of service unless other arrangements are specifically made with your therapist.

FOR PRIVATE PAY PATIENTS, PLEASE ASK YOUR CLINICIAN FOR A CURRENT FEE SCHEDULE.

If your health insurance fails to provide reimbursement, you will be responsible for the full cost of services provided. Outstanding balances not paid within 60 days are subject to a \$5 per month re-billing fee. **WE WILL ATTEMPT TO SUBMIT SECONDARY CLAIMS FOR UNCOVERED CO-PAYMENTS, HOWEVER IF DENIED, IT IS YOUR RESPONSIBILITY FOR PAYMENT, AND STATEMENTS WILL BE PROVIDED FOR YOU TO SUBMIT TO SECONDARY AND TERTIARY CARRIERS FOR REIMBURSEMENT.** Any questions about fees should be discussed with your therapist. In the event of a refund, any monies due to you will be sent no later than 60 days from discovery. Delinquent accounts may result in termination of services and/or assignment of the account for collection with a collection agency of therapist choosing.

PLEASE NOTE: When treating a child, it is NOT up to us to determine which parent is responsible for payment, nor any split payment (or other provision) that may be court ordered. Whichever parent brings in the child will be responsible for payment at the time of service.

RECORDS AND COPYING: Your therapist has up to 14 working days to retrieve and copy records. Your therapist will keep your records for the length of time required by law unless your therapist is contractually obligated by your insurance company to keep them longer. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but you may be charged for it. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You must make this request in writing and send it to your therapist. You must tell your therapist the reasons you want to make the changes. However, a therapist has the right to deny access to your PHI health care information if a therapist believes sharing this information could reasonably expect to cause danger to the life or safety of any person (RCW 70.02.090).

\$25 Clerical Fee

\$1.12 cents per page for the first 30 pages

\$0.84 cents per page for all other pages starting with page 31

CONFIDENTIALITY: The counselor-client relationship is legally privileged; all issues discussed in therapy are confidential. A written consent needs to be signed in order to release any records or information about your therapy, except as what was discussed in the "Consent to Your Health Insurance" section or as provided for by current law. Your therapist will not tell anyone about you and will not reveal that you are receiving therapy. In the case of family/marital therapy, your therapist will treat everyone involved as the client requiring that everyone in attendance

to sign a release of information. In all but a few situations, your confidentiality is protected by federal and state laws. Here are the most common cases in which confidentiality is NOT protected:

- 1) If this therapist believes or has suspicions that a child under 18 years of age or an elder has been or will be abused or neglected, the therapist is legally required to report this to the authorities. This is under RCW 26.44.
- 2) If the client makes a serious threat to harm themselves or another person the law requires this therapist to try to protect the client or the other person from imminent harm. This is under RCW 26.44.
- 3) In the case of death or disability of the client, the client's personal legal representative can authorize release of records.
- 4) The Department of Health can access the client's records when they are investigating a grievance or to determine compliance with the therapist's licensure.
- 5) In the event that your records are subpoenaed by a judge or a judicial officer, information must be released.

Please tell us if you have other concerns. You have the right to refuse consent or withdraw consent, in writing.

TEENAGERS: RCW 71.34 allows teens to consent for their treatment and the release of PHI. Sharing of any sensitive information can result in a significant lack of trust and negatively impact the counseling process. When working with teens (13-18 years of age), the therapist will not share information with parents without a current release of information signed by the teen. A written consent must be signed by the teen in order to release any records or information about their therapy, except as what was discussed in the "Consent to Health Insurance" section or as provided for by current law. For example, as a mandated reporter, if any abuse, suicide, or homicidal intentions arise, parents will be notified along with required authorities. Please be aware that without consent from your teen, these are the only situations where the counselor can break confidentiality. In some cases, scheduling and billing may be discussed with the parent/guardian.

ELECTRONIC/SOCIAL MEDIA: Your therapist will not accept any invitations for any social media or video games. Therapy sessions cannot be audio or video recorded unless your therapist and all parties sign a recording consent form. This is to protect your confidentiality and to keep the boundaries of therapy clear.

COMPLAINT PROCEDURES: Problems can arise in the therapy relationship. If you are not satisfied with any area of your work, please raise your concerns with your therapist at once. Therapy together will be slower and harder if your concerns are not worked out. Your therapist will make every effort to hear any complaints you have and to seek solutions to them. If you continue to feel your concern has not been resolved you can also contact Washington State Department of Health to help with your concerns (360-236-4700; www.doh.wa.gov).

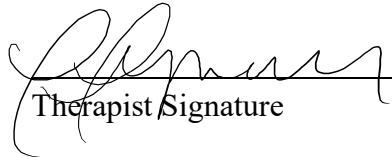
PHONE CALLS: Your therapist will spend most of his/her working hours in session and will be difficult to reach directly. Therapy is conducted during person-to-person sessions. If you have a problem that cannot wait until your next appointment, you may leave a message for your therapist directly. Please keep in mind that your therapist has varied working days and typically they do not check their voicemails when they are not working.

EMERGENCIES: Harbor Valley Counseling does not provide Crisis Response. When your therapist is away from the office, you may leave a voice message of a non-emergent nature. The nature of our therapy practice does not allow the therapist to provide emergency services. If you are experiencing a crisis, or in the case of a life-threatening emergency, call 9-1-1 or go to the nearest emergency room.

TERMINATION: If you intend to terminate, one final session is requested for concluding the therapy experience. You should make every effort to discuss any concerns with your therapist before ending therapy. At the conclusion of therapy, this agreement shall be concluded. Your resumption of therapy with the same therapist at shall require a new and separate agreement.

I, the client (or his/her parent or guardian), acknowledge that I have read, and understand the informed consent and/or other information about therapy. I have been informed about my privacy rights and PHI disclosure under the Health Insurance Portability and Accounting Act (HIPAA) by reading the complete description of the Notice of Privacy Practices (available in the office in print form or on the office website www.harborvalleycounseling.com.) I have had all my questions answered fully. If I have any future questions about any of the subjects discussed in this informed consent, I can talk to my therapist about them. My signature below shows that I understand and agree with all of these statements. I, the client do hereby agree to enter into therapy with the therapist indicated below, and to cooperate fully and to the best of my ability. I understand that I may revoke this consent in writing at any time, except to the extent that your therapist has taken action relying on this consent.

Responsible Party/Client Signature



Therapist Signature

Date

Additional Legal Parent/Guardian Signature

Date

☐ Copy accepted by client ☐ Copy accepted by additional person

****THIS FORM IS REQUIRED WHEN THERE ARE MINOR CHILDREN, EVEN IF THEY ARE NOT IN THERAPY***

AGREEMENT OF PARENTS/GUARDIANS IN CASES OF CUSTODY PROCEEDINGS

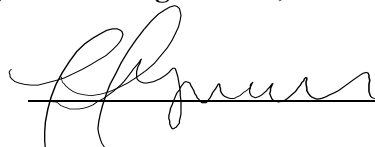
Therapy can be a very important resource for children experiencing separation and divorce. The therapist can provide an emotionally neutral setting in which children can explore these feelings. In this case, a child cannot be seen unless both parents agree to the child receiving therapy. An exception to this is if one parent has legal documentation (e.g., a legally signed parenting plan) stating they have sole decision making for mental health and medical treatment for the child. The parent would be required to provide a copy of this document to the therapist. However, the usefulness of therapy is extremely limited when therapy itself becomes simply another matter of custody dispute between parents. Any matter that is brought to the therapist's attention by either parent regarding the child may be revealed to the other parent unless otherwise stated in the parenting plan. It is requested that all parents or guardians remain in frequent communication with the therapist regarding the child's emotional well-being.

The therapist will not choose sides and cannot render a forensic opinion. The parent must understand completely that the therapist is providing treatment and is not acting as an evaluator. The parent must further understand that the therapist is not conducting a custody, visitation, or parenting evaluation. Both parents agree to not involve the therapist in any custody or visitation disputes, and understands that would not be in the best of interest of their therapy relationship and would be counterproductive to the therapeutic process. The therapist will not write letters to any attorney or share records without a subpoena requiring such records to be released.

I have read and understand the issues and points made above. I have discussed those points I do not understand and have my questions answered. I agree to act according to the points covered in this form. I am the legal custodian of this child and have no court orders in effect that would prohibit me from consenting to the treatment of this child. I also understand that the therapist can rely on my representation that I am authorized to consent to health care for the minor patient as true without incurring any civil or criminal liability for such reliance, pursuant to RCW 70.02.130. My signature below indicates I agree to these points and follow fully to the best of my ability.

If you do not sign or all legal parents/guardians do not agree to this agreement, we cannot treat your child.

Legal Parent/Guardian Signature



Therapist Signature

_____ Date

_____ Additional Legal Parent/Guardian Signature

_____ Date

☐ Copy accepted by Legal Parent/Guardian ☐ Copy accepted by Additional Legal Parent/Guardian

Therapist Disclosure

Kathy Ann Pregnall, MA, LMHC, CMHS, CCTP

Washington License No. LH00010665

Purpose of Disclosure Statement

This statement provides information about me and the treatment offered to assist you in selecting the provider and treatment which best suits your needs. It is every client's right to refuse or discontinue treatment. Every client has the right to choose a practitioner and treatment modality that best suits his/her needs. Please read the following information and discuss any concerns with me or the office staff

Education/Training/Experience

I hold a Masters Degree in Psychology Counseling, from City University in Bellevue, WA. I have also completed graduate studies at Pacific Lutheran University in Marriage and Family Therapy. I am a Licensed Mental Health Counselor, Child Mental Health Specialist and a Certified Clinical Trauma Professional I have been a practicing clinician working with children, adolescents, adults, couples, and families for over 23 years.

Treatment Orientation and Methods

My therapeutic orientation is based largely on a client centered approach to treatment. I put emphasis on joining with the client and/or client family, at times resulting in a team approach to treatment, which identifies individual and family strengths and inner resources. In doing so, it is my opinion that we can work towards growth and healing. I will be offering suggestions and providing guidance to facilitate change and growth. I urge you to make the most of the planned activities, appointments, and assignments, including active involvement on your part and full participation of all those involved.

The scope of my practice includes but is not limited to: Crisis intervention and safety planning, parent/caregiver education, parent-child interactions, blended family and divorce issues, high risk adolescent behavior, youth and families affected by foster care, adoption issues, ADHD, managing anxiety and stress, recovery from physical, sexual and/or emotional abuse, as well as collaboration with schools, juvenile justice, DSHS, and other community partners.

My treatment methods include utilizing an educational component, as well Trauma Focused Therapy, Narrative, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Solution Focused Therapy, guided imagery, and family systems therapy. I am also trained in methods to assist parents in strengthening nurturing attachments with adoption and foster children.

The length of time that individuals and families participate in therapy varies with the extent and type of issues that need to be addressed and the speed in which individuals and families are able to effect change and/or resolve issues. In light of this, it is not possible for me to determine the length of the therapy at the beginning of the process. It is also not possible for me to determine which methods may be most effective or what specific results you may attain at the beginning of therapy. Instead, we will maintain an ongoing dialogue as to the progress and outcomes of your treatment.

Electronic Health Records

I use secured electronic storage to store all client records. Additionally, I use Office Ally for billing. This business is certified HIPAA compliant. I will keep your records for the length of time required by law unless I am contractually obligated by your insurance company to keep them longer.

Communication with Your Therapist

I do not communicate electronically, with the exception of non-emergent emails. I will return phone calls at my earliest convenience. My voice mail is confidential and HIPAA compliant. I do not provide crisis response, and if you are calling with an emergency or urgent matter, please call 911.

_____ INITIALS

Consultants

I sometimes consult with other professionals about my clients. This helps me provide high-quality therapy. These professionals are also required to keep your information private and confidential. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.

_____ INITIALS

State requirements

Therapists practicing counseling for a fee must be licensed with the Department of Licensing and the Department of Health for the protection of the public health and safety. Licensure of a therapist does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment. The full law and regulations can be found in RCW 18.19.

Consent

I have read all of the above information and have received clarification as needed. I agree to the terms as stated above. I hereby enter into therapy with this therapist and to cooperate fully and to the best of my ability, as shown by my signature below.

Responsible Party/Client Signature



Therapist Signature

Date

☐ Copy accepted by client

☐ Copy accepted by additional person