TouchStone
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Where healing begins

Couple & Family

Welcome to Touchstone Behavioral Health, where healing begins.
For your first appointment, please complete this packet
and provide insurance card and photo ID.

**Please note that a parent/guardian must sign consent forms for children age 12 and under. Children age 13 and over must sign their own consent forms.

288 Martin St., Ste 100, Blaine, WA 98230 & 6046 Portal Way, Ste 104, Ferndale, WA 98248
Phone: 360-788-4228 Fax: 360-778-1423 - www.touchstonebhc.com
Revised 1/22/2020

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Billing and Scheduling for Couples and Families

In an effort to help Touchstone Health Clinic bill the appropriate party/parties, please provide the following information:

Appointments to be scheduled under (Name): _____

Name of **insurance(s)** you would like to use for these visits?

_____

_____

_____

Please have all parties 18 or older fill out their own Client Demographics. (You can request extra from the front desk). We will need insurance cards and photo ID's from all parties 18 and older.

Even if we are not billing all parties, we need to have demographic and insurance information for our records. If you are seen for Couples or Family counseling, you will have your own file with limited records indicating attendance/participation.

When calling to schedule, please indicate the family members that will be attending the session.

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CLIENT DEMOGRAPHICS

Site: ___ F ___B BHAP #_____

THERAPIST NAME: _____ Date file opened: _____

Client name		
Date of birth		
Address		
City, State, ZIP		
Phone Number		
Ok to leave a message at above #? Circle one: Yes No		
Email		
Race/Ethnicity (optional)	Sexual Orientation (optional)	
Gender Identity (optional)		
Emergency Contacts	Name: Number: Name: Number:	

INSURANCE INFORMATION

Primary Insurance	
Policy Number	
Group Number	
Phone #	
Secondary Insurance	
Policy Number	
Group Number	
Phone #	

Person responsible for bill:	

****COPY ALL INSURANCE CARDS & PHOTO ID FRONT AND BACK**

DIAGNOSIS(s) (ICD-10): _____ _____ _____ _____ _____

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CLIENT DEMOGRAPHICS

Site: ___ F ___B BHAP #_____

THERAPIST NAME: _____ Date file opened: _____

Client name		
Date of birth		
Address		
City, State, ZIP		
Phone Number		
Ok to leave a message at above #? Circle one: Yes No		
Email		
Race/Ethnicity (optional)	Sexual Orientation (optional)	
Gender Identity (optional)		
Emergency Contacts	Name: Number: Name: Number:	

INSURANCE INFORMATION

Primary Insurance	
Policy Number	
Group Number	
Phone #	
Secondary Insurance	
Policy Number	
Group Number	
Phone #	

Person responsible for bill:	

****COPY ALL INSURANCE CARDS & PHOTO ID FRONT AND BACK**

DIAGNOSIS(s) (ICD-10): _____ _____ _____ _____ _____

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DISCLOSURE STATEMENT TOUCHSTONE BEHAVIORAL HEALTH

Contact Information
You may leave a voice message at the clinic at 360.788.4228 x 1 or e-mail the Clinical Director at ecreydt@touchstonebhc.com if you would like to be transitioned to another counselor. The Clinical Director will return your call/e-mail ASAP. With your permission, we may send email appointment reminders. We do not provide communication via text message. Please be aware that if you decide to communicate via e-mail, messages exchanged over the internet through e-mail are not encrypted and thus confidentiality cannot be guaranteed due to the nature of the openness of the internet. If you ever choose to communicate with us via email, you assume the risks of and responsibility for keeping such communications private.

Emergencies
If you have a life-threatening emergency, please dial 911. If you are experiencing a mental health crisis, please call Crisis Care Line at 1.800.584.3578.

Patient Bill of Rights
- To receive quality medical, behavioral and mental health services regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
- To seek a consultation with a mental health provider of choice.
- To be treated with respect by Touchstone Health Clinic
- To information contained in your medical record (except when exempt under State and Federal Law).
- To have a right to participate in decisions involving your health care.
- To use your own resources to purchase the care of your choice.
- To refuse medical treatment even if it is recommended by the physician(s) or provider.
- To personal privacy. Any discussion consultation, examination and/or treatment regarding your care will be done discreetly.
- To confidentiality of your medical record and other information related to your medical condition.
- To be informed about your medical condition, the risks and benefits of treatment and appropriate alternatives.
- To receive full disclosure of your insurance plan in plain language.
- To be see in a safe and clean environment.
- To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

Patient Responsibilities
- To provide, to the best of your knowledge, complete information about your symptoms, past illnesses, medications and other matters relating to your plan of care.
- To schedule and keep your appointments, or to call to cancel your appointment in a timely fashion.
- To arrive on time, if you do not arrive on time, you acknowledge that your appointment time may be cut short, and/or your appointment may have to be rescheduled.

- To notify the clinic of any demographic changes, including but not limited to, changes in insurance coverage, address, and phone number.
- To ask questions when you do not understand explanations about your care or services.
- To be responsible for your actions if you refuse treatment or do not follow your providers instructions.
- To follow the organizations policies.
- To be courteous and considerate of Touchstone Health Clinic personnel and other patients.

Touchstone Policies

Your counselor is happy to work with you throughout the therapeutic process. Please be aware that your participation in counseling is voluntary and that you may terminate these services at any time (without any additional cost). You will always maintain the right to select another counselor. You have the right to ask your counselor to review your treatment approach at any time and you may request changes as you deem appropriate. You have the right to review your records and, upon written request, you may receive a copy at any time.

Counselors practicing counseling for a fee must be registered, certified, or licensed with the department of health, for the protection of the public health and safety. However, doing so does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. Some providers at Touchstone Health Clinic are master's and doctorate level students providing counseling under supervision as part of a clinical internship, practicum, or externship.

The Counselor Credentialing Act regulates counselors in order to provide protection for public health and safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. If you ever have any questions or concerns about your treatment or these policies, please let us know. We will work with you to address your concerns. Unresolved complaints may be directed to the Washington State Department of Health, Health Systems Quality Assurance, PO Box 47857, Olympia, WA 98504 or 360-236-4700.

Washington state law allows minors age 13 and older to access mental health services without parental consent or notification. While we encourage open family communication, we can communicate with the parents of minors age 13 and older only when the client consents, unless otherwise authorized by law.

Additional information about can be found in our HIPAA notice of privacy practices and your counselor's individual disclosure statement. If you are participating in family, couple, or group counseling, an additional consent form will also be provided. You will be asked to sign all of these forms. Failure to sign the forms will be noted, and Touchstone Health Clinic staff will continue to abide by the policies described within.

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Fee and Payment Information

The clinic is a preferred provider with most insurance plans. If we are not paneled with your insurance plan, we can submit the claim to your insurance company if you have an out-of-network benefit. If you have any concerns about your coverage, please contact the clinic to discuss these concerns. Ultimately, you are responsible for knowing your plan and agreement with your insurance company regarding portions you are financially responsible for. Outstanding balances will be billed to your credit card on file or your home mailing address, unless you make specific other arrangements for billing and payment. If we are unable to secure payment or a payment plan, unpaid balances may be forwarded to a collections service for payment collection.

Fees are based on time and complexity per patient, per encounter. Touchstone Health Clinic cannot guarantee insurance coverage for services rendered. Touchstone Health Clinic cannot guarantee that these will be the only services rendered to a patient, services rendered are on a as medically necessary basis.
Estimated Mental & Behavioral Therapy fees:

-Intake Interview (Individual/Couple/Family): $250+
-Individual Counseling (2nd session fee and beyond): $200+
-Group Counseling: $150+ for total group or $35 per individual (if individually paying)
-Couples Counseling: $150+
-Family Counseling: $150+
-Sliding scale fee is available via application (to be discussed during consultation)
-Missed Appointment Fee $35.00 (if not cancelled within 24 hours prior to appointment time)

In the event that you are unable to keep an appointment, please notify your counselor via phone 24 hours in advance (if possible). If you miss an appointment without giving prior notice, you may be required to pay the missed appointment fee. If you are late, the session will end at the regular ending time and you will be required to pay for the entire session, however. In the event of multiple missed appointments, your counselor may not be able to continue scheduling with you. In this case, you may contact the clinical director to discuss options, including a new intake with a counselor with caseload opening, if available.

In the event of an emergency on the part of Touchstone staff, you will be contacted to reschedule the appointment.

Limits of Confidentiality

All records relating to our sessions will be kept confidential, with the following exceptions:

1. I will release information to your physician, attorney, other mental health professional, or others if you sign a release of information form,
2. By using your insurance to pay for an appointment, you are authorizing the release of certain information to allow for the processing of insurance claims,
3. If you present an imminent threat to yourself or another person,
4. In cases of suspected abuse or neglect of a child or vulnerable adult,
5. If you are involved in litigation, we may be required to release records,

6. Under court order,
7. As otherwise authorized or required by law. See notice of privacy practices for more information.

At Touchstone Health Clinic, we provide counseling services. As such, our providers are supportive, empathic, and accepting of the client's perspective. Touchstone Health Clinic does not provide forensic evaluations. Clients who are seeking evaluations and recommendations related to litigation of any kind should seek the services of a forensic evaluator. This is not a service provided by Touchstone Health Clinic. We are happy to treat you, but we cannot provide letters, declarations, affidavits, testimony, or information in any form that indicate causation of a client's condition, make recommendations for legal purposes, or serve as an objective evaluation. At a client's request, and with a signed release of information, Touchstone Behavioral Health will release the treatment record. Clients who are involved in litigation should understand that once a person puts their mental or physical condition in issue in a law suit, they may automatically waive their privilege of confidentiality, and their record of treatment will be available to the other side. We will comply with court orders to supply client records. Clients should consult with an attorney to understand the specifics of confidentiality and privilege related to their specific case.

Informed Consent:

By signing below, I indicate that I have read, understand, and have had the opportunity to have my questions answered about and receive a copy of this disclosure. I agree to the above policy and terms, give my informed consent to receive counseling, and understand the limits of confidentiality. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

PRINT CLIENT NAME(S): _____

Clients age 13 and older must sign below. A parent or guardian must sign for clients under the age of 13.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Counselor Signature: _____ **Date:** _____

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Limitations on Confidentiality when Providing Counseling to Couples & Families

- This written policy is intended to inform you, (those that participate in therapy) that when Touchstone agrees to treat a couple or family, Touchstone considers the couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the family, Touchstone will seek authorization of all members of the treatment unit before Touchstone releases confidential information to third parties.
- If patients feel it is necessary to talk about matters that cannot be shared, patients may want to consult with an individual therapist who can treat the patient as an individual. This "no secrets" policy is intended to allow Touchstone to continue to treat the couple or family be preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated.
- Additional information about privacy can be found in Touchstone's HIPAA Notice of Privacy Practices, clinic disclosure statement, and Touchstone's Provider Disclosure Statement. Patients will be asked to sign all of the forms provided. Failure to sign the forms will be noted, and Touchstone Health Clinic staff will continue to abide by the policies described within.

Informed Consent

We, the members of the couple or family being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had the opportunity to discuss its contents and that we enter family therapy in agreement with this policy.

All those, age 13 and older, who participate, must sign below as well:

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Touchstone Provider Signature: _____

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Patient Bill of Rights

- To receive quality medical, behavioral and mental health services regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
- To seek a consultation with the physician(s) or provider of choice.
- To be treated with respect by Touchstone Health Clinic.
- To information contained in your medical record (except when exempt under State and Federal Law).
- To have a right to participate in decisions involving your health care.
- To use your own resources to purchase the care of your choice (based on medical necessity).
- To refuse medical treatment even if it is recommended by their physician(s) or provider.
- To personal privacy. Any discussion consultation, examination and/or treatment regarding your care will be done discreetly.
- To confidentiality of your medical record and other information related to your medical condition.
- To be informed about your medical or mental health condition, the risks and benefits of treatment and appropriate alternatives.
- To receive full disclosure of your insurance plan in plain language (to the best of our abilities).
- To be seen in a safe and clean environment.
- To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

Patient Responsibilities

- To **provide**, to the best of your knowledge, **complete information** about your symptoms, past illness and medical history, medications and other matters relating to your health.
- To schedule and **keep your appointments**, or to call to cancel your appointments in a timely fashion.
- To **arrive on time**, if you do not arrive on time, you acknowledge that your appointment time may be cut short, and/or your appointment may have to be rescheduled.
- To **notify the clinic of any demographic changes**, including but not limited to, changes in insurance coverage, address, and phone number.
- To **ask questions** when you do not understand explanations about your care or services.
- To **be responsible** for your actions, if you refuse treatment or do not follow your providers instructions.
- To follow the organization policies.
- To be **courteous** and **considerate** of Touchstone Health Clinic's staff, providers, interns and other clients; please be aware that **aggressive, abusive, or threating behavior towards staff, providers, interns and/or other clients by clients and/or their representative, will not be tolerated.**
- To understand your insurance plan and agreement with your insurance company regarding your financial responsibility for services provided.
- **Failure to follow patient responsibilities** may result in a formal discharge from services rendered at Touchstone Health Clinic.

Patient Signature: _____Print Patient Name: _____

Date: _____

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Insurance Disclosure/Assignment of Benefits/Financial Responsibility

By signing this document client acknowledges their financial responsibility for medical and/or mental health bills that result from deductibles, co-insurance, co-pays, non-covered services, missed appointment fees and other outstanding fees. Client is also aware of the potential reasons for Non-Covered Services and that a certain portion of the patient's care may not be covered by or may not be authorized by the patient's insurance plan. The most important thing is that patient's receive care and support needed, regardless of having an outstanding balance. Should finances be of concern, Touchstone Health Clinic respectfully requests that patient's be put on a payment plan to help cover outstanding costs. Payment plans are based on a sliding scale with factors such as income and household size based on the Federal Poverty Level for the current year. If we are unable to collect payment or arrange a payment plan with a patient, a payment collection service may be used for payment collections purposes, Touchstone Health Clinic reserve the right to charge 1% on outstanding balances, per Washington State Allowable Laws.

I authorize Touchstone Health Clinic to bill (name of the Ins. Company): _____ to pay by check or direct deposit made out directly to:

Touchstone Health Clinic, PLLC.

This is a direct assignment of my benefits and rights under this policy. This payment will not exceed my indebtedness to the assignee and I have agreed to concurrently pay any balances of said services which may exceed this insurance payment.

Signature of Policy Holder: _____ Date: _____

Signature of claimant, if not policy holder: _____ Date: _____

There is a possibility that insurance may not cover your services. This may be because of the following listed reasons.

Potential reasons for Non-Covered Services

- The service is or may be deemed investigational and/or experimental under the carrier's internal guidelines.
- The service is considered or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- The service and/or diagnosis may not be covered under the plan to which the patient is subscribed.
- The service and/or diagnosis may require pre-authorization which may not have been received or may have been denied, under the cost management guidelines of the policy.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for services so long as this disclosure is made and signed by the patient prior to their services being provided.

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Consent for Purposes of Treatment, Payment & Health Care Operations

I consent to the use or disclosure of my protected health information by Touchstone Health Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment or my health care bills or to conduct health care operations of Touchstone Health Clinic.

I understand that diagnosis or treatment of me by providers at Touchstone Health Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Touchstone Health Clinic is not required to agree to the restrictions I request. However, if Touchstone Health Clinic agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that Touchstone Health Clinic has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

Your provider at Touchstone Health Clinic will keep a record of the health care services provided to you. You may ask to see a copy of that record. Your provider will not disclose your record to others unless you direct them to do so or unless the law authorizes or compels them to do so. You may also ask to correct your record. You may also get more information about this by contacting your provider at Touchstone Health Clinic.

Print Name: _____ Date: _____

Signature: _____

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Notice of HIPAA Privacy Practices: Acknowledgement of Receipt of HIPAA Privacy Practices

- I understand I have a right to review Touchstone Health Clinic's Notice of Privacy Practices prior to signing this document.
- Touchstone Health Clinic's Notice of Privacy Practices has been provided to me.
- The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Touchstone Health Clinic.
- The Notice of Privacy Practices for the providers at Touchstone Health Clinic is also provided at the front desk of Touchstone Health Clinic.
- This Notice of Privacy Practices also describes my rights and the duties of the providers at Touchstone Health Clinic with respect to my protected health information.
- Touchstone Health Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
- I may obtain a revised notice of privacy practices by calling the office and requesting revised copy be sent in the mail or asking for one at the time of my next appointment.
- By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices, and have had an opportunity to discuss any questions I may have.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Date: _____

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Date: _____

******For Provider Use Only ******

Client (or personal representative) is unable or unwilling to sign this documents for the following reasons:

_____

_____

Describe attempts to obtain Signature: _____

_____

Provider Name: _____ Provider Signature: _____

Date: _____

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Notice of Missed Appointment Policy

All appointments are scheduled time between you and your provider; therefore, when an appointment is missed, someone else could have had that scheduled time with the provider.

Twenty-four (24) hour advanced notice is required for an appointment cancellation.

If this notice is not given, Touchstone Health Clinic reserves the right to charge you a $35.00 missed appointment fee. It is important to understand that insurance companies do not pay for this fee.

Please keep your appointments.

Thank-you!

I have read and agreed to the information provided above.

Patient Name: _____ Date: _____

Patient Signature: _____

Patient Name: _____ Date: _____

Patient Signature: _____

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