**Deborah DeWeber, MA, LMHC**
**Washington State License LH60200550**
**10024 SE 240th Street, Suite 116**
**Kent, WA. 98031**
**206.753.8776**

## DISCLOSURE OF INFORMATION, POLICIES AND CLIENT AGREEMENT

The attached brochure and the Notice of Privacy Practices included in this document will be helpful in explaining client rights and procedures. You may also call the Department of Professional Licensing at (360) 664-9098. Counselors practicing counseling for a fee must be registered or licensed with the Department of Health (DOH) for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.
The purpose of the Counselor Credentialing Act is a) to provide protection for public health and safety; and b)to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

### YOUR RIGHTS AS A CLIENT

As a client, you have certain rights that are important for you to know. There are also certain limitations to those rights which you need to know. I will hold everything we discuss in strict confidence with the following exceptions:

1. If I believe you are likely to harm yourself or another person, I am required by law to report my beliefs to the appropriate authorities.
2. If I believe that you may be physically or sexually abusing a minor, adult dependent, or a developmentally disabled person, I am required to report this to the appropriate authorities.
3. When you give written consent for disclosure of information, I will disclose only relevant information.

You have the right to make a written request that I keep no treatment records. According to WAC 246-810-035, I am required to retain the following: your name, fee arrangement, record of payments, dates of sessions and this disclosure form signed by both of us. I cannot agree with your request if maintaining records is required by other federal or state laws. Please request the proper form at the beginning of our first session.

It is your right to choose a counselor who best suits your needs and purposes. You have the right to request a change in treatment or to refuse treatment. It is important to me that your needs are met, so please tell me of any concerns that you have so that we can discuss them. Each client course of treatment is unique. You and I will develop goals for your treatment. You are responsible for your changes, growth and decisions. You must work on your issues inside and outside of our counseling sessions. I cannot guarantee any specific changes as a result of counseling.

If you believe that I have been unprofessional or unethical, please inform me so that the problem can be resolved. If you are not satisfied, you may contact: State of Washington Department of Licensing, Attn.: Counseling Division, P.O. Box 1099, Olympia, WA. 98507-1099, 360 236-4904.

The fee for each session is $100.00 cash or check, $120.00 for intake appointments. Each session is 45 minutes. The full fee will be charged if you fail to cancel 24 hours in advance. Payment is expected at the time of your appointment. Please have your check ready before you come in the counseling session. A $20 per check fee will be charged for all returned checks. Meetings, travel time, phone conferences, written reports, preparation time, or other work on your behalf will be billed at the hourly rate. Court testimony and preparation will be billed at $300 per hour. Fees are periodically increased due to inflation. When that occurs, you will be given 30 days notice. A late fee charge of $5 per

month will be charged on balances outstanding over 30 days. Balances over 90 days will be submitted to collection unless you have made arrangements with me. A $25 administrative fee will be added to the outstanding balance. Please make checks payable to me.

If I submit claims to your insurance company, the company will require some information regarding your treatment such as a psychological diagnosis, dates of service, type of service and the fee charged. They also request that your doctor be notified. You have the right to know the diagnosis that is used in any communication with the insurance company and your doctor. The diagnosis is based on *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*. By signing this, you give me consent to bill your insurance company. I cannot guarantee that your treatment will be covered by your insurance company. Please check with your company regarding eligibility for benefits. If your insurance denies payment, you are responsible for the balance.

**THIS NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**
**PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. Protected health information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. If you suspect a violation, you may file a report to the appropriate authorities in accordance with Federal regulations.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices in regard to PHI. I am required to abide by the terms of this Notice of Privacy practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make a revised Notice of Privacy Practice available upon request, or mail one to you at the address you provide.

I must verify the identity of any person requesting PHI. Where the identity or authority of a requestor is not known, I must also verify the authority of such a person to have access to the PHI. Documentation, statements, or representations, whether oral or written, that are required as a condition of disclosure must be obtained from the person requesting PHI. There are exceptions for uses and disclosures where a person is involved in the client's care and for certain other notification purposes.

**How I May Use and Disclose Health Information About You**

**For Treatment.** I may use medical and clinical information about you to provide you with treatment services.
**For Payment.** With your authorization, I may use and disclose medical information about you so that I can receive payment for the treatment services provided to you.
**For Health Care Operations.** I may use and disclose your PHI for certain purposes in connection with the operation of my professional practice.
**Without Authorization.** Applicable law also permits me to disclose information about you without your authorization in a limited number of other situations, such as a court order. These situations are explained below.
**With Authorization.** I must obtain written authorization from you for other uses and disclosures of your PHI.
**Emergency Situations.** Should I encounter a situation that may be considered an "emergency situation," I may use or disclose a client's PHI where I in good faith believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a client or member of the public.

**Your Rights Regarding Your PHI.** You have the following rights regarding PHI that I maintain.

**Right of Access to Inspect and Copy.** You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, costbased fee for copying and transmitting your PHI.

**Right to Amend.** If you believe the PHI that I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures of your PHI.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

**Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

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

**Complaints.** You have the right to file a written complaint to me or to the Secretary of Health and Human Services if you believe I have violated your privacy rights. I *will not retaliate against you for filing a complaint*

**I am my own Privacy Officer.** So, if you have any questions about this Notice of Privacy Practices, please contact me: Deborah DeWeber, 10024 SE 240 Suite 116, Kent, WA. 98031.

## Examples of How I May Use and Disclose Health Information about You

Listed below are examples of the uses and disclosures that I may make of your PHI. These examples are not meant to be exhaustive. Rather, they describe examples of uses and disclosures that may be made.

### Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations

**Treatment.** I may use your PHI for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers, or referral to another provider for health care services.

**Payment.** I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of paymentrelated 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.

**Healthcare Operations.** I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice including, disclosures to others for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to assist in the delivery of health care, provided I have a written contract with the business that prohibits it from redisclosing your PHI and requires it to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments

### Other Uses and Disclosures That Do Not Require Your Authorization

**Required by Law.** I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are healthcare licensure related reports, public health reports and law enforcement reports. Under the law, I must make certain disclosures of your PHI to you upon your request. In addition, I 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.

**Health Oversight.** I 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 payment to me (such as thirdparty payers) and peer review organizations performing utilization and quality control. If I disclose PHI to a health oversight agency, I will have an agreement in place that requires the agency to safeguard the privacy of your information.

**Safeguards.** As a sole practitioner, I must have in place "appropriate administrative, technical and physical safeguards to protect the privacy of PHI." Such safeguards might include, but are not limited to locked doors, locked file cabinets, password protected computer access and shredding of documents before disposal.

**Mitigation.** As a sole practitioner, I must mitigate, to the extent practical any harmful effect that is known to me of any use or disclosure of PHI in violation of my policies and procedures and/or harmful effects caused by any of my business associates. I am required to mitigate harm only where I have actual knowledge of harm and only to the extent "practical." I am not required to eliminate harm unless that is "practical."

**Abuse or Neglect.** I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to that information which is necessary to make the initial mandated report.

**Deceased Patients.** I may disclose PHI regarding deceased patients for the purpose of determining the cause of death in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

**Criminal Activity on My Business Premises Against Me or My Colleagues.** I may disclose your PHI to law enforcement officials if you have committed a crime on my premises, against me or my colleagues.

**Compulsory Process.** I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand and no protective order has been obtained and I have assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

## Uses and Disclosures of PHI with Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time unless I have taken an action in reliance on the authorization of the use or disclosure you permitted.

## Your Rights Regarding your Protected Health Information

Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

**You have the right to inspect and copy your Protected Health Information**

You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as I maintain the record. A designated record set contains medical and billing records and any other records that I use for making decisions about you. Your request must be in writing. I may charge you a reasonable cost based fee for the copying and transmitting of your PHI. I can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right of recourse to the denial of access. Please contact me if you have questions about access to your medical record.

**You may have the right to amend your Protected Health Information**

You may request, in writing, that I amend the PHI that has been included in a designated record set. In certain cases, I may deny your request for an amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me if you have questions about amending your medical record.

**You have the right to receive an accounting of some types of Protected Health Information disclosures.**

You may request an accounting of disclosures for a period of up to six years, excluding

disclosures made to you, made for treatment purposes, or made as a result of your authorization. I may charge you a reasonable fee if you request more than one accounting in any 12 month period. Please contact me if you have questions about accounting of disclosures.

**You have a right to receive a paper copy of this notice.**
You have the right to obtain a copy of this notice from me. Direct questions to me.

**You have the right to request added restrictions on disclosures and uses of your Protected Health Information.**
You have the right to ask me not to use or disclose any part of your PHI for treatment, payment, health care operations, or to family members involved in your care. Your request for restrictions must be in writing and I am not required to agree to such restrictions. Please contact me if you would like to request restrictions on the disclosure of your PHI.
**You have a right to request confidential communications.**
You have the right to request confidential communications from me by alternative means, or at an alternative location. I will accommodate reasonable, written requests. I may also condition this accommodation by asking you for information regarding how payment will be handled, specification of an alternative address, or other method of contact. I will not ask you why you are making the request. Please contact me if you would like to make this request.

## Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, as previously stated in this Notice. **I will not retaliate against you for filing a complaint.** You may also file a complaint with the U.S. Secretary of Health and Human Services.

**The effective date of this Notice is April 14, 2003.**

## MY EDUCATION AND APPROACH TO THERAPY

Master's Degree in Counseling Psychology (M.A.), Northwest University, Kirkland, WA.
Bachelor of Arts in Psychology (B.A.), Seattle Pacific University, Seattle, WA.

My experience as a Licensed Mental Health Counselor includes therapeutic work with individuals, children and their families; parenting, anger management and self-esteem groups; training and supervising individuals as a school counselor; consulting with churches and schools. I have training and experience in the following therapies: Client Centered, Brief or Solution Focused and Cognitive-Behavioral Therapy.

I believe that talk psychotherapy is a partnership between the client and myself. It is my belief that individuals have the capacity to become aware of problems and the ability to resolve the problem, once aware of it. As your counselor, I will provide a safe, supportive atmosphere for you to discover and explore new ways of feeling, thinking and behaving according to your goals. Treatment goals will focus on what you need and want to live a more meaningful and satisfying life. This may include exploring family of origin, religious, cultural and social backgrounds. Each course of treatment is unique to an individual. It is up to each person to make decisions and changes, thus, there are no guarantees that any specific changes will occur as a result of counseling.

## CLIENT CONSENT TO TREATMENT

I have read and have accepted the Disclosure of Information, Policies and Client Agreement. I understand the disclosure information provided. I agree to counseling under the stated terms and understand that I have the right to terminate treatment at any time.

I acknowledge receipt of the Notice of Privacy Practices.

My signature indicates acceptance of the agreement and also indicates that I have received a copy of this agreement.

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Client | Date | Deborah DeWeber, MA, LMHC | |
| _____ | | _____ | |
| Client | Date | | Date |

**PLEASE SIGN THIS PAGE AND THE FOLLOWING PAGE.**

CLIENT COPY

**Deborah DeWeber's COPY**

***DISCLOSURE OF INFORMATION, POLICIES AND CLIENT AGREEMENT***
***NOTICE OF PRIVACY PRACTICES***

**10024 SE 240, SUITE 116**
**KENT, WA. 98031**
**206.753.8776**

**CLIENT CONSENT TO TREATMENT**

In the course of treatment, it may be helpful for me to coordinate care with your physician. It is necessary for you to give consent before I can release any information. Therefore, I give consent to Deborah DeWeber, MA to release the following information as related to my medical condition regarding any mental health or chemical dependence/substance abuse conditions and treatment. I authorize this information to be released to my EAP and my insurance company in order to process claims and to my primary care physician for coordination of care.

___ I do not limit release of information to my PCP:

___ I do not authorize the release of any information regarding my treatment to my PCP.

This release is valid for 90 days unless I indicate another date here _____. This release may be rescinded at any time with my written notification.

I have read and have accepted the Disclosure of Information, Policies and Client Agreement. I understand the disclosure information provided, as well as the brochure for counseling or hypnotherapy clients I agree to counseling under the stated terms and understand that I have the right to terminate treatment at any time.

I acknowledge receipt of the Notice of Privacy Practices.

My signature indicates acceptance of the agreement and also indicates that I have received a copy of this agreement.

_____ _____
Client Date Deborah DeWeber, MA, LMHC

_____
Date

_____
Client Date