Office Policy and Consent Form

I. Welcome!

Thank you for choosing us as your provider. We appreciate the courage it takes to reach out for professional help when you are experiencing personal challenges in your life. This is an opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies.

II. Aims and Goals

Our major goal together is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychological/emotional healing and growth.

III. Appointments

Appointments begin at the scheduled time. Clients are generally seen weekly or more/less frequently as your situation dictates and you and the clinician agree. You may discontinue treatment at any time, but please discuss any decision with us.

Crisis intervention: We do not provide immediate crisis intervention services. If you need immediate assistance, please call the Care Crisis Line at (425) 258-4357 or 1(800)-584-3578 or 911.

IV. Confidentiality

Issues discussed in therapy are important and are generally legally protected as confidential information. However, there are limits to confidentiality'. These situations include: 1.) suspected abuse or neglect of a child, elderly person or a disabled person, 2.) when your therapist believes you are in danger or harming yourself or another person or you are unable to care for yourself, 3.) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4.) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) in natural disasters whereby protected records may become exposed or 7.) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals, medical professionals, or to other people you may want to include in your treatment. You have the right to refuse to sign a Release of Information.

V. Record Keeping

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

VI. Business Practices

We participate in ongoing professional consultations with a group of mental health professionals. These professionals are bound to the same rules of confidentiality and will protect any information we may share with them about your situation.

VII. Fees

We will check your benefits but advise you to do so as well. You are agreeing to pay for any amounts your insurance doesn't cover to include co-pays, co-insurance, and deductibles or if your insurance refuses to pay for any reason.

Please update us immediately if your insurance changes.

At times, you may feel a need to reach us by phone between our regularly scheduled therapy appointments. Phone calls to make or change appointments are expected. We will not bill you for phone calls during the week unless we talk for more than 15 minutes. We will bill you at $125 per hour rate if we talk longer than 15 minutes (prorated per minute). This bill will be due at your next session or upon receipt of the bill whichever occurs first. *If you need any legal work or if we are subpoenaed by your attorney to provide written statements, letters, affidavits, etc., We will bill you on an hourly basis for all the time we spend on your case. This includes talking or meeting with your attorney, writing reports, depositions, testifying on your behalf, travel time and preparation time. The fee for legal work is $275.00 an hour plus expenses and mileage.

24-hour notice is required for cancellation, otherwise there is a $100 fee!

VIII. Payment

Payment is due at the time of the session unless other arrangements have been made. We will file your insurance claim in most cases, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

IX. Reschedules, Cancellations, and Missed Appointments

You will be billed for any session that you reschedule or cancel with less than 24 hours' notice.

24-hour notice is required for cancellation, otherwise there is a $100 fee!

You may leave messages 24 hours per day. You will be billed your full rate – not just a co-payment. Insurance companies do not reimburse failed appointments.

X. Complaints

You have a right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform us and discuss the situation. If you do not feel your complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose. Please inform your clinician and please contact Kristin Roessler at 425-870-0895.

XI. Disclosure Statement

Kristin Roessler – MA, LMHC, CMHS

License Mental Health Counselor (#LH00005440)

Education:

master's in counseling – Argosy University 2003, Mental Health Professional, Child Mental Health Specialist

Training, and Experience:

- Private practice 2003-present
- Snohomish County Office of Children's Affairs 2006 - 2008
- Compass Health 1994 – 2006, Program Manager, Smokey Point Children's Extended Care
- Northwest Youth Services 2002 - 2012 -- Family Preservation Therapist
- Snohomish County Children's Commissioner – 2004 – 2006
- Child Protective Team member 2002 – 2016
- Catholic Community Services 1998 – 2003 -- Family Preservation Therapist
- Fairfax Hospital 1997 – 1998 -- Mental Health Specialist
- Harborview Medical Center 1995 - 1996 -- Mental Health Specialist
- Luther Child Center - A Turning Point - 1992 –1995 -- Crisis Specialist
- Northwest Youth Services 1991-1995 -- Lead Crisis Worker
- CAP (Children's Advocacy Program) Intern 2002

Kristin's approach to counseling is a client centered approach, incorporating solution focused, psychodynamic techniques, cognitive behavioral therapy, and dialectical behavioral therapy since 1994.

Elizabeth Myers – MSW, LICSW

License Mental Health Counselor (#LW60338717)

Education:

MSW – Southern Illinois University, Carbondale, Social Worker- Health/ Mental Health

Training, and Experience:

- Snohomish County Mental Health 2015 – Present
- Compass Health 2011-2015 – Crisis Triage, Case Management, Intake
- Dincin Center at Thresholds, Chicago, Illinois 2010-2011 – Community Support Specialist
- Southern Illinois University Carbondale Integrated Assessment Program 2008-2010 – Paid Intern
- Fairbanks Community Behavioral Health Center 2005-2008 – Activities Specialist, Employment Specialist, Case Manager
- Discover Healing Private Practice 10-2018 to present

Elizabeth's approach to counseling is a client centered approach, using cognitive behavioral therapy and solution focused approaches.

Kaia Scott – MS, LMHC

License Medical Health Counselor *(#LH00008029)*

Education:

Masters, Western Washington University

Training, and Experience:

- Compass Health 2001
- Private Practice 2002-2006
- Everett Clinic 2012-2022
- Discover Healing 2022-Present

Kaia's approach to counseling is to view the client as an individual, meaning that what works for one person may not work for another. Her approach is to work together with the client to discover what it is that will help change the things the client is concerned about. She explores how the client has adjusted to changes in their lives and works to identify “stuck” points. Ms. Scott will help the client identify thoughts that he or she may be having that are disrupting the way the client would like to feel or move forward in his or her life.

XII. Permission for Telehealth Visits

What is telehealth?
Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner. You can talk to your provider from any place, including your home. you don't go to a clinic or hospital.

How do I use Telehealth?
You talk to your provider by phone, computer, or tablet.

How does Telehealth help me?
You don't have to go to a clinic or hospital to see your provider.

Can Telehealth be bad for me?
You and your provider won't be in the same room, so it may feel different than an office visit. Technical problems may interrupt or stop your visit before you are done (though this is very rare).

Will my Telehealth visit be private?
We will not record visits with your provider. If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you. Your provider does not have anyone from their office that can hear or see you. We use Telehealth technology that is designed to protect your privacy. If you use the internet for Telehealth, use a network that is private and secure.

What if I try Telehealth and don't like it?
You can stop using Telehealth any time, even during a Telehealth visit. If you decide you do not want to use telehealth again let us know and we will give you a referral, if possible, to someone doing office visits.

How much does a Telehealth visit cost?
What you pay depends on your insurance. A Telehealth visit will not cost any more than an office visit.

What does it mean if I sign this document?
If you sign this document, you agree, we provided you with the information in this document. That we answered all your questions, and that you want a telehealth visit.

XIII. Client Rights to Professional Conduct

You have the right to receive professional care. If any of the following situations occur during your services with me, you are encouraged to contact the Department of Health (see address and telephone number below). The conduct, acts or conditions listed below could be considered a violation of law as defined by RCS 18.130.180.

1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not.
2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof.
3) All advertising which is false, fraudulent, or misleading.
4) Incompetence, negligence, or malpractice which results in injury to a patient, or which creates an unreasonable risk that a patient is harmed.
5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority of the state, federal, or foreign jurisdiction.
6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances to oneself.
7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
8) Failure to cooperate with the disciplining authority.
9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority.
10) Aiding or abetting an unlicensed person to practice when a license is required.
11) Violations of rules established by any health agency.
12) Practice beyond the scope of practice defined by law or rule.
13) Misrepresentation or fraud in any aspect of the conduct of the business or profession.
14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk.
15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health.
16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service.
17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession.
18) The procuring, or aiding or abetting in procuring, a criminal abortion.
19) The offering, undertaking, or agreeing to cure to treat disease by a secret method, procedure, treatment, or medicine.
20) The willful betrayal of a practitioner-patient privilege as recognized by law.
21) Violation of chapter 19.68 RCW.
22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplinary authority or its authorized representative or using threats or harassment against the patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent him or her from providing evidence in a disciplinary proceeding.
23) Current misuse of alcohol, controlled substances, or legend drugs.
24) Abuse of a client or patient or sexual contact with a client or patient.
25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

The Revised Codes of Washington (RCW's) and the Washington Administrative Codes (WACs) referenced in this document can be viewed online at http://slc.leg.wa.gov.

XIV. In-person Visits

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume or begin in-person services considering the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us. It is strongly recommended that we conduct our sessions via Telehealth at this time. However, we have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, it may be required that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if it is necessary, we may return to telehealth for everyone's well-being. If you decide at any time that you would feel safer with telehealth services, please make the request. If it is feasible and clinically appropriate telehealth services are an option. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss. Risks of Opting for In-Person Services You understand that by coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

XV. Consent for Treatment

By signing below, I state that I have read and understood this policy statement, clinician disclosures, permission for telehealth visits and I have had my questions answered to my satisfaction.

By signing, I also state that I have read and received separately a Notice of Privacy Practices. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

***If patient is 13 years or older, they must sign in the client signature/box**

Client Full Legal Name: _____Todays Date: _____

Client Signature: _____

(If couples Therapy, please have the partner sign below.)

Client Full Legal Name: _____ Todays Date: _____

Client Signature: _____

(If parent/ guardian of client, please sign below)

Parent/ Guardian Signature: _____ Todays Date: _____

Client Information

A. Identification Information (client being seen)

Client Full Name: _____ Date of Birth: _____

Client Address: _____ Apt: ____ City: _____

State: _____ Zip code: _____

Work Phone: _____ Home Phone: _____ Cell phone: _____

is it okay to leave messages on all these phones? _____

Ideal to leave a message on Which phone? (Work / Home / Cell): _____

Client Email: _____ Client Employer: _____

B. Insurance information

(Holder of insurance policy, if different than above)

Relationship to Insured: _____ Phone Number: _____

Insured's Full Name: _____ Insureds DOB: _____

Phone Number: _____ Address: _____ Apt: ____ City: _____

State: _____ Zip code: _____ Employer: _____

Insurance Policy Plan Name: _____

(If you have secondary insurance, please fill out the next section)

Do you have Secondary Insurance? _____

Relationship to Insured: _____ Phone Number: _____

Insureds Full Name: _____ Insureds DOB: _____

Phone Number: _____ Address: _____ Apt: ____ City: _____

State: _____ Zip code: _____ Employer: _____

Insurance Policy Plan Name: _____

C. Medical Information

Primary Physician: _____ Physicians Phone Number: _____

When was your last exam? _____

Have you had any Major operations, illnesses, or injuries?

_____

_____

_____

_____

Please list the current medications that you are on

Medication: _____ Dosage: _____ Prescriber: _____

How Effective is this medication for you?

_____

Medication: _____ Dosage: _____ Prescriber: _____

How Effective is this medication for you?

_____

Medication: _____ Dosage: _____ Prescriber: _____

How Effective is this medication for you?

_____

Please list previous medications that you have been on

Medication: _____ Dosage: _____ Prescriber: _____

How Effective has this medication been for you?

_____

Medication: _____ Dosage: _____ Prescriber: _____

How Effective has this medication been for you?

_____

Medication: _____ Dosage: _____ Prescriber: _____

How Effective has this medication been for you?

_____

Please type any of the following if you have had recent changes in…

Sleep | Nightmares | Amount of Exercise | Sexual Desire | Eating/ Appetite | Weight |

Answer:_____

D. Treatment Information

Have you ever received Psychological or Psychiatric counseling before? _____

When? _____ From Whom? _____

For what reason? _____

What was the outcome? _____

Have you ever been hospitalized for a psychiatric or emotional health reason? _____

When? _____ Where? _____

For what reason? _____

What was the outcome? _____

Have you ever been in a drug or alcohol treatment program? _____

If so, are you an inpatient, or an outpatient? _____

When? _____ Where? _____

For what reason? _____

What was the outcome? _____

E. Treatment Information

Please fill out your initial goals for us, we will come up with more goals as we work together!

Define your first Challenge: What are the priorities and goals for our work together?

_____

_____

Define your second Challenge: What are the priorities and goals for our work together?

_____

_____

Define your third Challenge: What are the priorities and goals for our work together?

_____

_____

Is there anything else you think we should know?

_____

_____

_____

***If patient is 13 years of age or older, they must sign in the client signature space**

Signature of client, or client's parent/ guardian/ legal representative.

_____

Release of Information

For billing purposes

If patient is 13 years of age or older, they must sign in the client signature space

Client Last Name: _____ Client First Name: _____ M.I: _____

Previous /Maiden name or alias: _____ DOB: _____

Discover Healing Clinicians may: (**Exchange** / Disclose / Receive)

the protected health information indicated below with:

Insurance Company: _____

Address (optional): _____

Phone (optional): _____

Fax (optional): _____

I authorize the release of any and all of the following medical or mental health information, as specified, which may be contained in my records. (Check all that apply)

Type X HERE IF YOU AGREE TO ALL OF THE AUTHORIZATIONS _____

Discharge Summary		Drug/ Alcohol		Intake Evaluation	
Medications		Medical Diagnosis		Medical History	
Psychological Eval.		School		Treatment Plan	
Psychiatric Eval.		Progress Notes		Laboratory Results	

Purpose of this disclosure (Type an X for all that apply)

ITA investigation/ Coordination		Facilitating Resident Placement		Determine Program Eligibility	
Assisting in Diagnosis and Treatment		Reporting to Probation Officer or Court		Educating Family Members	
Assuring Continuity of Care		Coordinating Service Delivery		Referring to Another Agency / Person	

Other? _____

Please Initial Below,

I understand that my record may contain information regarding diagnosis or treatment of drug or alcohol abuse. I give my specific authorization for these records to be disclosed. (42 CFR, Part 2)

Drug/Alcohol (Initials please): _____

I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. I understand that information used or disclosed in keeping with this authorization may no longer be protected by Federal Law and could be used or re-disclosed by the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. To revoke this authorization, I must submit a written request to Discover Healing, DBA Discover Healing. I understand that I may refuse to sign this Authorization and that my refusal to sign may affect my ability to obtain treatment. Unless revoked earlier by me, this authorization shall expire either 30 days after the end of treatment or after all billing is complete whichever is later.

***If patient is 13 years of age or older, they must sign in the signature space**

Signature of Client: _____ Todays Date: _____

Signature of 2nd Client: _____ Todays Date: _____

Parent / Guardian Signature: _____ Todays Date: _____