Kimberly Green, M.Ed, LMFT
3220 Uddenberg Lane Suite 1
Gig Harbor, WA 98335
Phone (253) 225-5418 Fax 877-410-5513

CONFIDENTIAL FEE AGREEMENT

Adult responsible for fees:_____Phone _____
Name of patient if different_____ Relationship
_____ Age_____
Fees will he paid by Cash _____; Check _____; Assignment of insurance benefits __; plus partial payment check/cash_____; Other_____ (e.g. Worker's Compensation. etc.) Please describe_____

1. I understand and agree that fees are established per the fee schedule in this information packet.
2. **That a fee equal to my session fee will be add to my bill if I fail to cancel with a minimum of 24 hours notice. I am aware that I am responsible for the <u>full</u> session fee *for* a missed session.**
3. That I am not responsible for fees for sessions, which for any reason the therapist cancels, postpones, or is unable to attend.
4. That I am financially responsible per the above and that <u>fees are due and payable at the time services are provided</u> excepting those fees paid by insurance or other third party providers.
5. That I *will be* assessed an additional fee of **$30** for any returned check.
6. That services and their respective fees that may be required that are not listed (litigation, home visit, school meeting, document generation-review, case management/consultation, etc.) will be discussed, agreed upon, fee noted and initialed per the description of that service below and that I am responsible in full for these services and may he required to pay for services in advance.
7. A billing fee of **$10**/per month will be charged for months in which a minimal payment is not received.
8. Any waivers or alterations to this agreement noted below, have been discussed and reviewed by my therapist with me and my signature indicates acceptance of them.
9. A service charge of $10 will be assessed for each billing of a secondary insurance or you may choose to bill your secondary insurance on your own. All fees to this office remain your responsibility regardless of whether your insurance pays or not.

_____Billing Fee adjustment and/or waiver_____
_____Other _____

*By signing this document I give permission for Kimberly Green, LMFT to disclose to my insurance carrier any and all information necessary for the utilization of insurance.

_____ _____
Signature of Responsible Adult Date

_____ _____
Signature of Therapist Date

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General Information

Your name_____ Today's Date _____
Birth date_____ Age _____ Social Security Number._____
Address_____
City _____ State_____ Zip _____
Home Phone _____ Work Phone _____ Cell phone_____
Please circle the number(s) where we may leave messages for you.

Emergency Contact Information: Name _____ Phone _____
Referred by _____Phone _____
Marital Status: Single/Married/Divorced/Widowed
Email Address _____

Insurance Coverage:	**Primary**	**Secondary**
Company Name:	_____	_____
Insured Name:	_____	_____
Plan/Group #	_____	_____
ID Number	_____	_____
Mailing Address:	_____	_____
	_____	_____
Telephone Number:	_____	_____
Insured's Employer:	_____	_____
Phone:	_____	_____
Employer Address:	_____	_____
	_____	_____

On the back of this form, please respond to the items below:
1. Briefly describe any traumatic events and/or major medical/mental health problems experienced by patient.
2. Describe those current concerns that led to your decision to seek treatment at this time.

THANK YOU FOR YOUR COOPERATION IN COMPLETNG THIS FORM

***ADULT* HEALTH HISTORY**

Name:_____Age: _____ D.O.B: _____
Today's Date: _____
Height: _____ Weight: _____ Allergies: _____
Primary Care Physician: _____Phone: _____
Address: _____
Fax: _____
Date of last physical exam: _____Reason: _____
Name of Psychiatrist: _____ Date last seen: _____
Phone: _____
Address:_____
Fax: _____

List and date any past hospitalizations (both physical and psychiatric):
_____
_____
_____

Current Health Concerns (within past 3 months):
_____
_____
_____

Please check any past or present medical conditions that apply to you:

__Head injuries, seizures, headaches
__Thyroid problem
__Heart or circulatory problems
__Liver disease, jaundice, hepatitis
__Stomach, bowel or gallbladder problems
__Sexual concerns
__Anemia or blood disorder
__High blood pressure
___Skin problems
___Diabetes
___Cancer
___Kidney, bladder or urinary problems
___Bone, joint, back or muscle problems
___Ear, nose, throat or head problems
___Birth defects
___Chronic pain
— Other medical condition(s):
_____

Please list all medications you are currently taking, including all prescription medications, birth control, and non-prescription vitamins and herbal supplements. (Continue on back if needed).

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ACKNOWLEDGEMENT OF CONSENT

INFORMED CONSENT FOR ADULTS

I hereby authorize Kim Green, M.Ed. LMFT, a licensed marriage and family therapist, to render mental health services to _____ This authorization constitutes informed consent without exception. I have read and understand the "Office Policy Statement" and 'Notice of Privacy Practices" and have received a copy of these policies *for* myself.

_____

Signature **Date**

INFORMED CONSENT FOR MINOIS

Washington Stale law recognizes the right of 13-17 year olds to consent to **their** own treatment, which also protects their rights to confidentiality. When working with adolescents Kimberly Green believes that it is important to work with the family while preserving the adolescent's right to confidentiality. Treatment is typically impeded if an adolescent does not feel s/he has a private place to talk about concerns. Thus, your therapist typically seeks the adolescent's consent before speaking with parents. Of course, the same limits to confidentiality that apply to adults (listed in the "Notice of Privacy Practices") also apply to minors.

I hereby authorize Kimberly Green, M.Ed, LMFT, a licensed marriage and family therapist to render mental health services to _____. This authorization constitutes informed consent without exception. I have read and understand the "Office Policy Statement" *and* "Notice of Privacy Practices" and have received a copy of these policies for myself.

Patient Signature **Date**

Parent/Guardian Signature **Date**

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PROVIDER DISCLOSURE STATEMENT
KIM GREEN, M.Ed, LMFT
MARRIAGE & FAMILY THERAPIST

What is a MARRIAGE & FAMILY THERAPIST? In the state of Washington a therapist who provides mental health services to clients must meet certain requirements. They include a minimum of a Master's degree ***from*** an accredited graduate school program and a minimum of two years of post-Master's degree counseling practice under the supervision of a qualified licensed therapist. Licensed therapists must also pass a state licensure exam.

I earned my Master's degree from the University of Oregon's Marriage and Family Therapy Specialization program in 2002 and have practiced child and family counseling in the state of Washington for the past 8 years.

I am a clinical member of the American Association ***for*** Marriage and Family Therapy.

Ethics:
If you believe that I have acted in an unprofessional manner, please tell me about it so that the problem can be clarified and resolved. If you feel that negotiation has not worked, you can contact:

Department of Health
Counselor Section
P.O. Box 47865
Olympia, WA 98504-7865
Telephone: (360) 236-4700

FEE SCHEDULE
(Effective January 1, 2011)
Intake Evaluation (first full session) **$150**

Individual/family (45 minute sessions) **$100**

Phone consults (10 minutes) **$20**

Report writing (per hour) **$100**

Legal Documentation (per hour**) $150**

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OFFICE POLICY STATEMENT

APPOINTMENTS

Your *appointment* time is held especially for you. Your ice is due and payable at the time of service. There is no charge for an *appointment* canceled or rescheduled **twenty-four** hours in advance.

CANCELLATIONS

Twenty-four hour notice is required *to* avoid a session charge. If you cancel with less than twenty-four hours notice, or fail to come to your appointment, the full session fee (per the fee schedule) will be charged. This charge is due and payable at the time of your next session. Insurance does not pay for missed appointments. If this office *is* able to schedule another appointment with someone else for your time slot, your fees may be partially waived. You are asked to understand that messages left over the *weekend on* the office voice mail for Monday appointments cannot he filled.

FEES

The therapy charge covers a forty-five minute visit, plus record keeping, preparation and billing. In addition to fees for intake and sessions, you may be billed for reports, letters, or phone calls on your behalf to physicians, attorneys, agencies, employers, etc., and for lengthy phone conversations. Please review the attached fee schedule and fee agreement.

PAYMENT POLICY

You or the minor's legal guardian is responsible for the accounts. You are expected to pay the bill when due, whether medical insurance pays for a portion or not, including charges for evaluation, printed materials, reports, letters, consultations and telephone calls. If 90 days passes without a payment or prior arrangement accounts may be sent to collections at your cost. Results of evaluation or reports may not be released until all accounts are paid in full. We understand that finances can be difficult, and you may set up a payment plan if necessary. This entails a written agreement to pay a fixed amount regularly each month until the balance is paid in full. If regular payment stops, the balance will be considered delinquent, and finance charges and collection procedures may be instituted. Bills are sent out monthly; if you have any questions about your bill, please ask.

INSURANCE

Kimberly Green is a contracted provider for some, but not all, insurance companies. You must check with your insurer to learn whether she is a provider for your plan. You must also determine if you need a referral or preauthorization to use your mental health

benefit, whether you have a separate annual deductible for mental health, and whether your mental health benefit has a maximum yearly number of visits or a maximum yearly dollar amount. Claims will be submitted to insurance companies with whom your therapist is contracted. In order for this to occur you must complete the insurance portion of the "General Information" form that was given to you with this office policy; you also need to provide a copy of your insurance card.

PHONE. CONTACT AND EMERGENCIES

Kimberly Green has a voice mail on which you may leave messages. If you are unable to reach Kimberly directly and are experiencing an emergency, **PLEASE CALL THE CRISIS LINE FOR YOUR COUNTY OF RESIDENCE. The Pierce County Crisis line number is (253) 798-4333, (800) 576-7764 (Pierce County/Tacoma).**

CONFIDENTIALITY

Please see the attached "Notice of Privacy Practices"

RECORD KEEPING

Please note that records are kept of your visits. You may request that no treatment records be kept. To do so, you must submit a request in writing to Kimberly Green. The letter must request that she maintain no treatment records, but also that you understand she must comply with Washington Administrative Code (WAC) 246-924- *354* and retain in your record your identity as the recipient of services, service dates and fees, description of services (e.g. individual session), and the request for no records. Kim Green has an obligation to not agree to the request if other state or federal law requires the maintenance of records.

RESPONSIBILITIES

Your therapist is responsible for developing and implementing a treatment plan that employs the most effective approaches and techniques available to help you deal with your problems. She is responsible for using therapy time therapeutically-—that is, for not wasting time or otherwise allowing its misuse. Kim Green is responsible for appropriate use of available resources to deal with a psychological emergency if you should experience one. She is responsible for making appropriate referrals to other health care providers if she becomes aware of a problem that is outside the limits of her therapeutic expertise.

You are responsible for changing. As part of that responsibility, you are responsible for working on your problems both during therapy sessions and in your daily life.

You are responsible for bringing into therapy your experiences, thoughts, and dealing openly with your *therapist* about them.

SNOW AND INCLEMENT WEATHER

If at any time you are concerned about whether the office is open due to wind, snow, rain, power outages, etc., please listen for closures of Peninsula School District 402 ***(Pierce County).*** If the School District determines it is best to close so will we. If the District is

late, please note that the office will likely also open late. Any appointments before 10:00 AM should be presumed cancelled, unless otherwise verified by this office.
We understand that if you are coming from an area that is hampered by the elements, even if we are not, that it is unfair to penalize you for a late cancel. You must call, however, to notify this office that you cannot make it in for your regular appointment.

Please speak with your therapist if you have any further questions.

This is your copy. Please sign the enclosed "Acknowledgment of Consent" for your therapist to keep in her records.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN CET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal *information* about you and your health. This *information* about you that may identify you and that relates to your past, present or future physical or mental health or condition related health care services is referred to as Protected Health Information ("PHI"). This notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *AAMFT Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

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

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

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

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

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

Following is a list of the categories of uses and disclosures permitted by ***HIPPA WITHOUT an authorization:***

Abuse and Neglect
Judicial and Administrative Proceedings
Deceased Persons
Emergencies
Family Involvement in Care
Health Oversight
Law Enforcement
National Security
Public Health
Public Safety (Duty to warn)
Research

Without Authorization: Applicable laws and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

*Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
* Required by Court Order
* Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

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

*__Rights of Access to Inspect and Copy__. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will he restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

*** Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the *information* although we are not required to agree to the amendment.

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

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

*__Right to Request Confidential Communication__. You have the right to request that we 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

If you believe we have violated your privacy rights, you have the right to file a complaint **in writing with the Office for Civil Rights, U.S. Department of Health and Human Services at: 2201 Sixth Avenue--Suite 900, Seattle, Washington 98121-1831. You may also contact them by:**

Voice Phone (206) 615-2287. FAX (206) 615-2297. TUB (206) 615-2296.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is March 3, 2010.