Jeanette Scott, LMHC

Revised 7/9/13

Background Information

Today's Date _____

I. Primary Client Name (If couple, family, or group, the one person who will be the identified client):

First Name _____MI_____ Last Name_____M___F___

Home Phone # ( ) _____ Work Phone # ( ) _____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Drivers license #_____Date of Birth (DOB) _____ SS# _____

Employer _____ Client E-mail _____

II, Spouses's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):

Relationship to primary client: Spouse_____ Parent _____ Legal Guardian _____ Child _____ Other_____

First Name _____MI_____Last Name_____M___F___

Home Phone # ( )_____ Work Phone# ( )_____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Driver's license # _____ Date of Birth (DOB) _____ SS # _____

Employer _____ Client E-mail _____

If we are billing your insurance please fill out the following information completely:

Are you using an Employee Assistance Program (EAP)? _____ yes _____ no If yes, who do we bill? _____

EAP Phone# ( )_____ How many sessions? _____ Authorization # _____

Primary Ins. Co _____ *Grp #* _____ *ID#* _____

Ins. Billing Address _____Ins. Phone # _____

City_____State_____Zip_____

Name of Subscriber _____ Relationship to client _____

Subscriber's Address (if not above)_____ DOB _____

City_____State_____Zip_____ SS# _____

Subscriber's Employer _____ Phone # _____

*Any secondary insurance?(please give complete information)*_____

_____

_____

Signature of person financially responsible for bill: (Include address and Phone # if not above) _____

_____

Have you (or any member of your family) previously been a client of Pearl Counseling Associates, LLC? □ Yes □ No
If yes, is your (or family members) portion of the account with that counselor clear and/or current? □ Yes □ No

PERSON TO NOTIFY IF EMERGENCY:
Relative: _____ Phone: ( ) _____
Name and address of person, organization, or ad that referred you:
_____Phone: ( ) _____

Jeanette Scott, LMHC
Pearl Counseling Associates, LLC
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860 x **346,** FAX: (253) 752-1890

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE CLAIMS PROCESSING

TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Jeanette Scott and/or her billing representative** to use and/or disclose the following protected health information: **Please initial.**

- ❑ _____ Information required to process manual claims
- ❑ _____ Information required to process electronic claims

ASSIGNMENT OF BENEFITS (Please initial)

- ❑ _____ I authorize my insurance benefits to be paid directly to the provider.

INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name_____

Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

DURATION

If not previously revoked, this authorization will expire one (1) year from date signed below.

***Specific Limitation**:* Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

SIGNATURE

This Authorization covers protected health information pertaining to *(client)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature: _____ Date: _____

Patient/Parent/Guardian/Other legal representative for health care decisions: _____

Renewal Signature: _____ Date: _____

Witness: _____ Date: _____

PEARL
counseling associates LLC

Jeanette Scott, MA, LMHC
Individual, Couple & Family Therapy

Intake Addendum

Date _____ Last Name _____ First Name _____

Is it acceptable to contact you at home? Y / N
If "no" then how can I contact you? _____

Are you currently under medical care? Y / N
If yes, then please explain/describe. _____

_____

_____

Name of Personal Physician & Phone Number: _____

Are you currently taking prescribed medications? Y / N
If yes, then please explain/describe. _____

_____

List any psychiatric/mental health medications you have taken. _____

_____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention. _____

_____

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation/Divorce	Relationships
Finances	Drug/Alcohol Use	Career Choices	Anger
Self-Control	Unhappiness	Insomnia	Religious Matters
Work/Stress	Health Problems	Cutting/Self-Mutilation	Thought Patterns

Your Goal in therapy: _____

_____

_____

PEARL
counseling associates LLC

Jeanette Scott, MA, LMHC
Individual, Couple & Family Therapy
Washington State Mental Health Counselor, License #MHC.LH.60306220

Informed Consent

This is to inform you of your rights as a client, my approach to therapy, and enough information about counseling for you to make an informed decision regarding the services you choose to receive. Please take your time in reviewing the information presented here and feel free to ask any questions that arise for you.

Counseling Approach

Counseling, or therapy, entails a person entering into a relationship with a professional in order to process issues impacting his or her well-being. There are many approaches to therapy. Mine is a mixture that allows me to flex with the client's needs, but is most closely aligned with self-psychology and object relations therapies, and draws heavily from attachment theory. At the core of these therapy approaches is the concept that it is in the relationship formed between client and counselor that healing and growth occur. We will focus on the issues that have brought you to therapy, and on the deeper causes of those issues.

Credentials

I hold a Master of Arts degree in Counseling Psychology from Mars Hill Graduate School in Seattle, Washington (now called The Seattle School of Theology and Psychology), and am licensed to counsel in Washington State. I am a current member of the Washington Mental Health Counselors Association (WMHCA).

Previous credentials include a Bachelor of Science in Biology from Seattle Pacific University (1977), Teaching Certificate in State of Washington (1979), and Bachelor of Science in Math/Computer Science from Seattle University (1985).

Billing and Insurance Information: The first (consultation) session is 30 minutes and incurs a flat rate of $25. Subsequent session fees are $130 per 50-minute session ($110 private pay). Payments are to be made at each session. Consistency in therapy is important; however there may be times when you will need to reschedule an appointment. Please provide at least 24 hours notice if you will miss an appointment, else you will be charged for half the session fee ($65/$55, not covered by insurance), (illness and emergencies excepted). Fees may increase periodically; at least two weeks notification will be given.

I am in network for a few insurance companies, and out of network with some others. For out of network situations I do not file insurance claims for you, but will provide you the needed information to complete the forms yourself. You will need to make arrangements with your insurance provider to reimburse you directly. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. I will be glad to fill out any part of the form that requires my input.

Scheduling Appointments: Appointments are generally made on a regular, weekly basis. Appointment times are not automatically held open for you from week to week unless you make such arrangements with me. It is your responsibility to reschedule at the end of a session.

Confidentiality: There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, I maintain the strictest ethical standards of confidentiality. I keep written record of services provided to you, unless you request in writing that I not. Information will not be released to outside sources without your written permission unless the law authorizes or compels me to do so. In instances where financial requirements for evaluation and/or treatment are not being met, referral to a collection agency may occur.

There are legal (state mandated) exceptions to confidentiality. The following situations are those in which the information you have shared with me may be shared with others:

1) The client gives written permission to share confidential information.
2) Anything that suggests a crime or harmful act. In the following circumstances I may use and disclose Protected Health Information (PHI) without consent or authorization:
    - Child abuse or neglect
    - Vulnerable adult abuse or neglect
    - Threat to health or safety of self or others

- Health oversight
- Judicial or administrative proceedings
- Workers compensation

Detailed information about these exceptions can be read in the Washington Notice Form (HIPAA).

3) If the client is a minor, and there is indication that she/he was the victim or subject of a crime.
4) The client brings charges against the counselor.
5) In response to a subpoena.
6) As required under chapter 26.44 RCW.

When it is possible, we will discuss any exceptions to confidentiality as they arise.
Please note: If we communicate via technology device (phone, text, email, etc.), there is a risk of loss of privacy (e.g. hacking) even though I take all reasonable precautions to protect your privacy in this regard.

Consultation: I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas about how to best help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

State Information:
Counselors practicing counseling for a fee must be licensed or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is
1) To provide protection for public health and safety; and
2) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure called "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and/or phone number:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.664.9098

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

Client's Rights
By Washington State law, you have the following rights:

- To be treated with respect and dignity
- To choose a counselor who best meets your needs and purposes
- To choose to continue or end therapy, or change to a different provider
- To receive therapy that is not discriminatory (especially due to race, religion, gender, family/nation of origin, age, disability, sexual orientation or socioeconomic status)
- To be safe from sexual harassment or exploitation
- Your health care record belongs to you. You may review and copy it on request
- To have any treatment or referral explained to your satisfaction, and to refuse any treatment or referral

Contacting Me by Phone: You may leave me a message at 253.439.8553. I will check these messages on a regular basis. Please limit your phone conversation needs to appointment scheduling and emergencies.

Emergencies: If you are in an emergency and cannot reach me, please call one of the following for help:

General Emergencies:	911
Crisis Line, Tacoma and surrounding area:	253.798.4333
Domestic Violence Hotline:	1.800.562.6025

Consent for Services and Financial Agreement

I have read and understand the information presented in this informed consent form. I agree to receive counseling services from Jeanette Scott according to the terms described above. I understand that although many people experience great relief and life improvement after engaging in therapy, there is no guarantee of a particular level of success. I have received my own copy of this form.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Date

Welcome! I am honored that you have chosen to enter into a professional relationship with me. I look forward to our work together. Please ask any questions that arise for you about the therapeutic relationship we are forming.

Financial Policy
Pearl Counseling Associates, LLC

Private Pay (not using Insurance)

Payment is due at time of service unless you make other arrangements with your counselor. If you do have an alternate agreement with your counselor, please make sure the Office Manager is aware of it.

We accept as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders, Cash, or online banking service. Make checks or money orders payable to your counselor (not to Pearl Counseling). Checks returned for non-sufficient funds (NSF) will be charged back to your account with an additional $18.00 service charge. If you prefer, you can use EASY PAY for billing. In that case, we will maintain your credit or debit card number on file to satisfy all fees charged, including late cancels, no shows, co pays, deductibles, coinsurances or other balances.

Insurance & Insurance Collection

Insurances doing business in the state of Washington have 30 to 90 days to pay or deny a claim. They normally respond in 2-3 weeks' time. If you have paid your account in full and insurance pays at a later date, or you pay more than is owed, you may choose either to receive a refund from your counselor or apply the credit toward future sessions.

It is your responsibility to know what your mental health benefits and financial obligations are with your insurance company. As a courtesy, we will also check on your benefits. Be aware that most insurance plans require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information. This information becomes part of the insurance company files.

We will bill your insurance for you. Co-pays, if applicable, are due at time of service. If you have a coinsurance (vs a co-pay) you will be billed after we receive the explanation of benefits from your insurer. If your counselor is out of network for your insurance, you may need to pay for the session in full, and then receive reimbursement directly from your insurance company. Note: Having more than one insurer does not necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays.

Late/Missed Sessions: Insurance does not pay for missed sessions, nor for missed time during a session. If you are late or miss a session, insurance will not pay for the lost minutes, and we will need to bill you for the missed time.

Minor Clients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment requires that charges be authorized to a Visa/MasterCard/Bank Card, or payment by cash or check at time of service has been verified, or we have the signature on file of the person(s) financially responsible for the bill and they have read and signed this policy.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibility for minors rests with the accompanying adult. An exception may be made if we have a written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

Collections / Rebilling Fees: We may charge a rebilling fee of $10.00 per bill on past due accounts (over 30 days). If it becomes necessary to send your account to collections., you will be responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collections process. Non-emergency counseling sessions will be suspended until your account is paid in full.

On Call Counseling: Pearl Counseling Associates, LLC offers "on call" counseling when crisis or emergency counseling is needed during your counselor's absence. If you meet with an "on call" counselor, payment is due at the time of service, at the counselor's rate. If the "on call" counselor is in network with your insurance and you fill out their intake form, your insurance can be billed.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Client or Responsible Party: _____ **Date**_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO 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 or condition and related health care services.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI 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 a copy of the required accounting of disclosures that I make 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. I will accommodate reasonable requests and will not ask why you are making the request.

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

Right of Complaint. You have the right to file a complaint in writing with me or with 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.

MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION

Treatment. Your PHI may be used and disclosed by me 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.

Initials _____

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related 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. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

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 public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my 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 professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

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 I disclose is limited to only that information which is necessary to make the initial mandated report. 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.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of the public or another person.

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

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 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 satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

Initials _____

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, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

THIS NOTICE

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 right 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 with respect 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 available a revised *Notice of Privacy Practices* by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

CONTACT INFORMATION

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Jeanette Scott, MA, LMHCA
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860x346

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of 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

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of this notice.

_____

Client's Signature *Date*

_____

Client's Signature *Date*

PEARL
counseling associates LLC

Jeanette Scott, MA, LMHC
Individual, Couple & Family Therapy

No Harm Agreement

I, the undersigned, agree that I will not cause bodily injury or death to myself or another person, either intentionally or unintentionally.

If I begin to feel that my behavior may become out of control or threatening in any way, I agree to follow one of the procedures listed below:

- 8:00am - 5:00pm on weekdays,
  I will call my counselor at 253.752.1860 ext.346, or cell phone 253.439.8553.
- After 5:00pm and on weekends,
  I will contact the Crisis Triage Line at 798-4333 or 1-800-576-7764.
- Call 911

I agree to attend all of my scheduled appointments with my therapist.

My next scheduled appointment is _____

Other instructions from my counselor that I will follow are:

_____

_____

_____

_____ _____
Client Signature Date

_____ _____
Counselor Signature Date

INSURANCE QUESTIONNAIRE

While we bill the insurance company for you as a courtesy and help facilitate your receipt of benefits, we are not responsible for whether your insurance company pays or not. To help you receive the best information regarding your mental health benefits, please contact your insurance company and ask the following questions. (These questions should be asked of each insurance policy you wish us to bill and for each family member that is seeing a counselor separately.)We ask that if you have not obtained this information before coming into our facility, that you please do so by your second session. Even though mental health benefits fall under the medical category, do not assume that you have benefits or that your benefits are the same for mental health as they are for medical expenses (they usually are quite different).

Do I have mental health benefits on my policy? If additional members of my family are seeing the counselor separately, do they have the same benefits?

If yes,

1) Is my counselor covered under my policy? (Be sure and get your counselor's credentials. My counselor's credentials are **LMHC, Licensed Mental Health Counselor**. (Some insurances will take only and MD, PhD, or licensed agency. Pearl Counseling Associates, LLC is not a licensed agency.) Is my counselor a preferred/participating provider or considered out of network? If my counselor is not preferred/participating, do I have out of network benefits? Are out of network providers with my counselor's credentials covered? Does my counselor need direct supervision by a MD or PhD to be covered?

2) Is this an EAP (employee assistance program) or am I using my regular insurance policy only (or both)? [If EAP, has my counselor been sent a packet for billing (If so, check with counselor to see if received)? How many sessions has my EAP approved? After my EAP sessions are finished, and I wish to continue, can I continue with my current counselor or do I need a referral?]

3) What are my deductible and/or co pay/coinsurance? (Have I met my deductible for the year? If not, how much do I still owe? When does it start over again?)

4) Do I need preauthorization, a referral from my physician (ex: family doctor) or a gatekeeper (ex. Magellan, MHN, HMC), for any or maximum benefits? If yes, questions to ask your physician or gatekeeper.
   a) How many sessions will they allow me to begin with?
   b) If necessary, who obtains the extension on the authorization?
   c) How soon will my insurance company receive the authorization so my sessions will be covered? (Client should check with insurance company a few days after expected date of receipt to see if authorization has been received.)
   d) What are the start date and ending date of my authorization? Will it cover sessions I've already had?

5) How many sessions will my insurance cover or what is the maximum dollar amount per year my insurance company will allow?

6) What are the exclusions on the policy, if any? Will my presenting issue be covered? (ex: often marriage and family issues are not covered).

7) What is the correct insurance address to send claims to? Is it different than what's on my card? Is it different for a preferred provider vs. an out of network provider?