Scarlet Cramer, LMFT

Revised 05/06/2015

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 # ( ) _____ **Cellular Phone # ( )** _____ **Work 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**_____

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? □ 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: ( )** _____

counseling as

SCARLET CRAMER, LMFT
Individual, Couple & Family Therapy

CLIENT DISCLOSURE INFORMATION

BACKGROUND

I graduated Grace Theological Seminary with an MA in Biblical Counseling with continued graduate studies in Marriage and Family Therapy at Indiana Wesleyan University. She is trained in Imago Therapy for couples and families that focuses on providing tools to promote healthy communication and relational connection. She is certified in Trauma and Abuse counseling through the Allender Center of Seattle, and she is certified in Eagala Equine Therapy. She specializes in parent/teen relationships through workshops and speaking engagements.

DESCRIPTION

Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing 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.

I am a licensed marriage and family therapist with the State of Washington, #LF60569431. As a therapist who is in private practice, I am solely responsible for services rendered. My therapeutic work does not necessarily reflect those of other independent therapists at Pearl Counseling Associates.

THERAPEUTIC METHODS

I am a seasoned therapist with over 25 years clinical experience in addressing life issues as it relates to couples, families, individual, and adolescent/parent struggles. I believe the world is based on relationships and connection. I take a collaborative approach by inviting a safe place to process ones own story. My counseling approach comes from a Christian based worldview, yet I am a respecter of all faiths and ones personal journey.

I am actively involved in adolescent culture through the ministry of Young Life and am aware of the present struggles and pressures preteens and teens are up against. I offer Heart & Soul Parenting Workshops with a focus on helping parents transition from control to influence as children move into identity formation.

I believe in the importance of honest, open communication in resolving family issues. Therefore, in the majority of situations I discourage secrets between family members who are my clients. However, in some instances (i.e., domestic violence) I reserve the right to use my professional expertise in proceeding with what I believe to be the best course of action. If you are an individual client, I will respect your confidentiality, within ethical and legal guidelines.

As your therapist, I will write and safely maintain confidential notes about our therapy sessions. These notes are available for you to review and/or have copies made of.

THERAPEUTIC PROCESS

Therapy is a joint responsibility, with the therapist and clients mutually working towards client goals. As your therapist, I will listen to your concerns, clarify your issues, encourage independence and offer professional insights into possible resolutions. I will also be available to answer questions pertaining to your therapeutic process.

For therapy to be most effective, I believe it is necessary for you to communicate honestly your thoughts, feelings, and behaviors, be willing to change, consistently attend therapy sessions and participate in between-session tasks.

Therapy involves change, with the potential for both risks and benefits. Risks may include dealing with other people's negative reactions to your behavioral changes. Benefits may include learning more effective ways of interacting with others.

Clients have the right to choose counselors who best suit their needs and purposes. As therapy is voluntary, you may terminate at any time, with the option of requesting a referral to another counselor.

SCHEDULED SESSIONS

Typically, sessions are scheduled for weekly 55-minute segments. Frequent cancellations or missing two sessions in a row warrant a discussion about whether to continue with therapy. If I am unable to keep our scheduled appointment, I will notify you.

In the case of an emergency, and I am not readily available, call the 24-hour crisis line: (253) 798-4333.

FINANCIAL ARRANGEMENTS

My fee is $130.00 per 55-minute session for billed services except for the initial session, which is $150.00. In the event that you are unable to keep an appointment, a 24-hour notice is required for cancellations. Except for unforeseen circumstances, you will be charged full fee of $130 for a "no show" and a late cancel fee of $65 for a cancellation without 24 hours notice. Charges for extended appointments will be assessed at $1.00 for each minute over 55 minutes. For example, should your appointment last 60 minutes; the fee would be $135.00. This $1 per minute rate also includes between session telephone calls lasting 10 minutes or longer. To those who are paying out of pocket and pay at the time of service, I will discount the charges to $135 for the initial session and $110 for subsequent sessions.

In addition, if we believe that it would be helpful for me to consult with another paid professional regarding your situation, you will be responsible for all fees, including my time. I also charge for my time when asked to write up evaluations and summaries of treatment. If you believe your health insurance will cover my services, please supply me with all necessary information and forms. If using insurance, the client is responsible for procedures that are not covered by their policies (ex. missed sessions and late cancellations).

ASSURANCE OF PROFESSIONAL CONDUCT

The State has determined a number of acts that constitute unprofessional conduct. Following are acts or conditions that give you a general idea of the kinds of behaviors that could be considered a violation of the law. If you feel that any of the following have occurred during your treatment, you can file a complaint with me as my own privacy officer or the U.S. Secretary of Health and Human Services

- Acts of unprofessional conduct
- Abuse of a client or sexual contact with a client
- Incompetence, negligence or malpractice that harms a client or creates an unreasonable risk or harm to a client
- Willful betrayal of the counselor-client privileges as recognized by law

- The commission of any act involving moral turpitude, dishonesty or corruption relating to the practice of counseling. The act does not have to be a crime to be a violation of the law regulating counselors
- Practicing counseling while suffering from a contagious or infectious disease in a way that would pose a serious risk to the public
- Aiding a client to obtain an abortion through illegal means
- Possession, use or distribution of drugs except for a legitimate purpose, addiction to drugs or violation of any drug law
- Habitual use or impairment from the use of alcohol. Misrepresentation or fraud in any aspect of the conduct of the profession
- Advertising that is false, fraudulent or misleading
- Offering to treat clients by a secret method, procedure or treatment
- Promotion for personal gain of any drug, device, treatment procedure or service that is unnecessary or has no acceptable benefit to the client
- Conviction of any gross misdemeanor or felony relating to the practice of counseling
- Violation of the rebating laws which includes payment for referral of clients
- Interference with an investigation by use of threats or harassment against a client or witness to prevent them from providing evidence in a disciplinary proceeding or other legal action

I have read the Disclosure Statement and am satisfied with my rights as stated above and agree to act in accordance with my responsibilities also outlined above.

_____ Date_____
Client Signature

_____ Date _____
Client Signature

_____ Date _____
Scarlet Cramer, LMFT

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:

Scarlet Cramer, LMFT
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860

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 Signature *Date*

Scarlet Cramer, LMFT
Pearl Counseling Associates, LLC
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860, 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 **Scarlet Cramer 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: _____