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|  | Safe Space Counseling615 North 2nd St.,Tacoma, WA 98403Phone: (253) 292-6756Email: Kelly@safespacetacoma.com |

**CLIENT INFORMATION**

Date:

Name: Date of Birth:

Marital Status:

Street Address:

City: State: Zip Code:

Home Phone: Leave Detailed Message? (Y/N):

Work Phone: Leave Detailed Message? (Y/N):

Cell Phone: Leave Detailed Message? (Y/N):

Email Address:

Occupation: Employer:

Presenting Issue - briefly summarize the purpose for seeking counseling today:

**Partner/Spouse Information**

Partner/Spouse Name: Date of Birth: N/A:

Work or Cell Phone: Leave Detailed Message? (Y/N):

**Emergency Contact**

Name:

Relationship to Primary Client:

Home Phone: Leave Detailed Message? (Y/N):

Work Phone: Leave Detailed Message? (Y/N):

**Responsible Party/Guardian** *(if client is a minor or other than primary)*

Name: Date of Birth:

Relation to primary client:

Street Address:

City: State: Zip Code:

Home Phone: Leave Detailed Message? (Y/N):

Work or Cell Phone: Leave Detailed Message? (Y/N):

**Primary Insured** *(if billing through insurance – N/A for cash clients or clients using their insurance plan’s out of network benefits)*

Name: Date of Birth:

Relation to primary client:

Street Address:

City: State: Zip Code:

Home Phone: Leave Detailed Message? (Y/N):

Work or Cell Phone: Leave Detailed Message? (Y/N):

Occupation: Employer:

**Referral**

How did you hear about Safe Space Counseling? (Personal referral, Psychology Today, etc.)**:**

**DISCLOSURE INFORMATION & INFORMED CONSENT**

*Safe Space Counseling is committed to providing professional mental health counseling to all individuals in compliance with recognized Federal and Washington State regulations and guidelines.* This *INFORMED CONSENT is written in accordance with Washington State WAC 246-809-710.Safe Space Counseling does not discriminate based on the established Federal classifications.*

**Introduction**

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

The following information is also provided to help you determine if what Safe Space Counseling offers meets your needs as a client and will be a good fit for you. This document contains important information about your provider’s therapeutic approach, education, fees, and your rights as a client including your rights regarding your private health information. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services.

I am not able to propose an appropriate course of treatment for you until we have spent some time together. As soon as I am able to identify an appropriate course of treatment, I will discuss it with you.

**A word about the counseling process**

The counseling process promotes growth and helps clients express feelings in a safe, supportive, and non-judgmental environment. Counseling improves coping skills and assists clients in identifying alternative solutions to life issues. The process is not an easy road, as there is often increased stress and anxiety when examining emotionally troubling or painful events. Often family and friends struggle with adjusting to the changes clients make while in counseling. Finally, despite the time spent, there is no guarantee that counseling will be successful for everyone. However, despite the potential difficulties, counseling is a therapeutic process in which the benefits may well far outweigh the risks.

***Kelly Carr, MA, MHP, LMHC (****LH6066776****)’s* Academic Qualifications and Experience**

I received a Bachelor of Arts in Psychology from Pacific Lutheran University in 2005. I then went on to earn a Masters of Arts in Pastoral Studies in 2012 from Seattle University. After completing my masters degree I completed a full-time 2 year post masters graduate program earning a Post Masters Certificate in Pastoral Counseling. This certificate focused on therapeutically working with people to identify their strengths, build on their strengths, and help promote growth and healing within the client. In addition the program trained me to see people and their behavior as part of a wider system rather than seeing people as separate from the communities in which they live and experience life. While in this program I completed a 18 month internship working with adults in recovery from Drug and Alcohol Abuse, and children suffering from trauma. In June 2014 I began working full time with adults, adolescents, and children suffering from trauma, anxiety, depression, bipolar, schizophrenia, grief/loss, anger, relationship issues, low self-esteem, and PTSD. I am also certified in Cognitive Processing Therapy, an evidenced based practice that helps people heal from trauma and recover from symptoms of PTSD. I have also obtained training in Lifespan Integration therapy, an evidenced based therapy which helps heal trauma and attachment in a gentle and noninvasive manner. For more information on Lifespan Integration Therapy please visit the website at [www.lifespanintegration.com](http://www.lifespanintegration.com). Please see the about page of my website ([www.safespacetacoma.com](http://www.safespacetacoma.com)) for more information on my style when working with clients

**Supervision**

Although not required by law, I have chosen to receive supervision from Sharmayne Arrington (LH60133297) once a month. I do this because I believe receiving supervision helps to provide the best possible therapy to my clients. Therefore, there may be times in which I ask my supervisor for guidance in my work with a particular client. However, when doing so any identifying information will be withheld in order to protect my client’s confidentiality.

**Confidentiality**

Information shared verbally in sessions as well as written progress notes will be held in the strictest confidence, and will not be released without your written consent, excluding the following scenarios:

* ***Safety***: If a client is in danger of harming self or others, disclosure will be made to the emergency contact on file, as well as the local medical, police, and community resources needed to ensure the safety of the client. Every attempt will be made to disclose information within the presence of the client (and with voluntary consent).
* ***Mandatory Reporting***: If abuse or other crime committed against an elderly person or minor is disclosed or a counselor has reason to suspect such, state law requires the counselor to report the information to the appropriate agency.
* ***Professional Consultation****:* A client case may be presented to other mental health professionals for the purpose of exploring alternative therapeutic techniques, identifying community resources, and mitigating client risk of harm. Personal client information is not included in the consultation.
* ***Counselor Absence:*** During periods in which the counselor is unavailable, another professional counselor will be selected to continue the therapeutic process and maintain the safety and well-being of the client. Only the client information and progress notes necessary to continue the counseling process will be disclosed during the period of absence. This practice is based on the American Counseling Association ethical guideline to “prohibit abandonment or neglect in counseling and make appropriate arrangements for the continuation of counseling” (ACA A.11.a).
* ***Legal Mandate:*** It is possible that counseling records may be subpoenaed. This practice is required by law to disclose information pertaining to suspected child or elder abuse, and/or neglect, threatened harm to oneself or others, or disclosure that a crime will be or has been committed.
* ***Minors (clients under 13)***: In situations pertaining to client safety and mandatory reporting, disclosure will be made to the parents/guardians on file. The progress of counseling for minors under 13 will be considered a part of family counseling and will be discussed as appropriate with parents and/or guardians.

**Appointment Scheduling**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

**Client Rights**

As a counseling client you have the right to:

* Refuse treatment
* Choose a practitioner and treatment modality that best suits your needs.
* See a copy of your medical record and request a summary or a copy of your medical record
* Ask us to correct your medical record
* Decide whom we share your protected health care information with
* Ask us to limit what we use or share
* Get a list of those with whom we’ve shared information
* Receive a copy of this privacy notice

Please ask your counselor for more information.

If you have a complaint about your counselor’s work, please bring it to her or his attention, as many of the conflicts that arise in counseling can be resolved through honest discussion. If you feel it cannot be resolved, it is within your rights to make a complaint to the Health Systems Quality Assurance Complaint Intake, P.O. Box 47857, Olympia, WA 98504-7857, 360-236-4700.

**Therapist Availability/Emergencies**

Telephone calls between your scheduled sessions are welcomed. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for me at any time on my confidential voicemail. If you wish for me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Nonurgent phone calls are returned during normal workdays (Monday through Friday) within 48 hours. I am not available to return calls on Saturdays or Sundays. If you have an urgent need to speak with your therapist, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (800) 576-7764 or (253) 396-5180

Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

WA State Domestic Violence Help: (800) 562-6025

**Again, If you are in need of more immediate assistance, please call the Pierce County at (800) 576-7764. In the event of an emergency situation, please call 911 or proceed directly to the emergency room of the nearest hospital.**

**Records**

All client records are stored in a cloud based system with bank level encryption that is HIPAA certified, encrypted, and kept secure. Here is an up to date list of all the ways your information remains secure: <https://www.simplepractice.com/security>

**Termination of Counseling**

I want you to receive the best possible therapeutic services available to you. Therefore, If at any point in time during the counseling process, you would like to terminate services, Safe Space Counseling can recommend another mental health professional (Note: All outstanding professional fees will be due upon notice of termination). If I find that my services are not going to be a good fit for a client or that the client’s needs are out of my scope of practice, I will make every effort to connect a client with a counselor that is more suited for what the client is looking for in therapy. Therefore, I reserve the right to terminate the counseling relationship at any point in time, with every effort to provide a smooth transition to another mental health professional. If you have questions about transition or the termination process, please contact the Washington State Department of Health at (360) 236-4700.

**File Closure due to Lack of Attendance**

I understand that an emergency may happen, and a client will be unable to attend their regularly scheduled session. Since clients have a set day and time for their appointment, if a client misses an appointment without notifying the me, I will assume that the client will be attending the next scheduled appointment. If a client misses a second session in a row without touching base with me and a week goes by without hearing from the client, then I will assume the client is no longer interested in services and I will proceed to close the file. Please let me know if you have any questions or concerns about this policy practice.

**Costs and Fees: *Cash, Checks, Debit Cards, and Credit Cards***

Safe Space Counseling accepts cash, checks, and credit cards. Fees for all services are due in full at each session. In order to be able to accept Credit and Debit cards Safe Space Counseling uses the Square card reader. The Square company keeps a small percentage of each transaction. Therefore, there will be a small surcharge when using your credit or debit card. This surcharge differs based on whether the transaction is swiped through the reader or manually entered. If an account is more than 60 days delinquent it will be sent to collections. If an account is sent to collections, the account holder will incur an additional $75.00 fee to cover clerical and processing costs.

**Counseling**

* Initial intake appointment - $140.00 per session.
* Individual client counseling session – $140.00 per session.

**Phone Calls & Documentation**

* Telephone calls and emails to collateral entities (such as schools, doctors, psychiatrists, other counselors or lawyers) - $12.00 per 5 minutes.
* Written documentation (such as summaries for schools and legal reports) - $12.00 per 5 minutes.

**Returned Checks**

* Checks returned for any reason will result in a $35.00 processing fee, in addition to the face value of the check. The original fee plus the returned check fee must be paid prior to scheduling your next appointment.

**Legal: Deposition & Testimonies**

* Legal depositions are billed at $175.00/hour with a $700.00 minimum.
* Court appearances, with or without counselor testimony, are billed at $1500.00 per day.
* All deposition and court appearance fees must be paid in full 30 days prior to the scheduled deposition or trial, unless other arrangements have been made in writing. NOTE: The party requesting the deposition or court appearance is responsible for payment.

By signing below, you indicate that you have read and understand the **“Costs and Fees: Cash, Checks and Credit Cards”**section above. Your signature represents a binding agreement between Safe Space Counseling,PLLC and the client or responsible party (in the case of a minor).

Printed Nameof Client Signature Date Signed

Printed Name of Financially Responsible Party Signature Date Signed

**Rescheduling, Cancellations, and Missed Appointments**

**An appointment must be cancelled or rescheduled a minimum of 48 hours notice in order to avoid a no-show fee (i.e. if your session is at 10am on Wednesday, cancellation or rescheduling must take place by 10am on Monday).**

* + - * For sessions that are missed or cancelled with less than 48 hours notice, client will be charged the cost of session. As part of my policies I keep a credit card on file in my secure online system for all clients. This credit card will be charged the cost of session plus a processing fee on the day your appointment was missed. If you prefer to pay the late cancellation or no show fee by check or cash you must contact the clinician by end of business hours on the day of the session (you can find the business hours at the bottom of each web page of www.safespacetacoma.com).**By signing this informed consent you agree to keep a current credit card on file and agree to be charged for your sessions and any late cancellations or no show appointments.**
* Safe Space Counseling understands that emergencies happen and reserves the right to decide what constitutes an emergency. Safe Space Counseling may wave the fee if the cancellation or no show reason falls into the classification of an emergency. Typically, Safe Space Counseling considers an emergency to be something that occurs that is out of the client’s control.

By signing below, you indicate that you have read and understand the **“Rescheduling, Cancellations, and Missed Appointments”** section above. Your signature represents a binding agreement between Safe Space Counseling, PLLC and the client or responsible party (in the case of a minor).

Printed Name of Client Signature Date Signed

Printed Name of Financially Responsible Party Signature Date Signed

**Costs and Fees: *Insurance (both In-Network and Out-of-Network)***

**In-Network Insurance Billing**

* Safe Space Counseling is only in network with Molina, Regence, Cigna, and Kaiser PPO plans. For these plans Safe Space Counseling will submit claims to your insurance company for intake, individual, or family counseling. Other counseling services will be charged as above.

**Out-of-Network**

* Those wanting to use their insurance but do not have Molina, Regence, Cigna, or Kaiser insurance providers may possibly use their out of network benefits. Safe Space Counseling encourages clients to check with their insurance provider to find out if their plan includes out of network benefits for mental health counselling. If you are able to be reimbursed through your out of network benefits and want to do so, please let me know so I can provide you with a superbill to send to your insurance provider.

**Missed or “No-Show” Appointment Charges**

* Most insurance companies DO NOT reimburse for missed appointments. Safe Space Counseling DOES NOT submit claims for this service to the insurance company. For all sessions that are not cancelled within 48 hours of the start of the scheduled session, the client will be charged the cost of session. This session charge is the responsibility of the client or guardian (in the case of a minor) and must be paid in full before future appointments will be scheduled.

**Documentation and Phone Calls**

* Most insurance companies DO NOT reimburse for written materials or phone calls. Safe Space Counseling DOES NOT submit claims for this service to the insurance company. The client or guardian (in the case of a minor) is responsible for full payment at the time of service; see rates above.

**Deposition and Testimony**

* Most insurance companies DO NOT reimburse for legal costs. Safe Space Counseling DOES NOT submit claims for this service to the insurance company. The client or guardian (in the case of a minor) is responsible for full payment at time of service; see rates above.

**Release and Assignment**

I hereby authorize Safe Space Counseling and/or my insurance company to release any information required for processing my insurance claims. I authorize my insurance benefits to be paid directly to Safe Space Counseling.

**The agreement of the client’s insurance company to pay the medical claim is a contract between the client and his/her carrier. The account with Safe Space Counseling remains the client’s responsibility. If the insurance company does not pay, the client, or financially responsible party, is responsible for paying the balance. Balances more than 60 days old will be referred to collection. If an account is sent to collections, the account holder will incur an additional $75.00 fee to cover clerical and processing costs.**

Printed Name of Financially Responsible Party Signature Date Signed

**Notice of Privacy Practices (Only needed if HIPAA Covered Entity)**

For the Office of Safe Space Counseling

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I’ve created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is “disclosed” when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also, request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for other, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

1. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operation Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:
	1. For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you’re being treated by a psychiatrist, I can disclose your PHI to you psychiatrist in order to coordinate your care.
	2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
	3. For health care operations. I can disclosure your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I’m complying with applicable laws.
	4. Other disclosure. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn’t required if you need emergency treatment, as long as I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.
2. Certain Uses and Disclosures Do Not Require Your Consent. I can use your PHI without your consent or authorization for the following reasons:
	1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
	2. For public health activities. For example, I may have to report information about you to the county coroner.
	3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
	4. For research purpose. In certain circumstances, I may provide PHI in order to conduct medical research.
	5. To avoid Harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel and veterans in certain situations. And I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.
	6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
	7. For workers’ compensation purposes. I may provide PHI in order to comply with workers’ compensation laws.
	8. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.
3. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
	1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
4. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven’t taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclosure your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.
2. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.
3. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don’t have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
4. The Right to Get a List of the Disclosures I have Made.
5. You have the right to get a list of instances in which I have disclosed you PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won’t include uses and disclosures made for nation security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.
6. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one based request in the same year, I will charge you a reasonable cost based fee for each additional request.
7. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don’t file one, you have the right to request that you request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.
8. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at Miranda Palmer, 1311 E Street, Modesto, California, 95354 209-602-1513, Mirandamft@gmail.com .

VII. EFFECTIVE DATE OF THE NOTICE

This notice went into effect on January 1, 2007

**Counseling Client Disclosure Information and Informed Consent Agreement**

Your signature indicates that you have read all proceeding pages of this agreement for services carefully and understand its contents. Your signature also states that you have read the above privacy practices and that you have been offered a copy for your records. If you have any questions or concerns, please ask your therapist to address any questions or concerns that you have about this information before you sign.

Printed Nameof Client Signature Date Signed

Printed Name of Therapist Signature Date Signed

**I am the parent and/or legal guardian of the above-mentioned minor child (under 13 years old).**

Printed Name of Parent or Guardian Signature Date Signed