

## **Diane Adams Nakamura, Ph.D., P.S.**

Diane Adams Nakamura, Ph.D.  
Licensed Psychologist PY2393

19203 99<sup>th</sup> Place South  
Renton, WA 98055  
(253) 852-4699

### **SERVICES AGREEMENT**

Welcome,

This document contains important information about my professional services and business policies. Please feel free to ask me any questions about this document or others that you will read today during our first session and at any time in the future. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or, if you have not satisfied any financial obligations you have incurred.

**Professional Qualifications:** I am a licensed psychologist in Washington State. I have a doctoral degree (Ph.D.) and a master's degree (M.S.) in clinical psychology from Auburn University (Auburn, Alabama). I am a member of the American Psychological Association (APA) and the Washington State Psychological Association (WSPA) and adhere to both the APA Code of Ethics and the professional standards of the Washington State Licensing Law.

**Psychological Services:** Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and between sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. If you decide to continue therapy, we will be able to develop a treatment plan within the first several visits. Please evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

## Meetings

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Should we both decide that it will be beneficial for you to work with me, I typically schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

## Professional Fees

	<u>At time of Service</u>	<u>If any type of billing is done</u>
Initial Intake	\$150	\$216
45 minute session	\$115	\$140
45 minute couples session	\$125	\$165
75 minute individual session	\$172	\$210
90 minute couples session	\$250	\$330 *
80 minute group therapy session	\$50	\$65

(\* There is no procedure code for this length couples session. So, if you want your insurance billed, check with your company to see if they will allow two couples sessions billed on one day .)

Payment is expected at the time of service unless we have discussed a billing arrangement. My hourly fee for other professional services is \$140 per hour. I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$400 per hour for preparation and attendance at any legal proceeding.]

**Appointments and Cancellations:** Appointments are generally 45-50 minutes (one hour and 20 minutes for group, one hour for coping skills groups), unless we arrange otherwise. The time scheduled for your session is set-aside for you. If you are late, you will be seen for the time remaining in your appointment, but charged the full rate. If you miss a session without canceling, or if you cancel with less than **48 hours** notice (for any reason), you will be billed for that time. The fee rates for missed or short-notice cancellations are as follows:

	<u>45-50 minute</u>	<u>75-80 minute</u>	<u>90 minute sessions</u>
First Time	\$25	\$37	\$50
Second Time or more	\$50	\$75	\$100

Please note that insurance will not pay for missed or less-than-48-hour notice cancellations and therefore, you are responsible for paying these fees. If you are a group therapy client and you are late beyond what the group has decided is an acceptable time period, you will not be admitted to that session, but you are still responsible for payment for that session. Group therapy clients are responsible for paying for all sessions while they are member of a group regardless of whether they attend or not.

**Payment Security:** Unfortunately I have had some instances of clients not paying fees owed for services, missed appointments, or less-than-48-hours notice of cancellation. For this reason, my biller has recommended that I get all clients' permission to bill their credit card in the event that a client has unpaid fees and has not remitted payment upon request or upon billing or both. I do not regularly accept credit card payments. If you do not wish to use a credit card, you may pay a retainer by cash or check that will be returned to you if unused when your case is closed.

### **Contacting Me**

Due to my schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor at least once every 24 hours, but usually more frequently. I will make every effort to return your call on the same day you make it with the exception of weekends and holidays [I do **not** monitor my voice mail from 2:20 p.m. on Friday until 9 a.m. on Monday and often cannot return calls made during the weekend until Monday evening at 8:30 p.m.]. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, follow the directions on our Crisis Plan Agreement form, or contact the King County Crisis Line at 206-461-3222, or go to the nearest emergency room and ask for the psychologist [psychiatrist] on call. Another option is for you to call your primary care physician or psychiatrist.

### **Limits on Confidentiality**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. However, there are some situations where I am permitted or required to disclose information without either your consent or Authorization such as situations involving information about child abuse, vulnerable adult abuse, health oversight by the Washington Board of Psychology, unopposed subpoena, court order, serious threats to health or safety, and worker's compensation. Please see detailed descriptions of these circumstances in your *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information*. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

As a result of new state regulations adopted by the Washington State Department of Health, I am required to report myself or another health care provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct by another licensed provider. If you have any questions or concerns about this requirement, please talk with me about them.

I may occasionally find it helpful to consult other health and mental health professionals about a case. If I consult with a professional who is not involved in your treatment, I make every effort to avoid revealing your identity. These professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health

Information). Please let me know today if you do not want me to consult with other professionals regarding your case even if your identity is not revealed.

## **PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Exceptions would be if I conclude that disclosure could reasonably be expected to cause danger to the life or safety of the patient or any other individual or that disclosure could reasonably be expected to lead to the patient's identification of the person who provided information to me in confidence under circumstances where confidentiality is appropriate. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of 65 cents per page for the first 30 pages and 50 cents per page after that, and a \$15 clerical fee. I may withhold your Record until the fees are paid. The exceptions to this policy are contained in the following Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they *cannot* receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that knowledge of the health care information would be injurious to your health or the health of another person, or could reasonably be expected to lead to your identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate, or contain information that was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes, or is otherwise prohibited by law.

## **Minors and Parents**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Since privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is usually my policy to request an agreement from the parents that they consent to give up access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's

treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

### **Billing and Payments**

You will be expected to pay for each session at the time it is held, unless we agree otherwise. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

### **Insurance or Other Third Party Reimbursement**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. Thus, it is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they

may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.**

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Second Name if couple or family member

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Second Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Diane Nakamura, Ph.D.  
Licensed Psychologist

\_\_\_\_\_  
Date

**RECEIPT of HIPAA NOTICE VERIFICATION**

By signing my name here I am indicating that I have received a Notice about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of my Protected Health Information (PHI). I understand that this Notice explains HIPAA and its application to my personal health information.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Second Name if couple or family member

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Second Signature

\_\_\_\_\_  
Date

**Basic Information Form – Relationship Version – Person One**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ SS# \_\_\_\_\_

Cultural Background/Race \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_

Please put a check mark next to any numbers where it is okay to leave a detailed message or indicate what type of message is okay to leave.

Billing Address \_\_\_\_\_  
Street City Zip code

Marital/Relationship History (please list length of previous and current relationships married or not)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Job History \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please List Children, their ages, and where they reside: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Previous therapy experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Health Problems (please list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you exercise? If so, how often and what type of regular physical activity do you do?

\_\_\_\_\_

Ever lost consciousness and why? \_\_\_\_\_

Alcohol and/or substance use history (describe use history, age of first use, frequency, amounts):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Suicide/self-harm/harming others (describe any history of these types of issues):

\_\_\_\_\_  
\_\_\_\_\_

Any pending, active or anticipated legal actions \_\_\_\_\_

Family of Origin (please list siblings and parents, their ages or if deceased when):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you seeking help and why now? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How long have you noticed problems/dissatisfaction in your relationship? \_\_\_\_\_

How could I become a more effective partner? \_\_\_\_\_

\_\_\_\_\_

What would make it difficult for me to change? \_\_\_\_\_

\_\_\_\_\_

How willing am I to change? \_\_\_\_\_

Spiritual/Religious Orientation: \_\_\_\_\_

I learned about Dr. Nakamura's services from: \_\_\_\_\_

If from the Internet, how did you search? \_\_\_\_\_

**Basic Information Form – Relationship Version –Person Two**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ SS# \_\_\_\_\_

Cultural Background/Race \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_

Please put a check mark next to any numbers where it is okay to leave a detailed message or indicate what type of message is okay to leave.

Billing Address \_\_\_\_\_  
Street City Zip code

Marital/Relationship History (please list length of previous and current relationships married or not)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Job History \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please List Children, their ages, and where they reside: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Previous therapy experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Health Problems (please list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you exercise? If so, how often and what type of regular physical activity do you do?

\_\_\_\_\_

Ever lost consciousness and why? \_\_\_\_\_

Alcohol and/or substance use history (describe use history, age of first use, frequency, amounts):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Suicide/self-harm/harming others (describe any history of these types of issues):

\_\_\_\_\_  
\_\_\_\_\_

Any pending, active or anticipated legal actions \_\_\_\_\_

Family of Origin (please list siblings and parents, their ages or if deceased when):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you seeking help and why now? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How long have you noticed problems/dissatisfaction in your relationship? \_\_\_\_\_

How could I become a more effective partner? \_\_\_\_\_

\_\_\_\_\_

What would make it difficult for me to change? \_\_\_\_\_

\_\_\_\_\_

How willing am I to change? \_\_\_\_\_




Spiritual/Religious Orientation: \_\_\_\_\_

I learned about Dr. Nakamura's services from: \_\_\_\_\_

If from the Internet, how did you search? \_\_\_\_\_

### Client Credit Card Pre-Authorization

In an effort to better serve my clients and simplify your billing experience, my practice offers credit card acceptance. Charge card information is filed with your confidential client information and kept secure.

<b>OPTIONS</b>	<p>_____ (initial) I hereby authorize Diane Adams Nakamura, Ph.D., P.S. to charge a retainer on my account for the amount of \$_____. This retainer is to cover any expenses not paid at the time of service.</p> <p>_____ (initial) I hereby authorize Diane Adams Nakamura, Ph.D., P.S. to charge the balance of my account automatically for any fees not paid at the time of service. I understand that usually I am expected to produce my credit card, should I wish to pay by credit or debit card, at the time of service.</p>
<b>PAYMENT INFORMATION</b>	<p><b>Client Name:</b> _____</p> <p><b>Client Billing Address:</b> _____</p> <p><b>Type of Card:</b>      <input type="checkbox"/>       <input type="checkbox"/>       <input type="checkbox"/> </p> <p><b>Card Number:</b> _____</p> <p><b>Expiration Date:</b> _____ <b>Security Code:</b> _____ <small>(last three digits on card)</small></p> <p>The undersigned guarantees performance of the financial provisions of this agreement.</p> <p><b>Card Holder Name:</b> _____</p> <p><b>Signature of Card Holder:</b> _____ <b>Date:</b> _____</p>
<b>CHARGE POLICY</b>	<p>Being the cardholder or the Corporate Officer, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I furthermore confirm that I have received all services and goods to satisfactory conditions.</p> <p>_____ (initial) Charges made for actual services performed by our office are non-refundable. In the event of pre-payment any unused funds will be refunded in <u>30</u> days.</p>

## Last Two Weeks Mood Survey – Person One

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Instructions.** Please circle the number to indicate how depressed, anxious or angry you've been feeling over the past **two weeks**, including today. Please answer all the items.

		<b>0 = Not at all</b>					<b>4 = Extremely</b>						
1. Sad or down in the dumps		0	1	2	3	4	10. Worrying about things		0	1	2	3	4
2. Discouraged or hopeless		0	1	2	3	4	11. Tense or on edge		0	1	2	3	4
3. Low self-esteem		0	1	2	3	4	12. Nervous		0	1	2	3	4
4. Worthless or inadequate		0	1	2	3	4	13. Frustrated		0	1	2	3	4
5. Loss of pleasure or satisfaction in life		0	1	2	3	4	14. Annoyed		0	1	2	3	4
6. Do you have any suicidal thoughts?		0	1	2	3	4	15. Resentful		0	1	2	3	4
7. Would you like to end your life?		0	1	2	3	4	16. Angry		0	1	2	3	4
8. Anxious		0	1	2	3	4	17. Irritated		0	1	2	3	4
9. Frightened		0	1	2	3	4	18. Urges to hurt someone		0	1	2	3	4

Please circle the number that describes how satisfied you are in your closest relationship where  
**0 = not at all satisfied**      **4 = extremely satisfied**

1. Communication and openness		0	1	2	3	4
2. Resolving conflicts and arguments		0	1	2	3	4
3. Degree of affection and caring		0	1	2	3	4
4. Intimacy and closeness		0	1	2	3	4
5. Overall satisfaction		0	1	2	3	4

Taking any medications? If so, please list \_\_\_\_\_

Taken any medications for emotional problems in the past? \_\_\_\_\_

If so, please list

±

Have there been any other significant changes in your life in the few months? (i.e. health status, pregnancy, job changes, financial stresses, child leaving home)

## Last Two Weeks Mood Survey – Person Two

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Instructions.** Please circle the number to indicate how depressed, anxious or angry you've been feeling over the past **two weeks**, including today. Please answer all the items.

					<b>0 = Not at all</b>						<b>4 = Extremely</b>
10. Sad or down in the dumps	0	1	2	3	4	10. Worrying about things	0	1	2	3	4
11. Discouraged or hopeless	0	1	2	3	4	11. Tense or on edge	0	1	2	3	4
12. Low self-esteem	0	1	2	3	4	12. Nervous	0	1	2	3	4
13. Worthless or inadequate	0	1	2	3	4	13. Frustrated	0	1	2	3	4
14. Loss of pleasure or satisfaction in life	0	1	2	3	4	14. Annoyed	0	1	2	3	4
15. Do you have any suicidal thoughts?	0	1	2	3	4	15. Resentful	0	1	2	3	4
16. Would you like to end your life?	0	1	2	3	4	16. Angry	0	1	2	3	4
17. Anxious	0	1	2	3	4	17. Irritated	0	1	2	3	4
18. Frightened	0	1	2	3	4	18. Urges to hurt someone	0	1	2	3	4

Please circle the number that describes how satisfied you are in your closest relationship where  
**0 = not at all satisfied**      **4 = extremely satisfied**

1. Communication and openness	0	1	2	3	4
2. Resolving conflicts and arguments	0	1	2	3	4
3. Degree of affection and caring	0	1	2	3	4
4. Intimacy and closeness	0	1	2	3	4
5. Overall satisfaction	0	1	2	3	4

Taking any medications? If so, please list \_\_\_\_\_

Taken any medications for emotional problems in the past? \_\_\_\_\_

If so, please list

±

Have there been any other significant changes in your life in the few months? (i.e. health status, pregnancy, job changes, financial stresses, child leaving home)

**Diane Adams Nakamura, Ph.D., P.S.**  
**19203 99<sup>th</sup> Place South**  
**Renton, Washington 98055**

---

**CRISIS PLAN AGREEMENT- Person One**

I, \_\_\_\_\_, agree to take the following actions to obtain assistance should I be in crisis.

**Immediate Risk:** If I am at *immediate risk* for harming myself or someone else, I will call 911, explain my risk and provide identification and location information.

**Crisis at Night**

**If I am in crisis and it is between the hours of 10 pm and 9 am, I will:**

1) Call my physician's after hours number and explain my crisis. My doctor's name is \_\_\_\_\_ and the after hours number is \_\_\_\_\_.

You must complete this item or if you do not have a physician, you must obtain one with 24 hour crisis coverage.

Or

2) Call the King County Crisis line at (206) 431-3222 and explain my crisis. To ensure my safety I agree to give my full name and whereabouts if asked for that information.

Or

3) Have someone take me to a hospital emergency room.

And

4) As soon as I am able, I will call Dr. Nakamura and inform her of my status or authorize someone else to do so.

**Crisis Morning to Evening**

**If I am in crisis and it is between the hours of 9 am and 10 pm, I will:**

- 1) Leave a message for Dr. Nakamura at (253) 852-4699.
- 2) Call Dr. Nakamura at (206) 234-7580 and leave another message. You **MUST LEAVE A MESSAGE** or I will not get the alert. I understand that Dr. Nakamura will make every effort to listen to my messages within 30 minutes and return my call.
- 3) If I do not hear from Dr. Nakamura within 30 minutes or I cannot wait 30 minutes, I agree to follow steps 1, 2, or 3 from the *Crisis at Night* agreement above.

I understand that Dr. Nakamura is not a physician and does not have admitting privileges at any hospitals. Therefore, should I require hospitalization, my doctor or the King County Crisis team may need to be informed. I further understand that if I am unable to follow this crisis plan agreement, Dr. Nakamura may refer me to other mental health resources and may decide to terminate our treatment if she decides this appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Diane Nakamura, Ph.D.  
Licensed Psychologist

\_\_\_\_\_  
Date

**Diane Adams Nakamura, Ph.D., P.S.**  
**19203 99<sup>th</sup> Place South**  
**Renton, Washington 98055**

---

**CRISIS PLAN AGREEMENT – Person Two**

I, \_\_\_\_\_, agree to take the following actions to obtain assistance should I be in crisis.

**Immediate Risk:** If I am at *immediate risk* for harming myself or someone else, I will call 911, explain my risk and provide identification and location information.

**Crisis at Night**

**If I am in crisis and it is between the hours of 10 pm and 9 am, I will:**

1) Call my physician's after hours number and explain my crisis. My doctor's name is \_\_\_\_\_ and the after hours number is \_\_\_\_\_.

You must complete this item or if you do not have a physician, you must obtain one with 24 hour crisis coverage.

Or

2) Call the King County Crisis line at (206) 431-3222 and explain my crisis. To ensure my safety I agree to give my full name and whereabouts if asked for that information.

Or

3) Have someone take me to a hospital emergency room.

And

4) As soon as I am able, I will call Dr. Nakamura and inform her of my status or authorize someone else to do so.

**Crisis Morning to Evening**

**If I am in crisis and it is between the hours of 9 am and 10 pm, I will:**

1) Leave a message for Dr. Nakamura at (253) 852-4699.

2) Call Dr. Nakamura at (206) 234-7580 and leave another message. You **MUST LEAVE A MESSAGE** or I will not get the alert. I understand that Dr. Nakamura will make every effort to listen to my messages within 30 minutes and return my call.

3) If I do not hear from Dr. Nakamura within 30 minutes or I cannot wait 30 minutes, I agree to follow steps 1, 2, or 3 from the *Crisis at Night* agreement above.

I understand that Dr. Nakamura is not a physician and does not have admitting privileges at any hospitals. Therefore, should I require hospitalization, my doctor or the King County Crisis team may need to be informed. I further understand that if I am unable to follow this crisis plan agreement, Dr. Nakamura may refer me to other mental health resources and may decide to terminate our treatment if she decides this appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Diane Nakamura, Ph.D.  
Licensed Psychologist

\_\_\_\_\_  
Date

**Diane Adams Nakamura, Ph.D., P.S.** \_\_\_\_\_

Diane Adams Nakamura, Ph.D.  
Licensed Psychologist PY00002393

19203 99<sup>th</sup> Place South  
Renton, WA 98055  
(253) 852-4699

THIS STIPULATION is entered into between the respondents, \_\_\_\_\_ and \_\_\_\_\_, and they declare and agree to the following:

All communications among the parties and the counselor will be confidential and privileged from disclosure. Both parties stipulate that Diane Adams Nakamura, Ph.D, will not be required to testify at or to produce for any proceeding or in any court, opinions, records, documents, or recordings formed or created as part of the psychotherapy process. It is in the best interests of the parties that no one feels influenced by any impending legal action when involved in psychotherapy. Without both parties entering into this type of stipulation, it is quite likely that the therapeutic alliance would be affected detrimentally. This stipulation does not preclude obeying the statutory requirements to report information about: child, adult dependent person or elder abuse, neglect or exploitation; an actual threat of violence against a reasonably identifiable victim(s); or mental illness that requires involuntary commitment because of danger to self or others or grave disability.

These stipulations have been explained to us and we agree to abide by them. We have been provided ample opportunity to inquire into the experience and credentials of the counselor.

We certify under penalty of perjury under the laws of Washington that the foregoing is true and correct and mutually agreed upon.

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

**Insurance Form**

Today's Date \_\_\_\_\_ Name of Insurance Co.: \_\_\_\_\_

1a. Insured's I.D. Number \_\_\_\_\_

2. Client's Name \_\_\_\_\_ 3. Client's Date of Birth \_\_\_\_\_  
Last, First Middle Initial

4. Insured/Subscriber's Name if different from Client \_\_\_\_\_  
Last, First Middle Initial

5. Client's phone and address: ( ) \_\_\_\_\_  
\_\_\_\_\_

6. Client's relationship to insured (i.e. self, spouse, child, other) \_\_\_\_\_

7. Insured's Address \_\_\_\_\_  
Street City ZIP code

8. Please check all that apply (client is) employed full-time student part-time student

If there is no other insurance plan that covers the client's health care check this box and skip to item 10.

9. Other Insured's Name: \_\_\_\_\_  
Last, First Middle Initial

Other Insured's phone and address: ( ) \_\_\_\_\_

9a. Other Insured's Policy and/or Group #: \_\_\_\_\_

9b. Other Insured's Date of Birth \_\_\_\_\_

9c. Other Insured's Employer's name or school: \_\_\_\_\_

9d. Other Insurance Plan Name or Program: \_\_\_\_\_

10. Is Client's condition related to: Employment? (current or previous) Yes No  
Is Client's condition related to: Auto Accident? Yes No  
Is Client's condition related to: Other Accident? Yes No

11. Insured's Policy Group Number: \_\_\_\_\_

11a. Insured's Date of Birth \_\_\_\_\_

11b. Insured's Employer's name or school: \_\_\_\_\_

11c. Insurance Plan or Program Name: \_\_\_\_\_

Phone and Billing Address for your Insurance Company: ( ) \_\_\_\_\_  
\_\_\_\_\_

Phone and Billing Address for other's Insurance Company: ( ) \_\_\_\_\_  
\_\_\_\_\_

## Notice of Dr. Nakamura's Policies and Practices to Protect the Privacy of Your Health Information

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

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must

immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

- **Health Oversight:** If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.
- **Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.
- **Health Care Providers:** I am required to report myself or another health care provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct by another licensed provider.

## IV. Patient's Rights and Psychologist's Duties

### Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

