Diane M. Adams, Ph. D., Licensed Psychologist
1412 SW 43rd Street, Suite 240
Renton, WA 98057
(253) 852-4699 phone (844) 848-1265 fax

DISCLOSURE AND CLIENT INFORMED CONSENT 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. Please read each section carefully and initial at the bottom of each page.

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. 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. My therapeutic orientation combines several different orientations, primarily humanistic, cognitive/behavioral, learning theory, brain science, and trauma theory. I often borrow from other perspectives, but do not use them extensively. 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 your thoughts, feelings and behaviors as well as your therapy goals both during 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 such as improved relationships, better life solutions, or significant reductions in feelings of distress. But, there are no guarantees of what you will experience.

During our first few sessions, I will be able to offer you some first impressions of what our work might include, but our treatment plan and your goals can develop and change over time if needed. Please let me know if something in our therapy does not feel like a good fit for you. I may be able to adjust or if not, perhaps help you find a therapist who is a better fit. Because therapy involves a large commitment of time, money, and energy, I want you to feel free to be selective in your choice of therapist. You may end therapy at any time, but I would only ask that we first discuss this in person. If more than 30 days have passed since our last contact, and I have not received word from

you, I will accept that as your notice that you no longer wish to continue therapy and that our therapeutic relationship is terminated.

Therapy Relationship and Professional Boundaries: These boundaries are not meant to indicate a lack of caring or interest, but rather to keep your therapy experience protected.

1. I will not, at any time, have a social relationship with you outside my office, even after we have ended our therapeutic relationship; this includes contact on social media sites and applications. I will not accept social or family event invitations from you or extend them.
2. Please do not bring me gifts other than perhaps a card or note.
3. If I see you in public, I will not initiate contact or familiarity. This is to ensure your confidentiality. If you initiate a greeting, I will reciprocate, but not initiate further communication unless you request it.
4. I will not have a relationship with you beyond my role as a psychologist. This means that I will not engage in other types of relationships with you such as other business relationships, other financial relationships, or providing services that I am not qualified to provide such as medical or legal advice (while I may share what others have shared with me or resources).
5. I will not at any time have physical or sexual contact with you except a handshake upon greeting or parting.

Meetings

We will decide together based on your clinical needs, your treatment goals, and your finances /insurance coverage how often and how long we will meet. Typically we will start by meeting for one session a week, but there may be exceptions.

Professional Fees

	At time of Service	If any type of billing is done
Initial Intake	$150	$216.00
25 minute session	$65	$97.00
45 minute session	$125	$155.00
53 minute session	$135	$193.75
45 minute couples session	$125	$155.00
80 minute group therapy session	$50	$90

Payment is expected at the time of service unless we have discussed and agreed to bill your insurance or some other entity (i.e. a relative). 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 may 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 are more than a couple of minutes late for your appointment, I may not be able to bill your insurance for a full session and you may need to pay out of pocket for what I cannot collect from your insurance company. For example, if we have a 53 minute session booked for you, but you are late and I can only bill your insurance for a 30 minute or 45 minute session, you may need to pay the difference. 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.] If I have to pay a subcontractor such as my biller or bookkeeper to do work on your behalf related to legal proceedings, the fee for their work would be charged to you or your attorney at the rate of $70 per hour.

Appointments and Cancellations: Appointments are generally 45 or 53 minutes (one hour and 20 minutes for group), 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 charged $40 the first time, $60 the second time, and $80 each time thereafter. You may cancel by leaving a voice mail or text message at any time night or day at my work phone 253-852-4699. Please do not use e-mail for scheduling. If you need to miss a therapy group, you will need to pay $50 for that group regardless of when you let the group know. This is because you are paying for a space in the group and I cannot fill your space with another client.

Payment Security: Unfortunately I have had many instances of clients not paying fees owed for services, deductibles, missed appointments, less-than-48-hours notice of cancellation, or other fees. For this reason, I require permission to charge your credit/debit card for any fees owed. If you do not wish to provide that permission, I do require a retainer for possible missed appointment or less-than-48 hours notice cancellation fees, deductibles and the like. Your credit care will typically be charged the same day or within a week of learning of an uncovered payment, but may be delayed longer if my office does not learn of an uncovered service until later (i.e. an insurance company takes a long time to process a claim or there are problems processing a claim). I do not require any advance payment for co-pays, co-insurance, or deductibles, but do collect those at the time of your appointment when it is reasonably clear that you owe it. I will typically ask to update your credit/debit care information about every 3-4 months. If you do not wish to use a credit card, you may pay a retainer that we decide upon by cash or check. Any unused portion will be returned to you, 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 within 24 hours with the exception of weekends and holidays. 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 1-866-427-4747, or go to your nearest hospital emergency room.

Sometimes clients ask if we can communicate by e-mail, text, or video conferencing. I do not do anything therapeutic via e-mail or text. Texting is fine for scheduling, letting me know you are running late, or asking administrative questions such as about billing. If you schedule via text, please be sure that you receive a confirmation reply from me.

_____Please initial if you wish to use un-encrypted texting for administrative purposes.

_____Please initial if you wish to send un-encrypted non-clinical information via e-mail (noting that I do this only in rare circumstances).

If you are not comfortable using un-encrypted electronic methods, do not use them please. Some insurance companies allow for secure video conferencing for sessions in certain circumstances.

Limits on Confidentiality
The law protects the privacy of all communications between a patient and a psychologist. In most situations except for known other healthcare providers, 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. Please see detailed descriptions of these circumstances in your *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information*.

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 am required by state law to report protective agencies if I suspect a situation were a dependent child or dependent adult to be at risk for neglect or abuse, or when I suspect a person to be a threat to the self or others.

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. With your permission, it also may make good clinical sense to consult with your other current health care providers.

PROFESSIONAL RECORDS
You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in in my office or within your electronic records. I use an electronic health care records system to create and store your medical record and to do billing. Your Medical Record 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. 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. 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 Medical Record. These Psychotherapy Notes are kept separate from your Medical Record. While insurance companies can request and receive a copy of your Medical 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.

Except in unusual circumstances, you may examine and/or receive a copy of your records, 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. Professional language in records can be misinterpreted by clients or upsetting. For this reason, I recommend that you initially review records in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed by Washington State law to charge a copying fee of $1.02 per page for the first 30 pages and $0.84 per page after that, and a $25 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.

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. 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 (i.e. we agree to use your medical insurance). 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. This applies to secondary or supplemental insurance coverage.

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 Medical 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].

Please initial each statement and sign below:

_____ I have read the Disclosure and Client Informed Consent Agreement.

_____ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure and Client Informed Consent Agreement.

_____ I agree to follow the terms in the Disclosure and Client Informed Consent Agreement.

_____ I give my consent for treatment as outlined in the Disclosure and Client Informed Consent Agreement .

_____ I will receive a copy of this Disclosure and Client Informed Consent Agreement with my signature.

_____ I understand that my therapeutic relationship with Diane M. Adams, Ph.D., Licensed Psychologist may be discontinued if the terms of this agreement are not fulfilled by either of 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 (i.e. a claim is in process with your insurance carrier or you still owe money for services).

_____ _____
Name (Please Print) Second Name if couple or family member

_____ _____
Signature Date

_____ _____
Diane M. Adams, Ph.D. Date
Licensed Psychologist

Basic Information Form
Diane M. Adams, Ph.D.

Name _____ Today's Date: _____

Birth Date_____ Age ____ Gender____

Home Phone(____)_____ Cell Phone(___)_____
Detailed message okay? ☐ Detailed message okay? ☐

Billing Address _____
Street City Zip code

Cultural Background/Race _____

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

_____

_____

_____

Highest Level of Education _____ Profession _____

Job History _____

_____

_____

Spouse's/ Partner's Name_____ (optional for group therapy)

Home Phone( ) _____ Work Phone( )_____

Birth Date_____ Age____ Gender____ Race _____

Address _____
Street City Zip code

Highest Level of Education _____ Profession _____

Please List Children, their ages, and where they reside: _____

_____

_____

Any pending, active or anticipated legal actions?_____

Previous therapy experience: _____

What do you see as your main reason for coming to therapy? _____

Please list any health problems and medications: _____

Ever lost consciousness and why? _____

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

Problematic Behavior History such as alcohol, drugs, sex/porn, gambling, etc. (describe history, age when started, frequency, pattern, etc.):

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

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

Spiritual/Religious Orientation: _____

I learned about Dr. Adams's services from: _____

If from the Internet, how did you search?_____

Anything else that is important for me to know about you? _____

Last Two Weeks Mood Survey

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.

0 = Not at all **4 = Extremely**

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)

Diane M. Adams, Ph. D., Licensed Psychologist
1412 SW 43rd Street, Suite 240
Renton, WA 98057
(253) 852-4699 phone (844) 848-1265 fax

CRISIS PLAN AGREEMENT

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. Adams 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. Adams at (253) 852-4699.
2) Call Dr. Adams at (425) 728-9196 and leave another message. **Please LEAVE A MESSAGE** or I may not get the alert. I understand that Dr. Adams will make every effort to listen to my messages within 30 minutes and return my call.

3) If I do not hear from Dr. Adams 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. Adams 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. Adams may refer me to other mental health resources and may decide to terminate our treatment if she decides this appropriate.

Signature:_____ Date:_____

_____

Diane M. Adams, Ph.D.
Licensed Psychologist

____/____/_____

Hello Clients,

If you do not wish to use your credit card or debit card to pay for fees, co-pays, or deductibles, I still require your permission to charge your card for any owed fees such as missed appointment fees. If you do not wish to complete this form, I will need a retainer for possible missed appointment fees. Usually you will be charged a fee within a day or two of a short-notice cancellation (less than 48 hours), even if it was beyond your control.

If I need to run your card with you not present due to a deductible that has not been met or a missed appointment fee, etc., I typical run cards on the day a fee becomes due or soon after. This is a regular part of my practice and I do not call to warn clients in advance of running their card.

Please fill out the form and allow me to visually inspect your card or provide me with cash or a check retainer. We can discuss the amount of the retainer, if you do not want your credit card or debit card used.

If you are having a financial issue, please let me know. We might be able to come up with another arrangement.

Sincerely,

Diane M. Adams, Ph.D.

Diane M. **Adams, Ph.D.**
Doctor Diane, P.S.
1412 SW 43rd Street, Ste. 240, Renton WA 98057

253-852-4699 Phone
844-848-1265 Fax

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.

OPTIONS

_____ (initial) I hereby authorize Diane M. Adams or the billing staff at Doctor Diane, 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.

_____ (initial) I hereby authorize Diane M. Adams or the billing staff at Doctor Diane, 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.

PAYMENT INFORMATION

Client Name: _____

Client Billing Address: _____

_____

Type of Card: ☐ VISA ☐ MasterCard ☐ DISCOVER

Card Number: _____

Expiration Date: _____ Security Code: _____
(last three digits on card)

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: _____

Signature of Card Holder: _____ Date: _____

CHARGE POLICY

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.

_____ (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 30 days.

Insurance Information

Doctor Diane, P.S.

Today's Date _____ Name of Insurance Co.: _____

1a. Insured's I.D. Number _____ Group # _____

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

4. Subscriber's name and birth date if different from Client _____
Last, First Middle Initial

Subscriber's date of birth _____

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

11a. Insured's Employer's name or school: _____

11b. Insurance Plan or Program Name: _____

Please present your card to be copied, just in case there is information on it that may be needed such as the address for your insurance company.

Notice of Dr. Adams' 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.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a copy of my new policies and procedures via US mail or in person.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Diane Adams, Ph.D. at 253-852-4699.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me, Diane Adams, Ph.D. at 19203 99th Place S., Renton, WA 98055.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 13, 2003

I will limit the uses or disclosures that I will make as follows: I will make every attempt to inform you of disclosures before I make disclosures whenever possible. However, I may not always be able to do so either due to practical constraints or if waiting to inform you would interfere with the treatment or safety or you or others as described previously by Washington State Law.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in person.

BY SIGNING BELOW I AM INDICATING THAT I HAVE READ AND UNDERSTAND THIS NOTICE.

_____
Name (Please Print)

_____ _____
Signature Date

_____ _____
Signature Responsible Party if not client Date

_____ _____
Diane M. Adams, Ph.D., Licensed Psychologist Date