20 Tacoma Ave North
Tacoma WA 98403
Peter Simón, LMHC

Tacoma Counseling, PLLC
heal grow transform

phone: 253 232-8722
fax: 253 627-1753
www.tacomacounseling.net

PURPOSE OF THIS INFORMATION

Welcome to Tacoma Counseling. Transparency is important to me. In order for me to provide the best care possible, I want people and couples with whom I work to have as much pertinent information as possible. If you have any questions or concerns about the health care or business practices of this office, please feel free to discuss them with me.

ABOUT THIS PRIVATE PRACTICE

I am the sole clinician in this private counseling practice. I am licensed or certified by the State of Washington for independent behavioral health practice, and am subject to the laws and ethical canons specific to my profession.

I am a Licensed Mental Health Counselor (LMHC), and am licensed in the State of Washington. My license with the Department of Health for the State of Washington is: LH 60215533, first issued on 03/23/2011.

I have been providing counseling services since 2007. My counseling focuses on working with adults, and with couples. Using training in EMDR, Solution-Focused, and Mindfulness-Based Cognitive Therapies, I provide treatment for: depression, anxiety, grief and loss, healing from trauma, and resolving distress due to transitions in life. I earned my Master of Arts in Psychology, with an Emphasis in Counseling from Chapman University in 2008. Following completion of my clinical internship and earning my degree to the present, I continue my work in a community mental health clinic, and have recently launched my private practice in 2018.

My treatment approach focuses on helping a person or a couple determine whether they are feeling stuck with some part of their health and wellness. I'm ready to partner with you to help you get unstuck. I'll hold your concerns with deep compassion. I'll listen actively, and work with you to address what's most important to you. I will meet you where you are with dignity and respect, to connect with you. Then, we work together to tailor a recovery plan that best fits your needs. Once we're both on the same page about your priorities for counseling, we roll up our sleeves, and lean into the work, to help you to heal, grow, and thrive. I'd be honored to walk with you on your path of healing and wellness, and help you find the answers for which you're searching. Most of the treatment I provide is relatively brief in duration, typically lasting from several weeks to several months for a particular episode of care. When appropriate, I treat some patients for multiple episodes of care over the long term.

EMERGENCY CONTACT

Messages left on voice mail are retrieved regularly and calls are returned as soon as possible. If you are experiencing an emergency situation, please call 911.

If you have anonymous call blocking on your phone, it is very important that you remove that function until you receive a call back. We will be unable to respond to your call if you have anonymous call blocking activated.

If you need more rapid attention for your own or someone else's safety, do not delay while waiting for a return call from your clinician. You may phone your regional crisis clinic, phone 911, or report to the nearest hospital emergency room.

INSURANCE BENEFITS AND PATIENT RESPONSIBILITY FOR FEES

I currently participate with a number of health plans, and am pursuing the credentialing process with other health plans. However, only your health plan can describe your benefits to you or verify provider eligibility. Although I may help you with this information, you must contact the health plan directly for verification. If charges are denied by a health plan, they become your responsibility, even if you had understood from your health plan that the charges would be paid by them.

FEES AND PAYMENT

Fees are $125 for an initial assessment appointment. Fees for subsequent appointments are $85 for a 60 minute individual session, and $105 for 60 minute couples session. For premarital counseling through St. Leo's parish, the fee is as follows: $70 per 60 minute session, and $100 per 90 minute session. Payments can be made with cash, check, or credit card/health savings account card. Card reader available on site.

If I have a provider agreement with your health insurance that calls for a reduced fee, that adjustment will be made by your health plan when a claim is submitted to them, I will then adjust your account accordingly. Payment for charges not covered by your health insurance (including copayment, coinsurance, deductible and non covered amounts) is due in full at the time services are provided.

If you are uncertain about your copay, I encourage you to contact your insurer. Until you know what the copay is, I would ask that you pay 25% of my fee (e.g. 25% of 1st session is $31.25, 25% of follow up individual is $21.25, or 25 % if follow up family/couples session is $26.25) at the time of each appointment.

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UNPAID BILLS

Accounts not paid according to the terms and conditions described above are both a business and treatment concern. If your account is overdue, we will attempt to arrive at a mutually agreeable plan to bring the account current. If this cannot be accomplished, seriously delinquent accounts may be referred for collection – information necessary to effect collection will be released to the collection agent. A collections fee will be added to the account equal to one-third (33%) of the outstanding balance. Should it become necessary to file suit in this context, you agree to pay reasonable attorney fees. Rebilling fees for unpaid balances are charged at $5 per month.

LATE CANCELLATIONS AND MISSED APPOINTMENTS

If you will be unable to keep an appointment you have scheduled, you must provide one business day notice. Failure to do so will result in a **charge for the full amount** of the scheduled appointment. Please note that **health plans do not pay for missed appointment, these charges will be your responsibility**. Every effort will be made to accommodate late cancellation for illness or weather, but we reserve the right to enforce this policy.

GRIEVENCE PROCEDURES

If you have any questions or concerns about administrative, business, or clinical matters in this office, you are encouraged to discuss them with your clinician. In addition, the following avenues are available:

1. You may contact your health plan or behavioral health benefit manager
2. If you feel the problem is serious and/or you have not reached resolution through the above avenues, you can file a complaint with your clinician's state licensing or certifying body, address to be provided upon request.

BREACH NOTIFICATION

If notice is required, I must notify any patient affected by a breach without unreasonable delay and within 60 days after discovery. My notice to you will include a brief description of the breach, including dates, a description of types of unsecured PHI involved, the steps you must take to protect yourself against potential harm, a brief description of the steps we have taken to investigate the incident, mitigate harm and protect against further breaches, and our contact information. Breach has the meaning of that term as defined in 45 CFR 164.402 and applicable regulations under that section. It includes the unauthorized acquisition, access, use, or disclosure of unsecured PHI that compromised the security or privacy of such information. Unsecured PHI has the meaning of that term as defined in 45 CFR 164.402. It includes protected health information (PHI) that is not secured through the use of a technology or methodology, such as encryption, specified by the Secretary of the US Department of Health and Human Services under that section.

When the practice becomes aware of or suspects a breach, as defined above, the practice will conduct a Risk Assessment, as outlined above. The practice will keep a written record of that Risk Assessment.

Unless the practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach as described above.

The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of the breach of PHI in its control, the practice will provide any required notice to patients and HHS.

After any breach, particularly one that requires notice, the practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

CONFIDENTIALITY & MEDICAL RECORDS

This document contains important information about your rights regarding confidentiality and your medical records. Please read it carefully. Make a note of any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY

The State of Washington and the federal Health Insurance Portability and Accountability Act (HIPPA), allow most issues discussed with me to remain confidential. These laws protect your right to privacy. For example, the information that I record in my psychotherapy notes is protected by HIPPA and cannot be used or disclosed without your specific, written authorization (there are a few exceptions; please see below).

Other health information is provided somewhat less protection by state and federal law. Examples include information pertaining to medication prescription and monitoring, counseling session start and stop times, dates of treatment, results of clinical tests, and

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summaries of your diagnosis, functional status, the treatment plan, symptoms, prognosis, and the progress to date. This information is called Protected Health Information (PHI) because it is still safeguarded and can be released only in limited circumstances and for specific reasons. In particular, it may be used or disclosed for purposes of treatment, payment, or health care operations.

- **Treatment** involves the provision, coordination or management of your health care and other services related to your health care. An example of treatment would be my consulting with another health care provider, such as your family physician or another therapist.
- **Payment** involves the reimbursement of RA for your healthcare. This can include the disclosure of your PHI to your health insurer, when required, to obtain reimbursement or to determine benefit 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.

By signing this document you provide your consent for me to use and disclose your PHI for these three purposes.

There are some instances in which your right to confidentiality is automatically waived. Any or all of your health information, including anything in my psychotherapy notes, may be released, even without your consent or written authorization, in the following circumstances.

- If I become aware that you may be abusing, exploiting or neglecting a child under age 18, a developmentally disabled person, or an elderly person, a report must be made to the appropriate authorities (RCW 26.44).
- If you become a danger to others, I must protect the other person(s) and you by warning the other person(s) at risk and report the danger to the appropriate authorities (RCW 71.05.120).
- If you become mentally ill and become unable to take care of your basic needs or become a danger to yourself or others and also refuse treatment, I must report your condition to the authorities (RCW 71.05).
- If you tell me that you are suffering from HIV-related illness, and do not have a physician providing for your care, I must report the identities of your IV drug-using or sexual partner(s) to the local health care officer (WAC 248-100-072).
- If my professional licensing board subpoenas me as part of its investigations, hearings or proceedings related to the discipline, issuance or denial of licensure of state licensed professionals, I must comply with its orders and disclose your relevant health information (RCW 18.130.180).
- 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 court order signed by a judge. 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 (RCW 18.83.110, RCW 71.05.390, and RCW 71.05.630).
- If you file a worker's compensation claim, with certain exceptions, I must make available upon request, 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 (RCW 51.36.110).
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease of FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

In all other instances, beyond those listed above, I will obtain an authorization from you before using or disclosing any of your health information. A valid authorization must be written and signed by you and specify the recipient of the information (including the institutional affiliation of this individual) and the particular information to be used or disclosed. For example, if you would like me to speak with a family member, you can complete an "Authorization to Disclose" form. A written authorization is valid for no longer than 90 days from the date you sign it. You may revoke an authorization at any time, as long as the revocation is in writing. You may not revoke an authorization for information that has already been disclosed based on that authorization. Neither may you revoke an authorization that was obtained as a condition of obtaining insurance coverage.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice
- Psychotherapy notes

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PLEASE NOTE: For couples participating in premarital counseling for St. Leo's parish, the priest and/or other clergy involved in marriage preparation may request I provide a verification letter to the priest, confirming a couple has completed a minimum of 2 premarital counseling sessions. By signing this document you further convey that you understand that such a letter will be written, which may contain PHI, and agree to have me share such a letter with the priest helping you prepare for marriage sacrament.

YOUR RIGHTS
REGARDING YOUR HEALTH INFORMATION: You have the following rights concerning the health information that I maintain about you (for as long as your records are maintained – a minimum of 7 years).

- *Right to Request Restrictions* – You may request restrictions on certain uses and disclosures of PHI. I may deny your request under certain circumstances, but is some cases you may have this decision reviewed.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – For example, if you did not want your family to know that you are in treatment, you could request that we 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. This request must be made in writing and, if you request a copy of the information, you may be charged a fee for the associated costs (e.g.,copying). I may deny your access to this information under certain circumstances, but in some cases you may have this decision reviewed. Because the information in psychotherapy notes is sensitive and potentially upsetting, I strongly recommend that you review these notes with me, should you choose to request a copy.
- *Right to Amend* – If you feel that the information I have about you is incorrect, you may ask that I amend that information. I may deny your request under certain circumstances. In some cases you may have this decision reviewed.
- *Right to an Accounting of Disclosures* – You may request a list of the individuals or agencies to whom your health information has been disclosed, unless the disclosures were made for treatment, payment, health care operations, or were made to you or following a written authorization given by you.
- *Right to Complaints*- If you are concerned that I have violated your privacy rights or you disagree with a decision made about access to your records, please discuss this with me. You may also send a written complaint to the Secretary of the US Department of Health and Human Services, address to be provided upon request.
- *Right to a Copy of this Document*- You may receive a copy of this document upon request.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out*-of-Pocket.-You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI*.-You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA privacy rule) involving your PHI; (b)that PHI has not been encrypted to government standards; and (c)my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

CHANGES TO THIS OFFICE POLICY: From time to time I may change the confidentiality and notice policies described in this document. I will attempt to notify you of changes.

AGREEMENT AND INFORMED CONSENT
I have had an opportunity to read this document and ask questions. My signature below conveys my understanding of the terms of all parts of this document, my agreement to abide by them, and my consent to receive behavioral health services.

_____ _____
Client, parent or legal guardian Date