Clarity Counseling Seattle, P.S.
1800 Westlake Ave N, Suite 302 Seattle, WA 98109
206-910-1218 www.claritycounselingseattle.com justin@claritycounselingseattle.com

TREATMENT AGREEMENT

FEES: The fee or co-payment per 50-minute therapy session is $_____. This is payable at the time of our session.

CANCELLATIONS: Please note that I charge the full private rate of $120 will be charged for missed sessions or those cancelled without 48-hour notice, except in cases of sudden illness or emergency.

BACKUP PAYMENT (REQUIRED): Clarity Counseling Seattle, P.S. uses a secure credit card payment system. By signing the line below, you agree to have your credit card information securely stored by Clarity Counseling Seattle, P.S. until your file is closed. You also authorize Clarity Counseling Seattle, P.S. to charge your credit card for any outstanding bills. Charges are typically made for such items as co-payments, no show/late cancellation fees, and deductible payments.

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date: __ __ / __ _ 3-digit number on card: __ __ __

_____ _____ _____
Client Signature Client Printed Name Date

Please sign the following ONLY IF using your insurance plan:
"I authorize the release of any information (which may include notes, treatment summaries and diagnosis) necessary to process insurance claims, to determine medical necessity of treatment, quality of care, or to request additional sessions."
(Sign here:) _____ (If applicable, second client sign here:) _____

"I authorize payment of benefits to be made to Charles Justin Pere, LMHC for services provided."
(Insured: Sign here:)_____

CONFIDENTIALITY: What you say in therapy, your records and your attendance is *all* confidential, except:
When you give written permission to release information; when your records are subpoenaed for legal reasons; when insurance that you are utilizing requests information to justify treatment;
When reporting is required or allowed by law (ex. Suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others); Other exceptions as listed in my *HIPAA Notice of Privacy Practices*

IN AN EMERGENCY: **Please note that I will not be available for clinical emergencies, either within business hours or after hours.** In the case of a clinical emergency, please call the King County Crisis Line (206-461-3222), call 911, or go to a hospital emergency room. Once you are able, please do inform me of the emergency that has occurred.

DISCLAIMERS: It is understood that any agreements made are between you and I only. I also cannot be responsible for the care provided by professionals or groups that I refer you to.

PRIVACY POLICY: By signing below, you agree to understanding and upholding the entirety of this Treatment Agreement document. By signing below you also acknowledge receipt of my *HIPAA Notice of Privacy Policies* (the very last two pages of this document). This Notice provides information about how I may use and disclose your private health information. I encourage you to read it carefully. My Notice is subject to change.

_____ _____ _____
Client Signature Client Printed Name Date

_____ _____ _____
Second Client Signature Second Client Printed Name Date

_____ _____
Therapist Signature Date

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INTAKE FORM

Please take a few moments to fill out the following 3 pages of the Intake Form, as it is helpful for your therapist to understand some of your past and present experiences and challenges. ***If you are attending couples counseling, please have each partner fill out this Intake form.** *Thank you.*

Today's Date _____

First Name _____ **Last Name** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Is it alright to send mail to this address? Y / N

Email Address _____

Home/Cell Phone _____ **Work Phone** _____

Is it alright to call you at home? Y / N ***Is it alright to call you at work? Y / N***

Date of Birth _____ **Emergency Contact/Relationship:** _____ **Phone:** _____

Occupation: _____ **Military? Date and branch:** _____

Have you participated in counseling with a therapist or psychiatrist in the past?
If so, when? _____
For what reasons? _____
How was that experience for you? _____

Are you currently taking any psychiatric medications? If so, which ones, for how long, and to treat what issue(s)?
_____

Are you currently taking any other prescribed medications?
_____

What would you say are your current life stresses?
_____
_____

Please circle any of the following issues that currently pertain to you:

Depression	Suicidal Thoughts	Career/Work	Self –Control
Anxiety	Eating Disorders	Health	Cutting/Self-Mutilation
Fear/Phobia	Abuse	Relationships	Family issues
Other Mental Disorder	Grief/loss	Sexual Identity	Drugs/Alcohol
Stress	Anger	Sleep/Insomnia	Divorce
Sexual Problems	**Other**:	**Other**:	**Other**:

What brings you into counseling at this time?

_____
_____
_____

What do you hope to get out of counseling?

_____
_____
_____

Are you currently experiencing, or have you ever experienced, any of the following:

	Currently:	**Past:**
Extremely depressed mood:	***Y / N***	***Y / N***
Wild Mood swings:	***Y / N***	***Y / N***
Rapid speech:	***Y / N***	***Y / N***
Extreme anxiety:	***Y / N***	***Y / N***
Panic attacks:	***Y / N***	***Y / N***
Difficulty concentrating:	***Y / N***	***Y / N***
Phobias:	***Y / N***	***Y / N***
Hallucinations:	***Y / N***	***Y / N***
Frequent body complaints:	***Y / N***	***Y / N***
Eating disorder:	***Y / N***	***Y / N***
Body image problems:	***Y / N***	***Y / N***
Repetitive or obsessive thoughts:	***Y / N***	***Y / N***
Repetitive Behaviors (frequent checking, hand washing):	***Y / N***	***Y / N***
Homicidal Thoughts:	***Y / N***	***Y / N***
Suicide Attempt:	***Y / N***	***Y / N***

Current Relationship:

Partner's name: _____ Partner's occupation: _____
How long have you been together? _____ Are you married? ***Y / N*** For how long? _____
Do you have children? If so, what age are they? _____
How would you say your relationship has been? _____
_____
What would you say are the current challenges in your relationship: _____
_____

How is your support network? Do you currently have friends or family for emotional support? _____
_____

Has substance use or abuse ever been a problem? If so, which substances, amounts, and when?

_____

Do you currently have any problematic sleep behavior (sleepwalking, nightmares, recurrent dreams)?

_____

How often do you exercise? _____

How are your eating habits? Have you had any recent change in your appetite? _____
_____

How were you referred to Clarity Counseling Seattle?

Family or friend: _____
Healthcare professional Name: _____
Contacting health insurance
Gottman Referral Network
Google/Bing search
PsychologyToday.com
CounselingSeattle.com
Other: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

**This document does NOT need to be printed out and brought into counseling with you. It is only for your reference.*

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
Required by Court Order

Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
Breach Notification. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
Right to a Copy of this Notice. You have the right to a copy of this notice.

CORRESPONDENCE: Please note that email and text correspondence methods are not considered to be secure. Charles Pere and Clarity Counseling Seattle, PS cannot guarantee and are therefore not responsible for the privacy and anonymity of email or text correspondence.

COMPLAINTS. If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. You will not be retaliated against for filing a complaint.