PEOPLEinc.

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Disclosure of Information, Policies and Client Agreement
-and-
Insurance Billing Authorization

Provision of the following information and written acknowledgement of its receipt are required by Washington State Law. Please read carefully.

Mental health counselors practicing counseling for a fee must be licensed. Any counselor that you meet with at PEOPLEinc. is licensed.

Your Rights as a Client in Counseling:

As a client of a counselor licensed by the State of Washington, you have privileged communications under the law. With the exceptions listed below, you have the right to confidentiality. This right cannot be waived without your specific written consent.

The following situations are exceptions to your right to confidentiality:

1. If I believe you are likely to do harm to yourself or another person, I am required by law to take steps to protect you and/or the other person.
2. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, I am required by law to report this to Children's Protective Services or Adult Protective Services.
3. Occasionally there is reason for me to discuss the general details of my cases with other professionals and colleagues to better meet the needs of my clients, yet without revealing any identifying information about you or your family.

You always have the right to change or refuse treatment. It is important that we work together in order to meet your needs. You may terminate therapy at any time; however, I believe it is of great value to you to discuss the decisions, reasons and process for termination with me prior to terminating.

Our Training and Approach:

Our preparation and education includes a Master's Degree with a concentration in Counseling.

We use a variety of approaches to counseling. Each therapist has their unique style of working effectively with clients to achieve the highest level of success. Any methods used are consistent with generally accepted theory and practice.

Sessions and Fees:

Sessions are scheduled for 50 minutes. Fees charged per session are $135 and/or other negotiated amounts that are unique to specific insurance plans. Payment is due at the beginning of each session. Should you need to reschedule or cancel an appointment we request a notice of 24 hours, otherwise it will be necessary to charge for the time that has been reserved for your session. The charge for a session that you do not show up for or cancel with less than a 24 (business) hour notice will be billed at $125. Under this policy, sessions on Monday require cancellation the Friday prior. Please be aware that if your sessions are covered under your insurance provider; they will not reimburse for missed appointments. Therefore, it will be your obligation to pay for any missed appointments that have not been cancelled or rescheduled within the 24 hour notice referred to above. Any outstanding balances are charged late fees of $25 per month.

Client Signatures:

I have received both this disclosure and the HIPPA information required by federal law.

____ __________

Signature Date

I consent to treatment from PEOPLE inc.

____ __________

Signature Date

(Signature is required for client 13 or older and for parent or guardian of client 12 or younger)

—Please fill in the following information as completely as possible.—

Patient Information:

Last Name: ____________________ First Name: ____________________ MI: ______

Date of Birth: ______________ Preferred Name (if different from above): __________________

Address: ____ Apt / Unit: ______

City: ____ State: ____ Zip: ________

Employer/School: ____ State: _____ Zip: _____________

Phone: _____________________ Cell____ Home___

OK to receive voicemail from PEOPLEinc? Yes___ No___

Work Phone: ________________________ Ext:_____

OK to receive voicemail from PEOPLEinc? Yes___ No___

Email: _____________________________

OK to receive email from PEOPLEinc*? Yes___ No (Phone Only) ____

*I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my care might be intercepted and read by a third party.

Female ___ Male ___ Trans M to F ___ Trans F to M ___ Nonbinary:________

Preferred Pronoun:______________

Married:___ Separated:___ Divorced/Permanently Separated:___ Partnered:___ Multiple Partners:___

Single: ___

Emergency Contact: _______________________Relation: ________________

Telephone: ___________________

Guarantor (Person Responsible for the Bill and/or the Primary Individual Insured):

Self: ___ Partner/Spouse: ___ Parent: ___ Other (please provide relationship): ____________________

Name: ____ Date of Birth: ________________________

Billing Preference: USPS___ Email* ___ Email address:_______________________________________

Address (if different from above): _____________________________________ Apt / Unit: __________

City: _______________________________State: _____ Zip: _____________

Telephone: ________________________ Cell___ Home__

OK to leave voicemail from People Inc? Yes___ No___

Employer: ____

Insurance Information:

Name of primary insurance: ____

If you would like us to bill on your behalf, please provide us with your insurance card to copy. We will bill your insurance as a courtesy but it is ultimately your responsibility to be sure that payment is made for your services. If we bill your insurance and they do not pay, it is your responsibility to pay for your services and any discrepancies with your insurance reimbursement will be yours to clear up with them directly.

Please also be sure to obtain any prior authorizations that may be required for your insurance to pay for this and future visits.

I authorize the release of all medical records to my insurance company. I further authorize insurance payments to be made directly to PEOPLEinc. I understand payment is due at time of service, even though we may choose to delay receipt until your insurance has been billed.

Managed Care:

I understand if service is not a covered benefit and that without an authorization/ referral form from my HMO/ IPA/ PPO (if required), I will be financially responsible for all charges I incur.

Signature of Responsible Party: ______________________________ Date: ___________