Tana Anderson, MA, LMHC
Licensed Mental Health Counselor
15600 Redmond Way, Suite 201, Redmond, WA. 98052
(425) 802-7146

Clinician Disclosure Information and Informed Consent

You have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You also have the right to terminate your treatment at any time for any reason. The following information is provided to help you determine if what I offer as a mental health counselor meets your needs as a client. This document contains important information about my therapeutic approach, my education, my fees, and your rights as a client including your rights regarding your private health information. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services.

I am not able to propose an appropriate course of treatment for you until we have spent some time together. As soon as I am able to identify an appropriate course of treatment, however, I will discuss it with you.

I have a Registered Therapy Dog in the office. If you have any questions or concerns about the presence of the dog in the office, please let me know so that we may discuss alternative options.

Confidentiality

Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account contact information which may include account name, address, phone, email, social security number, and the signature page of the consent for services may be submitted to a collection agency;
- If I have any other legal duty, obligation, or right to report.

I may also be required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44 and RCW 18.19.180(3), suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

If you have any questions regarding your confidentiality, the limits of confidentiality, or the exceptions to confidentiality, please let me know. I will be happy to discuss this with you further.

For additional information regarding your confidentiality rights, please carefully review the attached HIPAA and Washington State Notice of Rights and Privacy Practices.

Insurance Providers

Insurance companies and other third-party payers may require that I provide them with information regarding the services I provide to you. This information may include the type of service provided, the dates and times of service, your diagnosis, treatment plan, a description of impairment, progress of therapy, and case notes and summaries. If you do not want me to provide your confidential information to your insurance company, let me know so that we can discuss alternatives.

Group, Family, Couples and Marriage Counseling

If you are seeking group, family, couples, or marriage counseling, it is important you understand that I will adhere to the ethical and legal requirements of confidentiality as stated above, however, I cannot ensure that you or the other participants in group, family, couples, or marriage counseling will maintain confidentiality about your therapeutic experience including content discussed within the counseling session. In addition, in the case of family, couple, or marriage counseling the entire treatment record will be available to any and all participants in the family, couples, or marriage counseling and all participants must consent to any authorized third party disclosure.

If you have any questions about the limitations to confidentiality, or about the access to treatment records, for group, family, couple or marriage therapy, please let me know. I will be happy to discuss this with you further.

Consultation

I seek ongoing supervision and consultation from colleagues in order to provide you with the best services possible. I may disclose information about your counseling session in consultation with colleagues, in which case I will withhold your name and other easily identifiable information. I have an agreement with Steve Anderson, MC, LMHC to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to Steve Anderson, MC, LMHC accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

My Education, Training, and Experience

I am a Licensed Mental Health Counselor regulated by Washington State (Credential Number LH00004575). I received my Master of Arts in Psychology from Seattle University in Seattle, Washington in June 1991. I hold the designation of CDWF-Candidate as I am currently pursuing

certification as a Certified Daring Way™ Facilitator. My clinical experience has been established through working in community mental health centers, private practice, and corporate environments. I have had extensive training and experience in the treatment of depression, anxiety, grief and loss, personality disorders, and chronic mental illness. In addition, my clinical practice has focused on adolescent, adult and couple therapy, clinical assessment and diagnosis, and crisis intervention.

Therapeutic Philosophy

I employ a range of treatment modalities including Psychodynamic, Developmental, Existential-Phenomenological, ACT (Acceptance & Commitment Therapy), therapy based on the research of Brené Brown and CBT (Cognitive-Behavioral Therapy). I am committed to developing a positive and helpful partnership with clients during the therapy process and believe in the right of each client to be treated with respect and dignity regardless of ethnicity, religion, disability, sexual orientation, or economic status. I will be happy to provide you with additional information about my therapeutic approach if you so desire.

Financial Requirements

The cost of each 55 minute therapy session is $120. The cost of an initial 55 minute intake session is $150. Fees are to be paid by check, cash, Visa, MasterCard, AMEX or Discover cards at the completion of each session. Co-pays, co-insurance and unmet deductibles are also due at the time of service for health plans that I am a member of. Appointments may be suspended until payment of services is made in full if you accrue an outstanding balance due. A $50 fee is charged for each returned check.

Cancellations or rescheduling of appointments must be made 24 hours in advance of your appointment time. If an appointment is not cancelled or rescheduled within this time frame, you will be responsible for paying the full fee. Insurance does not cover missed appointments.

Under Washington State Law, you are not liable for any fees or charges for services rendered prior to receipt of this disclosure statement.

Electronic Communications and Social Media Policy

In the regular conduct of my practice, I may make use of a cellular phone, or other portable communication device, to communicate with clients. In such cases, I will limit the information I store in any portable communication device to the least necessary. Occasionally, I will offer online counseling to established clients. Please be aware that such forms of communication do have inherent risks to client confidentiality. If you would prefer that I do not store your name and telephone number in a portable communication device, or if you would prefer that I do not communicate with you via cellular phone, please inform me so that we can make alternative arrangements.

In order to best protect your confidentiality, I typically will communicate with clients via email and occasionally text, for the purposes of scheduling, canceling and billing for appointments only. If you need to communicate with me via email or text for any other purpose, please discuss that with me in person. Professional ethics standards do not permit me to communicate with clients via personal social media.

Emergencies

I return phone calls Monday through Friday, during the business week. If you have not heard back from me within 24 hours, please call me again. I prefer communication to take place via personal and/or phone conversations. If you need to speak to me immediately, please leave me a voicemail. While I will attempt to return your call promptly, I may not always be immediately available.

If you are experiencing an emergency or crisis, please call 911 or the Crisis Line at (206) 461-3222, or (866) 427-4747. In such situations, you may also go to the nearest hospital Emergency Room.

State of Washington Disclosures

The State of Washington requires that I provide you with the following information.

Counselors practicing counseling for a fee must be registered or licensed with the department of licensing for the protection of public health and safety. Credentialing of an individual with the department of Health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

I maintain a referral list of other Counselors with a wide range of specialties. I will provide you with a referral to another Counselor if I feel your needs are beyond the scope of my expertise, or if you request such referral information.

Consent for Treatment

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in counseling services provided by Tana Anderson, MA, LMHC.

_____ _____

Client Signature Date

_____

Print Name

_____ _____

Parent/Guardian (Client under age 13) Date

_____

Print Name

_____ _____

Tana Anderson, MA, LMHC Date

HIPAA and Washington State Notice of Rights and Privacy Practices

NOTICE:

I keep a record of the health care services I provide you. You may ask me to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it at Tana Anderson, 15600 Redmond Way, Suite 101, Redmond, WA. 98052, (425) 802-7146.

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

Your health record contains personal information about you and your health. State and Federal law protects the confidentiality of this information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health, or condition, and related health care services. If you suspect a violation of these legal protections, you may file a report to the appropriate authorities in accordance with Federal and State regulations.

I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by sending you an electronic copy, sending a copy to you in the mail upon your request, or providing one to you in person.

How I am permitted to Use and Disclose Your PHI

For Treatment. I may use medical and clinical information about you to provide you with treatment services.

For Payment. I may use and disclose medical information about you so that I can receive payment for the treatment services provided to you.

For Healthcare Operations. I may use and disclose your protected PHI for certain purposes in connection with the operation of my professional practice, including supervision and consultation.

Without Your Authorization. State and Federal law also permits me to disclose information about you without your authorization in a limited number of situations, such as with a court order.

With Authorization. I must obtain written authorization from you for other uses and disclosures of your PHI. You may revoke such authorizations in writing in accordance with 45 CFR. 164.508(b)(5).

Incidental Use and Disclosure. I am not required to eliminate every risk of an incidental use or disclosure of your PHI. Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to protect your PHI, and the information being shared was limited to the minimum necessary.

Examples of How I May Use and Disclose Your PHI

Listed below are examples of the uses and disclosures that I may make of your PHI. These examples are not meant to be a complete list of all possible disclosures, rather, they are illustrative of the types of uses and disclosures that may be made.

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation or supervision activities with other health care providers, or referral to another provider for health care services.

Payment. I may use your PHI to obtain payment for your health care services. This may include providing information to a third party payor, or, in the case of unpaid fees, submitting your name and amount owed to a collection agency.

Healthcare Operations. I may use or disclose your PHI in order to support the business activities of my professional practice including; disclosures to others for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to assist in the delivery of health care, provided I have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples of this type of disclosure include healthcare licensure related reports, public health reports, and law enforcement reports. Under the law, I must make certain disclosures of your PHI to you upon your request. In addition, I must make disclosures to the US Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of privacy rules.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If I disclose PHI to a health oversight agency, I will have an agreement in place that requires the agency to safeguard the privacy of your information.

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the required mandated report.

Deceased Clients. I may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish

protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Criminal Activity or Threats to Personal Safety. I may disclose your PHI to law enforcement officials if I reasonably believe that the disclosure will avoid or minimize an imminent threat to the health or safety of yourself or any third party.

Compulsory Process. I may be required to disclose your PHI if a court of competent jurisdiction issues an appropriate order, and if the rule of privilege has been determined not to apply. I may be required to disclose your PHI if I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, no protective order has been obtained, and a competent judicial officer has determined that the rule of privilege does not apply or if you waive the privilege.

Essential Government Functions. I may be required to disclose your PHI for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Law Enforcement Purposes. I may be authorized to disclose your PHI to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if I suspect that criminal activity caused the death; (5) when I believes that protected health information is evidence of a crime that occurred on my premises; and (6) in a medical emergency not occurring on my premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Psychotherapy Notes. If kept as separate records, I must obtain your authorization to use or disclose psychotherapy notes with the following exceptions. I may use the notes for your treatment. I may also use or disclose, without your authorization, the psychotherapy notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the Washington Department of Health or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law.

Uses and Disclosures of PHI With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. I will not make any other uses or disclosures of your psychotherapy notes, I will not use or disclosure your PHI for marketing proposes, and I will not sell your PHI without your authorization. You may revoke your authorization in writing at any time. Such revocation of authorization will not be effective for actions I may have taken in reliance on your authorization of the use or disclosure.

Your Rights Regarding Your PHI

You have the following rights regarding PHI that I maintain about you. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

Right of Access to Inspect and Copy. You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as I maintain the record. A "designated record set" contains medical and billing records and any other records that I use for making decisions about you. Your request must be in writing. I may charge you a reasonable cost-based fee for the copying and transmitting of your PHI. I can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right of recourse to the denial of access. Please contact me if you have questions about access to your medical record.

Right to Amend. You may request, in writing, that I amend your PHI that has been included in a designated record set. In certain cases, I may deny your request for an amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You may request an accounting of disclosures made for treatment purposes or made as a result of your authorization, for a period of up to six years, excluding disclosures made to you. I may charge you a reasonable fee if you request more than one accounting in any 12-month period. Please contact me if you have questions about accounting of disclosures.

Right to Request Restrictions. You have the right to ask me not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for restrictions must be in writing and I am not required to agree to such restrictions. Please contact me if you would like to request restrictions on the disclosure of your PHI. You also have the right to restrict certain disclosures of your PHI to your health plan if you pay out of pocket in full for the health care I provide to you.

Right to Request Confidential Communication. You have the right to request to receive confidential communications from me by alternative means or at an alternative location. I will accommodate reasonable written requests. I may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. Please contact me if you would like to make this request.

Right to a Copy of this Notice. You have the right to obtain a copy of this notice from me. Any questions you have about the contents of this document should be directed to me.

Right to Opt Out. While I will not contact you for fundraising purposes, you have the right to know that you can chose not to receive fundraising communications from your healthcare providers.

Right to Notice of Breach. You have the right to be notified of any breach of your unsecured PHI.

Contact Information

I act as my own Privacy and Security Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:

Tana Anderson, MA, LMHC
15600 Redmond Way, Suite 101, Redmond, WA. 98052
(425) 802-7146

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing with me, as my own Privacy Officer, as specified above. You also have the right to file a complaint in writing to the Washington Department of Health or to the US Secretary of Health and Human Services. I will not retaliate against you in any way for filing a complaint.

Effective Date

Effective date of this notice: February 12, 2015