Lacey Clinic Phone: 360-799-5782 ~ Fax 360-539-1715 ~ Longview Clinic Phone: 360-799-4556 ~ Fax : 360-846-1722
Website: http://www.pathwaysmhs.org

DISCLOSURES AND INFORMED CONSENT AGREEMENT

Mental Health, Telehealth and Wellness Program

Welcome! This is a therapy practice deeply committed to confidentiality, multicultural sensitivity, and quality care. It is our intent to provide quality-counseling services combined with systemic, cognitive, and solution-focused approaches. It is our hope that the issues that have brought you into therapy may be resolved as we work together.

In accordance with the Washington Administrative Code (WAC) and the Revised Code of Washington (RCW), the following Professional Disclosure Statement is provided for the client and must be signed by both the client(s) and the counselor. The client's signature indicates that she/he has read and understands the information.

Provider Information
PMHS counselors, therapists, interns, and associates are from a diverse educational background, with a varied set of clinical experiences in mental health, family therapy and addictions services. Clinical interns are working on getting their required training and experience in the field of mental health and addiction. Licensed Mental Health Professionals who work in our clinic are Marriage & Family Therapists, Mental Health Counselors, Master Addiction Counselor, Clinical Social Workers, and Psychologists who have, at minimum, a Master's degree and/or Doctoral degree in Psychology. They are licensed by the Washington Department of Health, State of Oregon, State of Utah, and State of Hawaii are considered independent practitioners in the field of behavioral/mental health. They are not allowed to prescribe psychotropic medications but could refer you to a medical prescriber while receiving psychotherapy from our facility.

Our Chemical Dependency Counselors (CDP) are certified by the Washington Department of Health. Those who have a CDP and/or Master Addiction Counselor (MAC) certificate are fully credentialed to supervise the Chemical Dependency Counselor Trainees (CDPT) who may be working with you. The CDPTs are working on getting their required training and experience in the field of addiction. For more detailed disclosure information about your individual provider, please see the Individual Provider Information Addendum to this Disclosure and Informed Consent Agreement, which your provider will give you during your first appointment.

Length of Sessions

- Individual Therapy or Family/Couples (Face to Face or Telehealth) - 50-55 Minutes
- Play Therapy with the Child - 40 Minutes + 10-15 Minutes with parents
- Group Counseling - 60-90 Minutes
- Wellness Program - Depending on your subscription plan

Financial Requirements:
The costs, financial requirements, agreements, and policies associated with the counseling services offered by PMHS are as follows:

Payment for Services: Fees are set with your insurance. If you are paying out of pocket, please refer to the attached fee schedule. If your insurance denies our claim you are responsible for the full amount. Our medical billing person handles all the billing for this practice, including coordination with *collection services.* An account sent to a collection agency is assessed with a $25.00 late fee in addition to the balance owed. Returned checks will be charged $25.00 along with any bank fees. Your payment/bill is due at the time of services rendered. ***If you changed your insurance and failed to inform us, you will be fully responsible for the balance owed to us***. **Client Initial:** (_______________)

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Cancellation/No Show/Missed Appointments: Missed appointments are NOT covered by your insurance. Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 business hours' notice is required for cancellation. Sessions that are last-minute cancellations, missed or no-show without this advanced notice will incur a penalty. Appointments canceled with less than 48 business hours' notice will be considered last-minute cancelations. If you have multiple cancelations, we may require proof of the reason. After 15 minutes of being late for your appointment, we will asked you to reschedule that appointment and it will be counted as a missed appointment. You will be charged a missed appointment fee if you are using private insurance and if you have Medicaid insurance this will count towards your 2 missed appointments.
Client Initial: (__________________)

State Insurance/Medicaid: A total of 2 last-minute cancellations and/or missed appointments will result in the termination of your treatment at Pathways. You may apply to be re-instated after 6 months.
Client Initial: (__________________)

Private Insurance or Self-Pay: A missed appointment without at least 48 business hours' notice will result in a charge of $65.00. In order to reschedule your appointment, you will be required to pay for your missed appointment first. In the case of multiple missed appointments, we reserve the right to require that you pre-pay for future appointments and/or cancel all future appointments. A total of 2 *non-payments* for last-minute cancellations or no shows will result in all of your future appointments being cancelled. Future sessions will only be scheduled once payment is received for the missed sessions. **Client Initial:** (__________________)

Private Insurance Patients/Clients

Billing Statement, Deductible & Balance on your Account:
A balance of $75.00 or more will result into putting your services on hold. We will cancel all future appointments if account not settled in full. This will assist you with keeping your account up to date and help you in terms of not getting into further debt and having a high balance on your account. **Client Initial: (________________)**

Billing Statement – This will be given to you in person, email to your patient portal account or it will be mailed to your home address on file with us. *Your payment is due upon receipt. It is your responsibility to pay your bill* and our practice will only send to you the billing statement to remind you of your balance and a request of payment from you. ***If no payment is received after 30 days, base on the date on the billing statement, your account will be sent to our collection agency***. Once your account has been submitted to our collection agency, all of your future appointments will be cancelled until you settle your account. Accounts sent to a collection agency are assessed with a $25.00 late fee in addition to your balance owed. **Client Initial:** (__________________)

Payment Plan - we will gladly work with you within the *30 days grace period* to set up a payment plan with us. Once a payment plan has been put in place, there will be no interruption of services. However, if you fail to honor your payment plan, future appointments will be cancelled once more until you are caught up with your account balance. ***It is not ethically sound for us to allow patients/clients to have a high balance on their account.***
Client Initial: (_________________)

Deductibles and Co-pays – private insurance has deductibles and co-pays. Payment is due upon receiving services from us. It is your responsibility to read your insurance policy on deductibles and co-pays. Non-payment of your deductibles and/or co-pays will result in your services being put on hold and we will cancel all of your future appointments until payment is made. A balance of $75.00 or more will result in having your appointments cancelled in order to assist you in keeping up with your account to date. **Client Initial:** (__________________)

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Insurance/EAP Authorization - It is your responsibility to request an authorization from your insurance company if their policy so requires. It is not our responsibility to request an authorization for your first session, initial assessment or on-going appointments, as it is your insurance. **Client Initial:** (__________________)

Using your Employee Assistance Program (EAP) & Continuing treatment after your EAP benefits – It is your responsibilities to provide us all the necessary insurance information, including a copy of your insurance ID Card. Please see the above policy on insurance authorization if this applies to you. We cannot schedule an appointment until we received all the required authorizations. **Client Initial:** (__________________)

Self-Pay: If you would like to see a seasoned and fully licensed provider, you will be charged a full fee of $125.00 per individual session. For couples and family therapy the cost is $150.00.

Reduced Fee and Clinical Interns: We offer a reduced fee of $25.00 per session if you would like to see one of our interns who are doing their clinical training at our clinics. The fee covers administrative costs related to your sessions. ***Medicare recipients*** who would like to be seen for mental health counseling have the option of seeing a clinical intern and will be charged $25.00 per session if we cannot find a provider who is able to take Medicare insurance. **Client Initial:** (__________________)

Late Policy

If you are late, your session will still end at the scheduled time. Please remember that individual, couples, and marital therapy is a 53-55 minute session or depends on your insurance set time. Play therapy is 45 minutes with the child and 10-15 minutes with the parent/guardian, which equals to 53-55 minutes per session. Group Therapy sessions are 90 minutes. *Being 15 minutes late will result to last minute cancellation and a charge of $65.00.*
Client Initial: (____________)

Department of Transportation (DOT) Substance Abuse Professional (SAP) Services

The Department of Transportation (DOT) Substance Abuse Professional (SAP) and Washington Commercial Driver's License (CDL) SAP assessment, and court or special alcohol and drug or mental health evaluations are billed at a flat rate. Case management and follow-up are billed separately. The fee is required to be paid in full prior to the start of the assessment.

Special Mental Health Evaluation

Special mental health evaluations are billed at $200.00 per 60-minute assessment. Testing materials associated with the evaluation will be charged directly to you in addition to the hourly charge of $200.00. If you are paying out of pocket for behavioral health or any alcohol and drug services, please see our fee schedule [MH - $200/hour, Testing fee $65.00, A & D - $150.00]. Urinalysis ($40.00) is not included in any of our service fee schedules and you are responsible for paying for those tests separately. The evaluation may last from 60-120 minutes.
Client Initial: (____________)

Effective September 1, 2015 we are no longer providing court-related alcohol and drug and/or DUI assessments. Requests for copies and the printing of the assessment are billed per DSHS guidelines. Please note that *we do not conduct child custody evaluations, psychological testing, domestic violence & anger management assessments, court-ordered chemical dependency assessments, or fitness-for-duty evaluations*.

Court Issues

Telephone consultations associated with the evaluation will be billed as regular individual therapy hour at $125.00 per 60 minutes; if the call is concerning couples/family issues, the fee is $150.00 per hour. Expenses incurred from requesting of records from previous providers will be charged to the client seeking the assessment.

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Court Appearances associated with custody issues and/or other legal matters at your request are billed at $200.00 for the first hour. Additional time is billed at $150.00, similar to couples/family therapy fees. In the case of court appearances, the clock starts from the time the clinicians leave the office until the court, judges, or attorneys dismiss them and they return to the office (Portal to Portal). Telephone calls that last more than 10 minutes associated with your legal issues will be billed as regular family therapy hours.

Verification Letter
Letters to institutions, companies, work, school, court, military, and other third parties for the purpose of verifying your participation in counseling, as well as other letters that we have to write on your behalf will be billed separately. A separate letter containing treatment summaries and diagnostic impressions which requires more than 30 minutes of billable time will be billed at a flat rate of $75.00. A simple form letter for attendance verification is available upon request A small per-page printing charge in accordance with fees authorized by WAC 246-08-400 will be assessed for printing. **Client Initial:** (____________)

Additional Charges

Request for Records: We will provide and release your records with a signed release of information. A small per-page printing charge in accordance with fees authorized by WAC 246-08-400 will be assessed to print your records for your personal use or provide them to third parties. Other financial considerations may arise in the counseling/therapy experience. At times, a workbook is required to attend and participate in group counseling treatment. Workbook fees vary, and your counselor/financial coordinator will discuss this with you.
Client Initial: (______________)

Disability or Other Paperwork: Completion of forms such as the FMLA, SSA, disability paperwork or any other paperwork directly related to your care needs to be discussed first with your counselor or therapist. The paperwork completion will take place at your individual time with your assigned counselor.

Electronic Records

We utilize a HIPAA-compliant electronic healthcare record (EHR) system in order to protect your confidentiality and privacy. The EHR provider has a Business Associate Agreement (BAA) with us that complies with HIPAA standards.

Confidentiality

Your participation in counseling, the content of your sessions, and any information you provide to your provider during those sessions is protected by legal confidentiality. Exceptions to confidentiality occur in the following situations where your provider may choose to, or be required to, disclose that information:

- If you give written consent to have the information release to another party;
- In the case of your death or disability, your information may be disclosed to your personal representative
- If you waive confidentiality by bringing legal action against your provider
- 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 your provider reasonably believes that disclosure of confidential information will avoid or minimize 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 30 days, the account name and amount may be submitted to a collection agency
- If the contemplation or commission of a crime or other harmful act is revealed

- If your provider has any other legal right or obligation to report

As a mandated reporter, your provider is required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05. For additional information regarding your confidentiality rights, please review our HIPAA and Washington State Notice of Rights and Privacy Practices.

Group Therapy Confidentiality

This statement applies in addition to the above confidentiality policy when we are facilitating group therapy. We strongly stress that group members adhere to protecting each other's sensitive information. In a group setting, confidentiality is highly valued and emphasized, but we cannot guarantee confidentiality in this setting. We can only assure confidentiality on our part and not on the part of other members of the group.

Minors in Outpatient Mental Health & Addiction Services (WA State)

Minors may receive outpatient mental health treatment if they are 13 years of age or older without the consent of a parent or guardian. The parents will not be notified without the minor's consent. (RCW 71.34.530). Therefore, we need a signed ROI for us to communicate with the minor's parents/guardians.

Minors 13 years of age or older may receive outpatient substance abuse treatment without parental consent. The provider will inform the parents that the minor is receiving outpatient treatment within seven business days if the minor gives written consent or if the provider determines that the minor is not capable of making a rational choice to receive the treatment. (RCW 70.96A.096, 230).

Social Media Policy

Professional ethics standards do not permit healthcare providers to communicate with clients via personal social media. Texting that is part of the Pathways Wellness Program platform is secured and HIPAA compliant. Our Telehealth platform is also HIPAA compliant, in order to protect your privacy and confidentiality.

Emergencies

If you are experiencing an emergency or crisis, please call 911, the Thurston County Crisis line at 360- 586-2800, the Cowlitz County Crisis line at 360-414-2029, or the Suicide Prevention line at 800-273- 8255. You may also go to the nearest hospital emergency room. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

State of Washington Disclosures

The State of Washington requires that we provide you with the following information: You have the right both to

receive appropriate care and treatment and to refuse any treatment you do not want. You have the right to choose a counselor who best suits your needs and purposes. Counselors practicing 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

It is our desire that your time spent in counseling/therapy and healing will be instructive, effective, and life-changing. It will be our pleasure to assist you through this rewarding and fulfilling process.

Telehealth, Telemedicine, Pathways Wellness Program (PWP)

I hereby consent to engaging in Telehealth, telemedicine and wellness program at Pathways Mental Health Services, LLC as part of my psychotherapy and online counseling. I understand that “telehealth/telemedicine” includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, texting, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth, mental health and wellness program may also involve the communication of my mental health information, by texting, orally and visually, to other health care practitioners licensed in Washington State, State of Oregon, State of Hawaii and State of Utah.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Pathways Mental Health Services, LLC via phone to coordinate alternative methods of treatment.

Telehealth Financial Obligations: Fees associated with Telehealth or wellness program appointments are payable by credit or debit card only. If fees may be associated with my Telehealth or wellness program services, I agree to have my credit/debit card information on file with Pathways MHS. My card will be billed the same day as my scheduled Telehealth appointment. If my card is declined, Pathways will cancel my appointment and I will be charged in accordance with the cancelation policy above. Pathways Wellness Program is billed on a re-occurring subscription basis. **Client Initial:** (_______________)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Pathways Mental Health Services and that Pathways may release any information to my insurance provider required for processing my claims.

Wellness Self-Pay clients: I am aware of the fees associated with Telehealth appointments and agree to pay at the time of my appointment. Pathways Wellness program is purchased by subscription only and billed prior to my appointment. I understand that I am responsible for cancelled Telehealth appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on this Informed Consent.

I understand that using the Telehealth and/or Wellness platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Pathways and is based on my provider’s normal clinic hours. Telehealth and/or Wellness appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

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Video/Audio Recording: As a general practice Pathways MHS DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth and wellness program. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive *exceptions to confidentiality* including, but not limited to: *reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim*; and where I make my mental or emotional state an issue in a legal proceeding. Pathways' Telehealth and Wellness program platforms are HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent above.

I understand that I have the following rights with respect to Mental Health, Telehealth and Wellness Program:

- I have the right to withdraw my consent at any time.
- I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
- I understand that I may benefit from telehealth and/or wellness program but that results cannot be guaranteed or assured.
- I understand that I have a right to access my mental health information and copies of medical records in accordance with Washington state law.

I have read and understand the information provided above. I will discuss it with my counselor/therapist/clinical intern, if I have any other questions. My signature below indicates my informed and willful consent to treatment using this platform.

Consent for Treatment, Financial Responsibility and Release of Information

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, contained in the Individual Provider Information and the fee schedule, and have been given the opportunity to ask questions. By signing this document, you are also consenting to participation in services provided by Pathways provider named below.

I agree to be financially responsible for cancelled appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on this Informed Consent. *I authorize insurance benefits to be paid directly to Pathways Mental Health Services and that Pathways may release any information to my insurance provider required for processing my claims.* **This updated policy is effective June 11, 2018 and supersedes all previous informed consent and/or policies of Pathways MHS.**

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______________________	______________________	______________
Client Name (please print)	Signature	Date
______________________	______________________	______________
Legal Guardian Name (if applicable)	Signature	Date

DO NOT WRITE BELOW: To be completed by Pathways MHS provider.

______________________	______________________	______________
Clinician Name and Credentials (print)	Signature	Date

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