Chris Chandler, MA, LMHC, CSAT

Professional Counseling for Individuals, Couples, Adolescents, Families & Groups

8195 166th Ave N.E. Suite 204, Redmond, WA 98052
330 112th Ave. N.E. Suite 302, Bellevue, WA 98004
10116 Main St. Suite 104, Bothell, WA 98011
(425) 998-8780

To New Patients:

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason you are unable to complete the paperwork before our session, I will have copies in my office and we will use your session time to complete the paperwork.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I look forward to meeting with you.

NAME OF SECTION	PAGE NO
Disclosure Statement about Counselor, Training, Counseling Orientation, General Information, And Counseling Fees	2
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Acknowledgement of Receipt of Notice of Privacy Practices and Financial Agreement	8
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Chris Chandler, MA, LMHC, CSAT

Checklist for completing this paperwork:

- Please print your name in the space provided on this Page (Page 1).
- Read through the Disclosure Statement on pages 2 through 3. Sign on page 3.
- Read Acknowledgement of Receipt of Notice of Privacy Practices and Financial Agreement on pages 4 through 9.
- Sign on page 9.
- Read through and sign the Video and Audio Recording Release on page 10.
- Tap Root Billing Disclosure 11.
- Complete the Credit Card Authorization Form on page 12.
- Initial all pages in lower right hand corner to indicate that you have read and understand the information provided.

Patient Name: __________________________________
(please print)

Patient Name: __________________________________
(please print)

_________, _________ (Patient Initials)

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DISCLOSURE STATEMENT
Counselor Training, Counseling Orientation, General Information, and Counseling Fees

Training and Degrees: I received my Master of Arts in Counseling Psychology from Mars Hill Graduate School (now Seattle School of Theology and Psychology) in December 2005. This program is fully accredited by TRACS, a national accrediting agency that is recognized by the Council for Higher Education Accreditation. I received my Bachelor of Arts degree in Psychology from Western Oregon University. In addition to my formal training, I have over 14 years of experience working with adolescents and adults in a variety of contexts including inpatient and outpatient hospital settings. I am credentialed as a Washington State Licensed Mental Health Counselor (LH00011043). I am affiliated with and practice collaboratively at Integrity Christian Counseling, PLLC.

Counseling Orientation: I offer counseling to couples at any stage in their relationship, whether they have been dating for six months or married for sixty years. As in my work with individuals, I use a client-centered approach that is tailored to the needs of each couple, focusing on the strengths of the relationship and encouraging honest and open communication. During the initial visit, I will get to know the couple's needs and help them to establish goals for their counseling experience. Throughout our sessions together, we will identify relational dynamics that work well, as well as dynamics that seem to hinder intimacy. The goal of any couple's therapy experience is to deepen trust and intimacy so that the couple feels empowered to grow in their love and commitment to each other. Therefore, I aim to foster an environment in which both clients feel safe from judgment and free to express themselves in a way that honors and respects their partner. When appropriate, I draw on Biblical illustrations and teachings to enrich our understanding of healthy relationships. Rather than offering cut and dry advice to couples, I try to empower them to understand their relationship better and to use their experience to grow in love and intimacy that will last for a lifetime.

Fees: The fee for counseling is **$160** per 53-minute session for initial consultation and **$150** per 53-minute session thereafter. Consultations conducted offsite will be billed at the same, predetermined rate plus round-trip travel time. Travel time will be pro-rated at the hourly rate of $150 in increments of quarter-hour intervals. Fees are adjusted annually on January 1 and will not increase more than $10 per year. Payments (cash, check or credit) are to be made at the beginning of each session. Credit Card payments will include a processing fee of up to 3.7% plus $0.15 per transaction and will be the same fee that the credit card company charges me. A $30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone a minimum of 24 hours in advance. E-mail and text messages are not adequate notice. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Termination of Treatment: When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

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Testifying in Court: If you become involved in any legal proceedings that require my participation, you will be expected to pay for all my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $185 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

State Mandated Disclosure: I have broad discretion to release any information that I deem relevant in situations where I believe my patient or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Consultations: I regularly consult with other professionals regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

State Registration: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (a) to provide protection for public health and safety, and (b) to empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure titled "Counseling or Hypnotherapy Patients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
PO Box 47869
Olympia WA 98504-7869
(360) 664-9098

Contacting Me by Phone: You may leave me a voice message at **(425) 998-8780.** I check this message periodically and will typically return you call within 24 hours. Please limit your phone conversation needs to appointment scheduling and emergencies.

Emergencies: If you are in an emergency situation and cannot reach me, please call one of the following numbers for help:

General Emergencies: 911
Crisis Clinic: (800) 244-5767 or (206) 461-3222

I have read and understand the information present in this form.

Patient_______________________________ __________________________ Date__________________
(signature) (printed name)

Patient_______________________________ __________________________ Date__________________
(signature) (printed name)

Counselor____________________________ __________________________ Date__________________
(signature) Chris Chandler, MA, LMHC, CSAT

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HIPAA COMPLIANCE
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical Records - Health Care Access and Disclosure." Please review it carefully.

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

Protected health information means individually identifiable health information:
- Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
- Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:
- In Washington State, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose (RCW 70.02.030(6)). Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  medical quality review by your health plan;
  accounting, legal, risk management, and insurance services;
  audit functions, including fraud and abuse detection and compliance programs.

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Your Health Information Rights

The health and billing records we create and store are the property of health care provider. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact our Privacy Officer:

Chris Chandler, MA, LMHC, CSAT

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Bellevue, WA 98004
Tel: (425) 998-8780

8195 166th Ave N.E. Suite 204
Redmond, WA 98052

10116 Main St. Suite 104
Bothell, WA 98011

Psychotherapy Notes:

Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes is required except if used by the originator of the notes for treatment, to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, if the notes are to be used in the course of training students, trainees or practitioners in mental health; to defend a legal action or any other legal proceeding brought forth by the patient; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by law.

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Our Responsibilities:

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office or medical records department to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at the above address.

If you believe your privacy rights have been violated, you may discuss your concerns with the Privacy Officer. You may send a written complaint to the Washington State Department of Health at:

510 4th Avenue W, Suite 404
Seattle, WA 98119

You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. This would be limited to your name and general health condition (for example, “critical,” “poor,” “fair,” “good” or similar statements). In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

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We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws -** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes,** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.
- **To Coroners, Medical Examiners, Funeral Directors**. We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.
- **Organ and Tissue Donations**. If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.
- **Incidental Disclosures**. We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.
- **Limited Data Set Disclosures**. We may use or disclose a limited data set (PHI that has certain identifying information removed) for purposes of research, public health, or health care operations. This information may only be disclosed for research, public health and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

_________, _________ (Patient Initials)

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Special Authorizations

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse Treatment Records (RCW 70.96A.150)
- Mental Health Services for Minors (RCW 71.05.390-690)
- Communicable and Certain Other Diseases Confidentiality (WAC 246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

If we need your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most important, if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future use and disclosure.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: ____________________, 20____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

Chris Chandler keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Written requests should be made to the Privacy Officer at the following address:

Chris Chandler, MA, LMHC, CSAT

330 112th Ave. N.E. Suite 302
Bellevue, WA 98004
Tel: (425) 998-8780

8195 166th Ave N.E. Suite 204
Redmond, WA 98052

10116 Main St. Suite 104
Bothell, WA 98011

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

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PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity shall not be liable for the acts or omissions of others.

AUTHORIZATION TO RELEASE INFORMATION – IF APPLICABLE: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for all charges not paid by insurance. I understand this amount is due at the beginning of the session.

INSURANCE COVERAGE – IF APPLICABLE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

______________________________	______________________________
Patient or legally authorized individual signature	Date
______________________________	______________________________
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, representative)
______________________________	______________________________
Patient or legally authorized individual signature	Date
______________________________	______________________________
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, representative)

_________, _________ (Patient Initials)

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VIDEO AND AUDIO RECORDING RELEASE

As an additional support for your counseling process it is sometimes beneficial to use video feedback as part of our work together. This means that I may ask to video or audio record you during specific dialogues, exercises, or during entire sessions. This will give us the option to play back these recordings in session to help you see patterns of behavior in yourself or your significant other (if applicable). Because it usually takes some time to setup a video camera or audio recorder, I'm requesting that we do the paperwork for this on the front end so that we can devote as much time to working on the issues that bring you into counseling. By viewing the video or listening to the audio recording in session, it allows us to "stop action" and process how you might approach an issue in a more productive way. It also allows you to witness your progress with your counselor and/or your relationship.

In addition to in-session use, I occasionally may use the video footage or audio recording to receive consultation from other health care professionals that I consult with. This may occur during time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission and it will be deleted when it is no longer needed for these purposes.

These recordings are the property of **Chris Chandler, MA, Licensed Counselor** and will remain solely in my possession throughout the course of your counseling and until they are destroyed. Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems at all times to ensure maximum confidentiality.

I _______________________hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts. *No recording is permissible without prior authorization.*

In no way will the refusal to grant consent for this video or audio recording effect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and affect.

Patient_______________________________ __________________________ Date__________________
(signature) (printed name)

Patient_______________________________ __________________________ Date__________________
(signature) (printed name)

Counselor____________________________ __________________________ Date__________________
(signature) Chris Chandler, MA, LMHC, CSAT

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Tap Root Billing Disclosure:

1. I have a contract with Taproot Billing, a billing service. As required by HIPAA, I have a formal business associate contact with Taproot Billing, in which the individual doing the billing promises to maintain the confidentiality of information as specifically allowed in the contract or as required by the law.

INSURANCE REIMBURSEMENT:

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment.

If you use your insurance benefits, you are responsible for the co-pay at each session. You are also responsible for the annual deductible charged by your insurance company (usually at the beginning of the calendar year.)

IF YOUR INSURANCE COMPANY DOES NOT PAY A CLAIM FOR ANY REASON, YOU ARE RESPONSIBLE FOR FULL PAYMENT OF THE BILL.

You should be aware that your contract with your health insurance company requires that I provide information relevant to services rendered. I am required to provide a clinical diagnosis. I may be required to provide additional clinical information; usually a treatment plan.

I use a billing service to directly bill your insurance for you at least once a month. YOU WILL RECEIVE MONTHLY STATEMENT FROM TAP ROOT BILLING TO REFLECT ACCOUNT BALANCES. IF YOU HAVE QUESTIONS OR CONCERNS, PLEASE CALL Lacey L. at 425.681.1190 or by email lacey@taprootbilling.com.

Your signature below indicates that you have read the above Provider-Client Services Agreement and understand its contents. It also serves as an acknowledgement that you received a copy of the HIPAA Notice of Privacy Practices described in the Services Agreement, have read it and understand its contents.

Subscriber Name: ___________________________________ Date of Birth: __________________________
Relationship to Client: _________________________________
Insurance Provider: ___________________________________ Phone # ________________________________
Policy ID# _______________________________________ Group #_______________________________

Client Signature Date

Chris Chandler, MA, LMHC, CSAT Date

_________, _________ (Patient Initials)

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Christian Health Services** to debit your credit card as listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with **Christian Health Services**, and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I, ____________________________________ (full name printed) authorize **Christian Health Services** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of $160 per 53-minute session for initial consultation and $150 per 53-minute session thereafter. Initial sessions are run in the 53-minute session format. Credit Card payments will include a processing fee of up to 3.7% plus $0.15 per transaction and will be the same fee that the credit card company charges me. This is the exact same fee that I am charged by my credit card processing company.

Billing Address ____________________________ Phone# ________________________

City, State, Zip ____________________________ Email ________________________

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date _______________

CVV2 (3-digit number on back of Visa/MC/Discover, 4-digits on front of AMEX) _____________

I authorize **Christian Health Services** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE ____ DATE ____________________

_________, _________ (Patient Initials)

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Chris Chandler, MA, LMHC, CSAT

Professional Counseling for Individuals, Couples, Adolescents, Families & Groups

8195 166th Ave N.E. Suite 204, Redmond, WA 98052

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10116 Main St. Suite 104, Bothell, WA 98011

(425) 998-8780

AUTHORIZATION TO RELEASE OF INFORMATION

I, ______________________________________, hereby authorize the entities listed below to receive, release, and exchange my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug, and/or alcohol use, etc.).

Chris Chandler, MA, LMHC 2820 Northup Way, Suite 105 Bellevue, WA 98004 Phone: 425.998.8780 Fax: 425.576.0654 Attention:__________________	AND	____________________________________ Person or Facility ____________________________________ Street ____________________________________ City State Zip Phone:______________________________ Attention:____________________________

EXCEPT the following information about me: ____
____

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of __________________________ **[90 days if not indicated otherwise]** or the date my coverage ends with **Chris Chandler, MA, LMHC.**

I understand that I have a right to revoke this authorization by providing written notice to **Chris Chandler, MA, LMHC.** However, this authorization may not be revoked if **Chris Chandler, MA, LMHC** has taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Client: ______________________________________

Signature of Client: ___________________________________ **Date:** _______________________________

If applicable, Legal Representative sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: ________________________________

Signature of Legal Representative: ______________________________ **Date:** __________________________

_________, _________ (Patient Initials)

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