Andi Hefton, MS, LMHC
Professional Counseling for Individuals, Couples, Families, Adolescents, Children and Groups
3212 Northwest Byron Street, Silverdale, WA 98383
(360) 519-4303

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.

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Checklist for completing this paperwork:

- Please print your name in the space provided on this page.
- Read through the Disclosure Statement on pages 2 through 3. Sign on page 3.
- Read Special Authorizations. Page 7
- Online Therapy Informed Consent Part 1 & Part 2. Page 8 & 9.
- Patient Acknowledgement. Page 10.
- Complete the Credit Card Authorization Form on page 11.
- Initial all pages in lower right-hand corner to indicate that you have read and understand the information provided.

Patient Name: _____
(please print)

_____ (Patient Initials)

Seattle Christian Counseling

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

Training and Degrees: I have an MS in Mental Health Counseling, a BA in Psychology, and a BS in Interdisciplinary Science from Central Washington University. Additionally, I have an AA, an AAS in Management and Accounting and a Business Certificate from Peninsula College. I have worked with people in various settings since high school. I have been a camp counselor for both junior high and high school, AWANA leader, and assistant youth leader. From young adulthood, I found myself making deep connections at my jobs until I decided to return to school to become a counselor. I am credentialed in the state of Washington as a Licensed Mental Health Counselor #LH61037387. Seattle Christian Counseling, PLLC provides office space and administrative support to Daybreak Counseling, PLLC. Daybreak Counseling is responsible for all patient care.

Counseling Orientation: Having God at the center of my life gives me direction and purpose. I have a clearer vision of how to navigate challenges in life that I would likely struggle with more if I did not use God as my compass. My approach to counseling is to accept each individual right where they are as God does and encourage them with hope in a world full of pain.

Fees: The fee for counseling is **$140** per 53-minute session for individuals, couples, and families. 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 end of each session. Credit Card payments will include a processing fee of up to 2.97% plus $0.15 per transaction. 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 or email a minimum of two days (48-hours) in advance. 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.

_____ (Patient Initials)

Testifying in Court: If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of 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 $285 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 **(360) 519-4303**. 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:	(888) 910-0416

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

Date:_____ _____
Patient Signature

Date:_____ _____
Andi Hefton, MS, LMHC

_____ (Patient Initials)

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES
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 were to obtain insurance.

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

Andi Hefton, MS, LMHC

3212 Northwest Byron Street
Silverdale, WA 98383
Tel: (360) 519-4303

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.

_____ (Patient Initials)

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.

_____ (Patient Initials)

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 PRACTICESAND FINANCIAL AGREEMENT

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

Andi Hefton 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:

Andi Hefton, MS, LMHC

3212 Northwest Byron Street
Silverdale, WA 98383
Tel: (360) 519-4303

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.

_____ (Patient Initials)

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ONLINE THERAPY INFORMED CONSENT PART-1

https://doxy.me/andihefton

I hereby consent to engaging in telemedicine (also referred to as online therapy) with Andi Hefton for psychotherapy services. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Washington or outside of Washington.

I understand that I have the following rights with respect to telemedicine: I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during 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 or myself; and where I make my mental or emotional state an issue in a legal proceeding. This information is detailed in the Notice of Privacy Practices that I received. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent. I accept that telemedicine does not provide emergency services.

During our first session, Andi Hefton and I will discuss an emergency response plan. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts ormaking plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support. I understand that I have a right to access my medical information and copies of medical records in accordance with Washington and Washington law.

I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. Advantages of telemedicine include but are not limited to increased access to a broader range or providers, elimination of transportation concerns such as access and cost, easier access for clients whose concerns around travel/anxiety/interaction would have prevented their access to services, reduced risk for medically fragile clients, increased comfort, and familiarity for clients in their own environments.

_____ (Patient Initials)

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ONLINE THERAPY INFORMED CONSENT PART-2

https://doxy.me/andihefton

I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases, may even get worse.

I understand that there are technological risks specific to telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto- remember" usernames and passwords, or use my work computer for personal communications; and that I am solely responsible for securing this end of our interaction.

I understand that I am responsible for:

(1) Providing the necessary computer, telecommunications equipment for my telemedicine,

(2) Personal security and or protection on my computer,

(3) Location with sufficient lighting and privacy that is free from distractions or intrusions,

(4) Reliable and secure high-speed internet connection.

(5) Backup form of communication (handy and on record) if the internet connection fails.

After we connect, I will help my therapist complete a check-in to ascertain the immediate suitability of telemedicine by verifying my name, location, whether I am in a situation conducive to a private, uninterrupted session, and my readiness to proceed. I will maintain current local emergency contact information with my therapist.

I have read and understand the information provided above.

Patient Name: _____

Patient Signature: _____

Date: _____

_____ (Patient Initials)

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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 is signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

_____ (Patient Initials)

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Seattle Christian Counseling, PLLC** 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 **Seattle Christian Counseling, PLLC**, 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 **Seattle Christian Counseling, PLLC** 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 **$140** per 53-minute session for individuals and couples and charged up to 2.97% plus $0.15 for electronic processing of the charge. 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 **Seattle Christian Counseling, PLLC** 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)