Meridian Counseling Services
13210 SE 240th St., Suite A-5, Kent, WA, 98042 * (206) 291-8466

# Mental Health Services Contract and Disclosure Form

Meridian Counseling Services (MCS) agrees to provide the undersigned client with professional counseling services based on the terms outlined below. Please read this form carefully before signing it.

## FEE INFORMATION AND PAYMENT POLICY:

The cost of a 50-minute individual or couple's counseling session is **$135**. The cost of a group counseling session is **$50**. Payment in full is due at the beginning of each counseling session in the form of cash or check made out to Meridian Counseling Services (or MCS). Please have your check written in advance so as not to use valuable session time for this. You may also pay with a credit/debit card or a Health Savings Account card with an additional $5 service fee.

## CANCELLATION POLICY

When you make an appointment, that time is exclusively reserved for you. If you need to cancel an appointment, please do so at least 72 hours in advance. ***Cancellations made less than 24 hours in advance will be charged full fee.***

## INSURANCE REIMBURSEMENT

Meridian Counseling Services is not contracted with any insurance companies, which means we are considered an "Out of Network" provider. You will be responsible for the full amount of fees for the services we provide you. As a courtesy, your therapist can provide you with an insurance billing form that includes dates of service, diagnostic codes, and CPT codes for you to submit to your insurance company. MCS does not guarantee that you will receive any reimbursement from your insurance company for your counseling services. You should contact your insurance company to determine what, if any, coverage will be provided.

## TELEPHONE OR EMAIL CONSULTATION:

Time spent on telephone or email consultations in excess of 10 minutes per week may be billed on a pro-rated basis at the rate of your therapist's individual session fee. This includes consultations with you, or other healthcare professionals that may be involved in your care.

## RETURNED CHECKS:

If you choose to pay with a check and it is returned to MCS, you will be responsible for covering any bank fees that are charged to our agency as a result of this.

**THERAPIST INFORMATION:**
Our therapists are Licensed Mental Health Counselors and Associates in the state of Washington. They treat individuals, couples, and families and provide group therapy. More information can be found about each therapist on our website at: www.meridiancounselingservices.com.

**APPROACH TO TREATMENT:**
Our theoretical orientation is based on a belief that understanding one's thoughts, feelings, and behaviors enable the challenging of negative voices and patterns of relating that are problematic. We believe this is accomplished by developing a strong therapeutic relationship where you are treated with the utmost dignity and care. In our work with clients, we use a variety of counseling methods and techniques including Cognitive Behavioral, Interpersonal, Marriage and Family Therapy, DBT, Internal Family Systems, Post Inductive Therapy, Narrative Therapy, Solution-Focused, Psycho-Dynamic, Eclectic, and Lifespan Integration.

**TRANSFER PLAN**
In the unlikely event that your therapist is no longer able to provide services, you will be contacted by someone at Meridian Counseling Services and provided with a referral for another therapist. Your records will be kept for 5 years.

**LIMITS OF CONFIDENTIALITY**
The Meridian Counseling Services (MCS) team is comprised of a team of therapists and administrative staff who work with client information and keep it confidential from anyone outside of our agency without expressed written permission from clients. Our therapists may consult with one another about a client's individual case. This consultation allows clients to benefit from the diverse clinical backgrounds and perspectives that our team has to offer. The MCS policy regarding release of information is that all information given by a client in a session with a therapist is confidential and will not be revealed to any person or agency ***outside of MCS*** without the client's written release, or without other substantial justification for such release (listed below). It is the policy of MCS to uphold the maximum client confidentiality possible, under the laws of Washington State.

There are certain circumstances in which Washington State law ***requires*** healthcare professionals, including licensed mental health professionals, to disclose information about a client to other individuals or agencies, ***with or without that client's permission***. This includes the following circumstances:

1. If a therapist is aware that a client intends grave bodily harm to any other person.
2. If a therapist is aware that a client intends grave bodily harm to himself or herself.
3. If a court of law issues an order requiring the disclosure of information.
4. If a therapist has reasonable cause to believe that abuse or neglect of a child has occurred.
5. If a therapist has reasonable cause to believe that abuse or neglect of a dependent adult or developmentally disabled person has occurred.

When such disclosures are required, it is the policy of MCS to make a sincere effort to inform the client that such a disclosure is going to be made, if at all possible, prior to making the disclosure.

Additionally, a healthcare provider or healthcare facility ***may*** disclosure health care information about a patient without the patient's authorization to the extent a recipients needs to know the information, if the disclosure is:

1. To a person who the provider reasonably believes is providing healthcare to the patient (WA Rev. Code 70.02.050(1)(a)).
2. To any person if the health care provider or healthcare facility reasonably believes that disclosure will avoid or minimize and imminent danger to the health or safety of the patient or any other individual (WA Rev. Code 70.02.050(1)(c)).
3. For payment, including information necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled (WA Rev. Code 70.02.050(1)(d)).

**STAFF COUNSULTAION:**

We are a team of therapists who are collectively invested in providing the best care possible for our clients. To this end, your therapist may discuss your case fully and openly with other MCS therapists for coordination of care. Your signature on this disclosure indicates your permission to do this.

**USE OF TECHNOLOGY**

If you choose to use technology (primarily email or text) to correspond with us, it is important to understand that your information is not secure in cyber space as we do not have an encrypted website.

**TERMINATION**

Once you have terminated treatment, your client record will be closed and held for a period of 5 years. If at any time you choose to return to therapy, your file can be re-opened. If you decide to discontinue treatment without notifying your counselor, we will make an attempt to contact you. After 30 days of no contact, we will assume you have terminated treatment and we will close your file.

**NOTICE OF PRIVACY PRACTICE**

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in a professional record. It includes information about your name, dates of service, fees, a description of the services provided, your diagnosis, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in the unusual circumstances that we conclude disclosure could cause danger to the life or safety of the patient or any other individual. A copy fee may apply.

**You have the right to:**

*Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully, however, we are not required to agree with all of the restrictions.
*Request that we use a specific telephone number and address to communicate with you.
*Request amendments or additions to your health record.

*Request an accounting of certain disclosures of your health information made by us.
*All of these requests must be made in writing.

You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services in Olympia, Washington.

**ACKNOWLEGMENT AND AGREEMENT FROM CLIENTS**

Your signature below indicates that you have read this therapy contract and agree to its terms. It also serves as an acknowledgement that you have received and read our disclosure statement including the Limits of Confidentiality, and a Notice of Privacy Practice HIPAA summary about your privacy protection and patient rights with regard to the use and disclosure of your protected health information.

_____
Client's name *(Printed)* Date

_____
Client Signature Date

_____
Client's name *(Printed)* Date

_____
Client Signature Date

_____ _____
Client's name (If minor) Date Parent/Guardian Signature Date

_____ _____
Client's name (If minor) Date Parent/Guardian Signature Date

_____
Witness Signature Date