Intake Questionnaire

Pg. 1 Background

FOR CONFIDENTIAL USE ONLY INTAKE DATE_____

1. Primary Client Name (If couple, family, or group, the one person who will be the identified client):

First Name _____ MI _____ Last Name _____ M___ F___
Address _____ City _____ State _____ Zip _____
Mailing Address if different from above:_____
Home Phone _____ Okay to Leave Message? Yes ___ No ___
Cell Phone _____ Okay to Leave Message? Yes ___ No ___ Okay to text? Yes ___ No___
Work Phone _____ Okay to Leave Message? Yes ___ No ___
Drivers license #_____ Date of Birth (DOB) _____ SS # _____
Employer_____ Client E-mail _____
Education Level _____ Religious Affiliation _____

2. Spouse's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):

Relationship to primary client:: Spouse _____ Parent _____ Legal Guardian _____ Child _____ Other _____

First Name _____ MI _____ Last Name _____ M___ F___
Address _____ City _____ State _____ Zip _____
Mailing Address if different from above:_____
Home Phone _____ Okay to Leave Message? Yes ___ No ___
Cell Phone _____ Okay to Leave Message? Yes ___ No ___ Okay to text? Yes ___ No___
Work Phone _____ Okay to Leave Message? Yes ___ No ___
Drivers license #_____ Date of Birth (DOB) _____ SS # _____
Employer_____ Client E-mail _____
Education Level _____ Religious Affiliation _____

If we are billing insurance please fill-out the following information completely:

Are you using Employee Assistance Program (EAP)? ☐Yes ☐ No **If yes, who do we bill?**_____
EAP Phone # ( ) _____ How many sessions? _____ Authorization # _____

Primary Insurance Company _____ *Grp #* _____ *ID #* _____
Ins. Billing Address _____ ***Ins. Phone #***_____
City _____ **State** _____ **Zip** _____
Name of Subscriber _____ **Relationship to client** _____
Subscriber's Address (if not above) _____ **DOB**_____
City_____ **State** _____ **Zip** _____ **SS #** _____
Subscriber's Employer _____ **Phone #** _____

*Any secondary insurance? (please give complete information)*_____
_____

Signature of person financially responsible for bill: (Including address and phone # if not above) _____

Intake Questionnaire Continued

Pg. 2 Background

_____

3) Marital Status:

Single	_____	How long? _____
Married	_____	How long? _____
Separated	_____	How long? _____
Divorced	_____	How long? _____
Widowed	_____	How long? _____

Number of previous marriages _____

4) Children

Name	Relation to client	Living in Household?	Age	Gender	School/Grade

5) Emergency contact _____ Phone _____ Relationship _____

6) General Information

Gross Family Income $_____ week month year (circle one)

Have you received counseling from a pastor, psychiatrist, or other counselor (including psychological hospitalization) ☐Yes ☐ No

If yes, Name _____ When and for how long? _____

Address _____ Telephone _____

Name and address of person, organization, or ad that referred you: _____

_____

What do you see as the major reason for seeking counseling at this time? _____

_____

_____

_____

_____

Intake Questionnaire Continued

Pg. 3 Male

7) Health

Physician's Name _____ Telephone _____

Address _____ Last Physical Exam _____

Relevant Physical Conditions (including allergies) _____

_____

Medications _____ Dosage _____

_____ _____

_____ _____

8) PLEASE CHECK ANY OF THE SYMPTOMS BELOW WHICH ARE OR HAVE BEEN A PROBLEM FOR YOU

(Please mark "**C**" (current) for symptoms within past 6 months and "**P**" (past) for symptoms experienced more than 6 months ago)

_____ Alcohol Abuse/Dependence
_____ Anger Problems
_____ Avoidance/Withdrawal
_____ Authority Issues
_____ Binging/Purging
_____ Co-Dependence
_____ Crying (Occasional)
_____ Crying (Frequent)
_____ Crying (Uncontrollable)
_____ Crying (Never)
_____ Depressed Mood
_____ Difficulty Concentrating
_____ Eating Disorder
_____ Edgy
_____ Euphoria/Elevated Mood
_____ Family Problems
_____ Fatigue/Low Energy
_____ Fear of Abandonment
_____ Financial Problems
_____ Flashbacks
_____ Gambling Problem
_____ Grief/Loss
_____ Guilt
_____ Health Problems
_____ Hearing Voices
_____ Hopelessness
_____ Irritability
_____ Isolation
_____ Job Problems
_____ Learning Disability
_____ Legal Problems
_____ Loss of Interest/Pleasure
_____ Memory Problems
_____ Muscle Tension
_____ Nervousness/Anxiety
_____ Nightmares
_____ Obsessions/Compulsions
_____ Parent-Child Problems
_____ Passiveness
_____ Physical/Emotional/Sexual Trauma Perpetrator
_____ Physical Pain
_____ Rebelliousness
_____ Relationship/Marital Problems
_____ Sadness
_____ Self-Destructive Thoughts/Behavior
_____ Self-Sabotaging Behavior
_____ Separation Anxiety
_____ Shakiness
_____ Shortness of Breath
_____ Sleeping Problems
_____ Strange Thoughts/Beliefs
_____ Stress
_____ Worthlessness
_____ Other _____
_____ Other _____

9) PLEASE RATE THE EFFECT OF IMPACT OF THE ABOVE SYMPTOMS ON THESE AREAS OF DAILY LIFE

	No Effect	Mild Effect	Moderate Effect	Marked Effect	Extreme Effect
Marriage/Relationship/Family	1	2	3	4	5
Job/School/Performance*	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Activities of Daily Living	1	2	3	4	5
Sleeping Habits**	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Eating Habits***	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

* Job _____ Disability/Leave _____ Job Jeopardy

** Sleeping _____ Difficulty Falling Asleep _____ Difficulty Staying Asleep _____ Early Morning Awakening

*** Eating _____ Weight Loss _____ lbs. _____ Weight Gain _____ lbs.

Intake Questionnaire Continued

Pg. 4 Female

7) Health

Physician's Name _____ Telephone _____
Address _____ Last Physical Exam _____
Relevant Physical Conditions (including allergies) _____
_____

Medications _____ Dosage _____
_____ _____
_____ _____

8) PLEASE CHECK ANY OF THE SYMPTOMS BELOW WHICH ARE OR HAVE BEEN A PROBLEM FOR YOU

(Please mark "**C**" (current) for symptoms within past 6 months and "**P**" (past) for symptoms experienced more than 6 months ago)

_____ Alcohol Abuse/Dependence
_____ Anger Problems
_____ Avoidance/Withdrawal
_____ Authority Issues
_____ Binging/Purging
_____ Co-Dependence
_____ Crying (Occasional)
_____ Crying (Frequent)
_____ Crying (Uncontrollable)
_____ Crying (Never)
_____ Depressed Mood
_____ Difficulty Concentrating
_____ Eating Disorder
_____ Edgy
_____ Euphoria/Elevated Mood
_____ Family Problems
_____ Fatigue/Low Energy
_____ Fear of Abandonment
_____ Financial Problems
_____ Flashbacks
_____ Gambling Problem
_____ Grief/Loss
_____ Guilt
_____ Health Problems
_____ Hearing Voices
_____ Hopelessness
_____ Irritability
_____ Isolation
_____ Job Problems
_____ Learning Disability
_____ Legal Problems
_____ Loss of Interest/Pleasure
_____ Memory Problems
_____ Muscle Tension
_____ Nervousness/Anxiety
_____ Nightmares
_____ Obsessions/Compulsions
_____ Parent-Child Problems
_____ Passiveness
_____ Physical/Emotional/Sexual Trauma Perpetrator
_____ Physical Pain
_____ Rebelliousness
_____ Relationship/Marital Problems
_____ Sadness
_____ Self-Destructive Thoughts/Behavior
_____ Self-Sabotaging Behavior
_____ Separation Anxiety
_____ Shakiness
_____ Shortness of Breath
_____ Sleeping Problems
_____ Strange Thoughts/Beliefs
_____ Stress
_____ Worthlessness
_____ Other _____
_____ Other _____

9) PLEASE RATE THE EFFECT OF IMPACT OF THE ABOVE SYMPTOMS ON THESE AREAS OF DAILY LIFE

	No Effect	Mild Effect	Moderate Effect	Marked Effect	Extreme Effect
Marriage/Relationship/Family	1	2	3	4	5
Job/School/Performance*	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Activities of Daily Living	1	2	3	4	5
Sleeping Habits**	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Eating Habits***	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

* Job _____ Disability/Leave _____ Job Jeopardy
** Sleeping _____ Difficulty Falling Asleep _____ Difficulty Staying Asleep _____ Early Morning Awakening
*** Eating _____ Weight Loss _____ lbs. _____ Weight Gain _____ lbs.

Yolanda Villegas, MA LMHC
Family Foundations Counseling
2002 65th Ave West
Fircrest, WA 98466
(253) 566-5559, FAX (253) 565-0274

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE PROCESSING

TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Yolanda Villegas and/or his billing representative** to use and/or disclose the following protected health information: (**Please initial)**

_____ Information required to process manual claims
_____ Information required to process electronic claims

ASSIGNMENT OF BENEFITS **(Please Initial)**

_____ I authorize my insurance benefits to be paid directly to the provider

INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name _____
Address _____ Business Phone _____
City_____ State _____ Zip _____

REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

DURATION

If not previously revoked, this authorization will expire on (1) year from date signed below.
Specific Limitation: Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

SIGNATURE

This Authorization covers protected health information pertaining to *(client-print name)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature _____ Date _____
Patient/Parent/Guardian/Other legal representative for health care decisions _____
Renewal Signature _____ Date _____
Witness _____ Date _____

Yolanda Villegas, MA LMHC
Individual, Couple & Family Therapy

Court Release Acknowledgement

I understand that I, _____ am receiving therapy from Yolanda Villegas. I understand that Yolanda Villegas is providing behavioral/mental health treatment and is not acting as an evaluator.

I further understand and agree not to involve Yolanda Villegas in legal disputes, as I understand that would not be in the best interest of my treatment and would be counter-productive to the therapeutic process.

I agree not to involve Yolanda Villegas in court proceedings regarding any treatment now or in the future, nor will Yolanda Villegas be asked to share my records regarding any such proceedings.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

Yolanda Villegas, MA LMHC
Individual, Couple & Family Therapy

Court Release Acknowledgement for Minors

(To be filled-out by parent or guardian when client is a minor)

I understand that my child _____ is receiving therapy from Yolanda Villegas. I understand that Yolanda Villegas is providing behavioral/metal health treatment and is not acting as an evaluator.

I further understand that Yolanda Villegas is not conducting a custody or visitation evaluation for my child. I agree not to involve Yolanda Villegas in any custody or visitation disputes, as I understand that would not be in the best interest of my child's treatment and would be counter-productive to the therapeutic process.

I agree not to involve Yolanda Villegas in court proceedings regarding any treatment of my child now or in the future, nor will Yolanda Villegas be asked to share my child's records regarding any such proceedings.

_____ _____
Parent / Guardian Signature Date

_____ _____
Therapists Signature Date

Yolanda Villegas, MA LMHC
Individual, Couple & Family Therapy

Client Information and Disclosure Statement

Welcome to Family Foundations Counseling. The following is to inform you about office policies and your rights as a client. Please read this material carefully and ask for clarification if needed.

Professional Profile

I am a Master's level therapist who is trained and experienced in doing one-on-one therapy with individuals, adolescents (15 years and over), and couples.

- I received my Bachelor of Arts Degree at Evergreen College
- I received my Master of Psychology at Chapman University of Washington Tacoma emphasis on Marriage and Family Therapy
- I am an active License Mental Health Counselor in the state of Washington.
- I am a member of the Pierce County Counseling Association
- I have worked with the Hispanic community for over 25 years.

As a therapist trained in family system theory, I became to understand that individuals learn, grow and behave according to their context and become part of their relationships. I view the counseling process as forming an alliance with you to explore the nature of your problem(s). Although we will spend time exploring the specific problem(s) that brought you to counseling, we will also look at the nature of your relationship with other significant people in your life. According to my theoretical orientation, many of the forces and dynamics that have influenced the complexity and intensity of your problem(s) are rooted in relational issues. My Christian worldview leads me to believe that you are made to relate in a satisfying and self-giving manner. This is the source of your greatest joy but also of your deepest problems. We will explore how your relational style interferes with experiencing a meaningful life. This is also meant to give you hope, that by not only dealing with the problem itself, we will aim at the source of the problem. I believe that certain problems can have a physical component as well. In such cases, medical consultation will be advised.

I am an independent private practitioner. My work as a therapist is solely my responsibility and does not necessarily reflect the view of the independent therapists at Family Foundations Counseling.

Services

Our time together will be primarily conversational and last 40-50 minutes per session for individual therapy or 1.5 or two hours for group therapy. It is important to note that during the process of therapy feelings may become intense and disrupting. You may feel as if things are getting worse before they get better. This is common during the process of change. However, there are no guarantees regarding outcomes of treatment. Desired change and outcomes of therapy are up to you.

An important part of your therapy will be practicing new skills that you learn during sessions. I will ask you to practice between our sessions, and we will work together to set up take-home assignments for you. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change may sometimes be easy and quick, or slow and frustrating. There are no instant, painless cures and no "magic pills." However, you *can* learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

We will typically meet once a week, then less often, and eventually therapy comes to an end. The process of ending therapy, called "termination," can be a very valuable part of our work. You have the right to terminate therapy at any time. You can expect to be heard without judgment. Although I personally adhere to a Christian belief system, I will respect and work with you, whatever belief system you may have. Please feel free to express your religious and life convictions openly and honestly. I also encourage you to ask questions about the counseling process, the treatment plan, or any other matters. In the event that I am unable to meet your needs, I will provide a referral for you. You have the right to end therapy at any time without additional obligation other than those already accrued.

Confidentiality

The counseling relationship is a confidential one. Anything you share with me will be kept in confidence. I believe personal growth is enhanced by honest communication. One way I practice that in therapy is to keep communication lines as open as possible. I keep no secrets between couples and family members when all are clients.

Disclosure of information about you to anyone requires your written consent. However, as a counselor, I am legally and ethically obligated to release information in the following situations:

A. As required by law (RCW 70.02.050):

1. when there is a threat or risk of self harm (suicide), or harm to another person (homicide)
2. when there is "reasonable cause" to suspect abuse or neglect of a child, disabled, or elderly person, from anything reported in a counseling session
3. if I receive a subpoena from a court of law

B. Professional consultation: As part of professional responsibility I consult with colleagues, and may also receive clinical supervision from qualified supervisors

C. Insurance: If you are using insurance, be advised that your insurance company may require us to disclose confidential information

A record of counseling services provided to you is kept in the office. You may ask to see the record and have a copy for a nominal fee.

Ethics & Professional Standards

I subscribe the ethical and professional standards of the Washington State Licensing Law. If you have questions about our work together, please talk with me about this so that we can come to an understanding about your specific needs and the direction of our work together. In the event that you feel I have acted in an unethical manner, please discuss the situation with me so that we can come to a resolution. If you find that our negotiation has not been satisfactory, you may contact directly the U.S. Secretary of Health and Human Services.

Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. (WAC 246-810-031)

Office Policies

Fees: My hourly fee is $125. The initial/first session (intake) is $160. Charges for extended appointments will be assessed according to your hourly rate. This also includes between-session telephone calls lasting longer than 5 minutes. In addition, if you and I agree that it would be helpful for me to consult with another paid professional regarding your situation, you will be responsible for all fees, including my time.

In the event that I'm called to testify in any court proceedings, a $100/hour rate will be charged for any and all time spent. A charge for mileage of 42.5 cents per mile and any parking fees will also be assessed.

Financial considerations are a necessary part of counseling. Openness and flexibility are needed when determining a client's financial obligation. It is my policy to not let a client accrue a balance of more than $150 in personal debt (excluding amount owed by insurance). If at such time your balance goes beyond that amount, reasonable efforts must be made to reduce your balance before continuing counseling.

Insurance: If you believe your health insurance will cover my services, please supply me with all the necessary information to process your claims. Our office manager will bill the insurance company for you. (All insurance claims will be billed at the $100/hour rate). You are responsible for paying any deductible or co-payment at each session. You are responsible for paying fees for any services that are not covered or paid by your insurance or third-party provider. The company may limit their authorization to a certain number of sessions or a certain amount of payment each year.

Appointments: A typical session lasts approximately **40-55 minutes**. It is important to attend every session. If you won't be able to keep your appointment, please call 253-566-5559 to notify the office of your cancellation 24 hours in advance of your appointment. **You will be charged 50% of FFC's hourly fee if cancellation is not received with proper notice**. **If you miss an appointment without canceling ahead of time, you will be charged the full fee and a future appointment will not automatically be scheduled for you**. I will wait to hear from you to reschedule. If you do not arrive within 15 minutes following your scheduled appointment time, your session is considered cancelled and payment may be required. Please initial here to signify you understanding and acceptance of this policy.

Initials_____

In the event of my absence (vacation or illness) you will be notified if it conflicts with a scheduled appointment and will be provided with a crisis clinic number to be used in emergency situations.

Emergency Services

Family Foundations Counseling is not an emergency or 24 hour service. In an emergency, you should call 911, the Pierce County Crisis Line at 1-800-576-7764, medical emergency services, or other appropriate agencies.

Disclaimer Regarding Children (Minors)

Unless children are a part of the therapy session it is recommended that they not be brought to the office. I am unable to guarantee their safety if left unattended in the waiting. Our receptionist, if present, cannot be responsible for keeping an eye on them, as well.

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Since privacy in therapy is often critical to successful progress, particularly with teenagers, it is usually policy to request an agreement from the parents that they consent to give up access to their child's records. If they agree, during treatment, they will be provided only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. A summary of the child's treatment (when it is complete) will be provided to the parents. Any other communication will require the child's authorization. An exception to this policy would be if the assigned therapist believed the child presented a danger to themselves or others. In such a case, the parents would be immediately notified of the concern. This would be discussed with the child, if possible, and any objections raised would be taken into consideration.

Signed Consent

Your signature below indicates that you have read and have been offered a copy of this document, as well as the opportunity to clarify any questions you have pertaining to this document.

My signature indicates the accuracy of the information within this document and my declaration to uphold the conditions listed within. Any exceptions or additions to this disclosure statement appear below.

Date	Printed Name	Signature
Date	Printed Name	Signature
Date	Therapist – Yolanda Villegas, MA LMHC Washington State License # LH60183269	

Notice of Privacy Practices

Family Foundations Counseling

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

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected Health Information," (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental condition and related health care services.

Your Rights Regarding Your PHI:

You have the following rights regarding your PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a Copy of this Notice. You have the right to a paper copy of this notice.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION

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

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use of disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of you PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

Initials _____

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OF OPPORTUNITY TO OBJECT

Required by Law. I may use of disclose your PHI to the extent that the use of disclosure is required by law, made in compliance with the law, and limited to the requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to you health or safety or to the health or safety of the public or another person.

Criminal Activity on My Business Premises/Against My Staff or Me. I may disclose you PHI to law enforcement officials if you have committed a crime on my premises or against my staff or me.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and not protective order has been obtained, and I have satisfactory assurance that you have received notice of an opportunity to have limited or quashed the discovery demand.

USES AND DISCLOSURES OF PHI WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must subsequent claim(s) for payment.

THIS NOTICE

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

CONTACT INFORMATION

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, contact me. My contact information is:

Yolanda Villegas, MA, LMHC
2002 65th Ave West
Fircrest, WA 98466
(253) 566-5559

Initials _____

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this *Notice.* I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this notice is April 14, 2003.

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of this notice.

_____	_____	_____
Date	Printed Name	Signature
_____	_____	_____
Date	Printed Name	Signature

Financial Policy

Family Foundations Counseling

Thank you for choosing the providers at Family Foundations Counseling for your mental health care needs. We are committed to your treatment being successful. Financial consideration is an important part of the counseling process. In order for you and your counselor to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment and what this office expects from you.

In order to provide you with the highest quality service while keeping our billing costs low, we offer paperless billing. We simply maintain your credit or debit card number on file to satisfy all fees charged including late cancels and no shows and, if using insurance, co pays, deductibles, coinsurance and other balances not covered by your insurance. Our Accounts Manager will be more than happy to give you more information about EASY PAY.

All non-insurance clients are required to pay their full fee at the time of service unless other arrangements have been made. These arrangements will be done through the Accounts Manager or your counselor by your second visit and must be in writing to be valid. If at any time you pay more than is owed, you may choose either to receive a refund from your counselor or use the credit toward future sessions.

WE ACCEPT as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders and Cash. **Please make checks or money orders payable to Family Foundations Counseling.** (If you use an online banking service to make payment, make sure the merchant is your counselor. Any checks returned to your counselor for non-sufficient funds (NSF) will be charged back to your account along with an additional $25.00 service charge.

If you are a non-insurance client you may skip this next section and go to page 2 and begin at "Divorce Decrees."

INSURANCE & INSURANCE COLLECTION

Our Accounts Manager will work very hard to make sure your paperwork is filed accurately and promptly. Nevertheless, please understand that insurance reimbursement can be a long and difficult process. If fact, insurers will routinely stall, deny, and reduce payments. Depending on the type, insurance doing business in the state of Washington have 30 to 90 days to pay or deny a claim. However, even though our Accounts Manager had undergone training to maximize your insurance reimbursement, while reducing the time by which they pay, there may be instances in which we haven't received a payment or denial from the insurance company within the appropriate time. In this case, you then become responsible for paying the account in full if we have not received payment within 90 days.

In this case where you have paid you account in full and insurance pays at a later date or you pay more than is owed, you may choose to receive a refund from your counselor or apply the credit toward any future sessions.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions please call your insurance company and inquire. Your counselor of the Accounts Manager will help you in any way they can if you have problems deciphering the information you receive from your carrier.

You should also be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands we have no control over what they do with it.

For each client choosing to have a claim submitted to insurance we need the Intake form filed out completely (for both primary and secondary insurances) and making sure the "Authorization for Use or Disclosure of Protected Health Information for Insurance Claims Processing" form is signed and that we have a copy of your insurance cared. We cannot file a claim on your behalf without this release signed.

Initials _____

As a courtesy, we will bill your insurance for you. For all plans, co-pays, if applicable, must be paid **each and every visit.** There can be no exceptions due to contracting and uniform compliance rules. **You are also responsible for getting proper referral information in advance of your appointment.** Please contact your insurance and ask for you outpatient mental health benefits to see if this applies to you. If you have a **PPO** plan and you counselor is contracted with them, we have agreed to accept the discounted rate from your plan. If you have a coinsurance rather than or in addition to a co-pay you will be billed for these amounts after we have received an explanation of benefits from your insurer. For **Non-Contracted** plans we also expect deductibles, coinsurance, and/or co-pays to be paid at the time of service. Some non-contracted insurance companies may reimburse you for the services rather than us. You are required to pay us in full at the time of service. If you have not done so, and we received notice from the insurance company that you've been paid, you are expected to pass that amount onto us in addition to the additional amount you owe. For **Non-Contracted plans we also reserve the right to not bill your insurance.** You will be informed of this at the beginning of your counseling. In this case you will receive the necessary paperwork for you to get reimbursement from you insurance company and will be required to pay in full at the time of service.

If you want us to bill insurance for you, make sure you give us all information in a timely manner as we will not bill any insurance for dates of service older than 90 days unless obligated to do so under contract.

Secondary Insurers

Having more than insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balance after your insurance(s) has cleared. The above ruled for primary insurances apply accordingly to secondary insurances.

Late to an Appointment

If you are using insurance and are late for an appointment, we can only bill insurance for the time that you are actually seen; therefore, you are responsible for the "late" time. (Ex. If you show up more than 20 min. late for an appointment – we will bill your insurance for half and you for half). By signing this policy you agree to waive your rights of health care coverage under your benefits and make complete payment for you portion of the services you were late.

Hold Harmless

You counselor may perform, with your consent, procedures that are not covered under your insurance policy. These may include marital, family, and/or sexual counseling as well as behavioral disorders and others. Furthermore, you may have obtained services that have not received the proper preauthorization for the date of service rendered. By signing this policy you agree to waive your rights of health care coverage under your benefits and make complete payment for these services rendered to the extent that any contracts will allow.

Usual & Customary Rates

Our practice is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary fees. This applies to non-participating plans only.

Divorce Decrees

This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibilities for minors rests with the accompanying adult. (See below for additional details.) An exception may be made if we have written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment will be denied unless charges have been authorized to a Visa/MasterCard/Bank Card payment by cash or check at time had been verified, or we have the signature on file of the person(s) financially responsible for the bill on record and they have read and signed this policy.

Collection and Rebilling Fees

While it is never our preferred choice, it may become necessary to send an account to collections. You are responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collection process.

Initials _____

We are not a billing company. We may charge a rebilling fee of $10.00 per bill on past due accounts (over 20 days).

If you do not follow through on payment arrangements or if your account is sent to collections and you are an active client, non-emergency counseling sessions will be suspended until such time as your account is brought up to date and paid in full.

If you are a returning client that has previously been seen by a counselor at Family Foundations Counseling and was at any time sent to collections, you will first be required to have your account clear with the collection agency (or us) and then be required to pay your counselor in full with cash or money order at the time of service. The exception is, if you have insurance that your counselor is contracted with (preferred provider), we will continue to bill the insurance for you and you will be required to any co-pays, with cash or money order at the time of service. (If your counselor is a non-contracted provider with your insurance company you will pay in full and, as a courtesy, we may bill your insurance for you. Any insurance payments that may come to us will be refunded to you or applied to future sessions per your instructions.) If at any time payment is not made at the time of service you will not be allowed to reschedule until your account is paid and current.

On-Call Counseling

Sometimes it is necessary for clients to see an "on call" counselor at Family Foundations because their counselor is not available and crisis or emergency counseling is needed during their counselor's absence. If you need the services of an "on call" counselor, it is your responsibility to pay the "on call" counselor at the time of service. The charge will be at the "on call" counselor's rate. **Insurance will not be billed for these sessions. Exception:** If the "on call" counselor is a preferred provider for your insurance and you wish to bill the insurance then you will need to intake with the "on call" counselor as if you are a new client.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Date	Printed Name	Signature of Patient or Responsible Party
Date	Printed Name	Signature of Patient or Responsible Party

Easy Pay Consent

Family Foundations Counseling

(Optional Payment plan for those paying by debit/credit card)

This form is for those who wish us to keep your debit/credit card number on file and we will automatically deduct any payments owed from your debit/credit card. (**Examples of payments are copays, deductibles, coinsurance, late cancels, no-shows or full payment if not using insurance.)**

I authorize **Yolanda Villegas, MA LMHC** to charge my credit /debit card for fees charged (including late cancels and no-shows) and if using insurance, copays, coinsurances, deductibles and the balance of charges not paid by insurances within 90 days.

Not to exceed $_____ per

- ☐ Month (Please note the day of the month to make deduction) _____
- ☐ Semi-monthly (the 15th and the last day of the month)
- ☐ Week (Please not the day of week to make deduction _____
- ☐ Each session

Insurance clients

I assign insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I understand that if my insurance should pay at a later date I may choose either to have a refund issued by my counselor or use it as a credit towards future payments owed.

_____ _____

Cardholder Signature Date

Client Name_____

Cardholder Name Exactly as it Appears on the Card _____

Cardholder Address _____

City _____ State _____ Zip _____

☐ Visa ☐ MasterCard ☐ Visa Debit Card ☐ MasterCard Debit Card

Credit Card Number

_____

Date of Expiration _____/_____ V-Code (3-digit Security Code on back of card) _____

Cardholder Signature _____