DISCLOSURE STATEMENT, AGREEMENT FOR SERVICES, AND NOTICE OF PRIVACY PRACTICES

TRACY HENDERSON COUNSELING

MA | LMHC | CCTP | ADHD CCSP

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Introduction This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information about Tracy Henderson MA | LMHC | CCTP

Tracy Henderson is currently a Licensed Mental Health Counselor (LH60980971) and an Approved Supervisor in the State of Washington. NPI (1700292638) Tracy received a MA in Counseling Psychology from Bastyr University in 2014. Tracy has been trained in evidence-based therapeutic models, such as Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Motivational Interviewing (MI) for individual and couples' therapy. Tracy has completed levels I and II in the Gottman Method Couples Therapy and uses Gottman Method Couples Therapy in his work with couples. Tracy has completed the Clinical Certified Trauma Professional certification as well as certification as an ADHD – Certified Clinical Services Provider. These models and practices are made-up of strength and value-based therapies which have been found to be highly effective working with individuals and couples. Tracy has completed all required coursework modules for Discernment Counseling through the Doherty Relationship Institute.

Fees and Insurance The fee for individual therapy delivered through teletherapy and/or in-person is $125 per 55-minute session. The fee for couples' therapy delivered through teletherapy and/or in-person is $150 per 55-minute session. Phone sessions and emergency contacts over 10 minutes are billed at the same rate.

Individual Sessions and conjoint (marital /family) sessions are approximately 55 minutes in length. However, at certain points you and your therapist may determine that longer sessions are necessary in advance or a crisis may arise that necessitate a longer session. Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Fees are reviewed annually. If my fees change at any point in the future, I will provide 60 days' notice of any changes.

Payment in full is due at the time of each session including private pay amounts, copays, and deductibles. Please note - you will be billed for any remaining balance.

No Surprises Act (NSA) disclosure will be provided separately. The NSA disclosure is intended to let you know about your protections from unexpected medical bills if you are paying privately, out of pocket, as an individual and/or if payment will be made outside of your healthcare plan. It also asks whether you would like to give up those protections and pay more for out-of-network care. You are not required to sign the form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less. You will receive a separate disclosure explaining your rights along with estimated costs for services provided prior to any appointments taking place. In addition to the disclosure, a Good Faith Estimate (GFE), will also be provided and the client can request a (GFE) for scheduled services.

Client Responsibility You are responsible to verify insurance coverage prior to the beginning of your appointments. You are also responsible for anything not covered by your insurance plan, including denials.

You should be aware that insurance plans generally limit coverage to certain diagnose mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples’ therapy. This means that if you participate in family, and/or marital/couples’ therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her “no secrets” policy and how it may apply to you.

INFORMED CONSENT Discernment Counseling 1. Discernment counseling is not a legal service, and no legal advice is provided. Please consult with an attorney or visit a court self-help center in your county if you have questions about the legal issues related to divorce. 2. Participation in discernment counseling does not relieve you from any obligations you may have in an ongoing divorce case 3. By participating in discernment counseling, you agree that you will not seek to use in a court proceeding any statements made by the other party or by the counselor at any discernment counseling session. You also agree that you will not call as witness or seek to obtain for court purposes any of the notes or documents prepared by the discernment counselor. 4. Any information you provide will remain confidential. However, in order to provide effective service, if a referral is made to an outside professional, you hereby grant permission to share client information with that professional.

Record Keeping Your records are maintained in a web-based system. What this means is your records are stored online in a secure, encrypted, HIPAA compliant system that is backed up to ensure records are not lost due to technical problems. This system provides certain benefits to client including online payment, online scheduling, and secure messaging to your therapist. Please ask any questions or report any concerns you have regarding online record keeping. As with any record keeping method, every foreseeable precaution has been taken to protect privacy, but there are no guarantees.

Appointment Scheduling Sessions are scheduled to occur as agreed. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

“Telehealth” Appointments include the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using a system that is encrypted to the federal standard and HIPAA compatible. It is the

client's responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the technology that you are interacting with. It is the client's responsibility to inform the therapist if the client will be outside the State of Washington. Additionally, the client agrees not to record any Telehealth sessions. During a Telehealth session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. I will ensure that I have a phone with me, and I have provided that phone number. I understand that all fees for Telehealth and non-Telehealth services are the same. I am financially responsible for all services rendered, late cancellations, and missed appointments.

Cancellation Policies In order to cancel or reschedule an appointment, you are expected to notify your therapist at least **24 hrs**. in advance of your appointment. If you do not provide your therapist with at least **24 hours**' notice in advance, you are responsible for a **$50 fee** for the missed session.
Please note - ALL late cancellation and missed appointment fees are in accordance to your therapist's private practice policy. If you have concerns or would like to dispute the fees, your concerns will need to be directed to your therapist.

Therapist Availability/Emergencies Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 48 hours. Your therapist is not available to return calls on Saturdays or Sundays or after 8 pm. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis: Crisis Hotline: (206) 461-3222 Youth Homeless Shelter: (206) 632-1635 Domestic Violence Help: 800-562-6025 Community Services: 211 Lifeline: 988 and Immediate Emergency(s) 911.

About the Therapy Process It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation; your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist and you will also periodically exchange feedback regarding your progress.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Notice of Privacy Practices for Tracy Henderson MA | LMHC | CCTP

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI) I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also, request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for other, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operation Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons: For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to you psychiatrist in order to coordinate your care. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims. For health care operations. I can disclosure your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws. Other disclosure. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so. Certain Uses and Disclosures Do Not Require Your Consent. I can use your PHI without your consent or authorization for the following reasons: When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding. For public health activities. For example, I may have to report information about you to the county coroner. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization. For research purpose. In certain circumstances, I may provide PHI in order to conduct medical research. To avoid Harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel and veterans in certain situations. And I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or

other health care services or benefits I offer. Certain Uses and Disclosures Require You to Have the Opportunity to Object. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI You have the following rights with respect to your PHI: The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclosure your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. The Right to Get a List of the Disclosures I have Made. You have the right to get a list of instances in which I have disclosed you PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for nation security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one based request in the same year, I will charge you a reasonable cost based fee for each additional request. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that you request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices. **Unprofessional Conduct:** The brochure called "Counseling or Hypnotherapy Clients" 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 P.O. Box 47869 Olympia, WA 98504-7869 360.664.9098 VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at Tracy Henderson, 206-228-5753 - Tracy@tracyhendersoncounseling.com

VII. EFFECTIVE DATE OF THE NOTICE This notice went into effect on March 23, 2016

Therapist Communications Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by informing your therapist below by indicating in the space provided below. Please be sure to inform your therapist if you do not wish to be contacted at a time or place, or by a particular means.

Phone: Yes/No **If yes:**

Text Messages: Yes/No Voicemail: Yes or No

Email: Yes or No If yes:

Mail: Yes or No If yes, address:

(Address)

INFORMED CONSENT My therapist may contact me through the approved methods I have provided.

[PatientName]

Client Name (Print)

Client Signature - [CurrentDate]

Client acknowledges the information enclosed in this document and has been provided a copy of the required disclosure information and that the client has read and understands the information provided

Tracy Henderson MA | LMHC | CCTP Date