To new clients:

This packet includes information about my services 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.

The ***Disclosure Statement*** outlines my policies regarding financial matters, confidentiality of information, and other administrative issues.
The ***Communications Policy*** describes appropriate methods of communication with me.
The ***Communication by Email, Text Message, and Other Non-Secure Means*** form allows you to give your consent for non-secure methods of communication if you desire.
The ***Credit Card Authorization Form*** provides me with a backup form of payment in the event of a missed appointment or absence of payment at the time of session.
The ***Intake Form*** provides me with significant information about your life and situation that will provide me with a context for our work together.
The ***Emergency Notification*** form provides me with information on who to contact if you experience an emergency while in session.
The ***Acknowledgement of Receipt of Notice of Privacy Practices*** *(one page)* asserts that you have received the ***Notice of Privacy Practices*** (the last six pages of this document).

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.

***Fred DuMez-Matheson, MA, LMHC***
**Mental Health Therapist**

**Checklist for completing paperwork:**

- Please print your name in the space provided on this page.
- Read my **Disclosure Statement**. Sign and date.
- Read the **Communications Policy**.
- Read the **Communication by E-mail, Text Message, and Other Non-Secure Means** form and sign if you agree.
- Complete, sign, and date the **Credit Card Authorization Form**.
- Complete your **Intake Form**.
- Complete the **Emergency Notification.**
- Please sign the **Acknowledgement of Receipt of Notice of Privacy Practices**.
- Read through the **Notice of Privacy Practices** regarding your therapy.
- ***Initial all pages*** to indicate that you have read and understand the information provided.

Client Name: _____(please print)

# Disclosure Statement

**Contact Information:**

Mailing Address: 19504 8th Ave NW, Shoreline, WA 98133
Phone: 206.569.4937
Email: fred@avagabondsjourney.com

**Washington State Counseling License: #LH60525325**

**Training and Degree:** In 2012, I received a Master of Arts in Counseling Psychology from The Seattle School of Theology and Psychology. This was after completion of an internship at Atlantic Street Center, a social service agency in Seattle's Rainier Valley that specializes in empowering families of color. After graduation, I continued to work there for the next two years, working with children, adolescents, and their families, primarily in the school setting, addressing issues of trauma, depression, and anxiety. During this time I also served two years as an assistant instructor of counselors-in-training in The Seattle School's Practicum program, facilitating small group and individual interpersonal development. I continued this work for four years as a Practicum instructor. Additionally, I am trained by Seattle Pacific University as a mathematics/science teacher having served 12 years as a certified instructor of middle school/high school students, during which time I received my Master of Science Education degree from Western Washington University. I have been in private practice since January 2015.

**Counseling Orientation:** The counseling process involves the formation of an alliance with you to explore the nature of the issues that bring you to counseling. This relationship is the primary context for change. Although we will spend much time exploring the issues that bring you to counseling, we will also look at your relationships with other significant people in your life, both past and present. My approach explores the intricacies of these relationships and their influence on your specific difficulties in an effort to find and address the sources of problems.

In particular, the Biblical foundation underlying my counseling leads me to believe that you are made to relate in a satisfying and self-giving manner. In relationship is the potential for both immense joy and deep struggle, and thus your interactions with others are of particular interest in our work together.

It's important to recognize that progress in counseling is not linear. It can be a disruptive process as you deal with parts of your life that you have never addressed. Your symptoms or concerns may increase for a time. This is often a normal part of the counseling path. However, if you are unsure of the direction of our work, I welcome your questions and feedback.

In addition, clients who are most successful in their work with me

1) appreciate honest discussion and investigation of their personal histories
2) value their counseling time, maintaining a consistent appointment schedule of once a week sessions
3) build resourcefulness through outside assignments, (e.g., reading, journaling, or other creative outlets)

Finally, I believe that certain problems can have a physical component. In such cases, I will advise medical consultation.

**Billing and Insurance Information:**

| | Individual | Couple/Family |
|---|---|---|
| **53-minute session:** | **$160** | **$180** |

All appointments are scheduled for an hour. (A 53-minute session will be listed as an hour for invoicing.) Occasionally, you may wish to schedule longer or shorter sessions. Please discuss with me how payment is structured for these sessions.

**Your regular fee will be charged, on a prorated basis**, for any additional professional services rendered at your request, such as **phone contacts *over 5 minutes***, consultations with other professionals, and/or letters/reports. (*These services are generally not covered by insurance.*) **Court time** and related preparation will be billed at the rate of **$250 per hour**, including travel and wait time, even if I am called to testify by another party. Fees are adjusted annually on January 1 and will not increase more than $10 per year. I accept cash, personal checks (made out to "A Vagabond's Journey Counseling"), and credit cards (see below). Returned checks will be charged $35. ***Payments are to be made at the beginning of each session.***

**Credit Card Authorization and Purpose**: This *required* authorization will be used to process payment for your session unless you prefer to use cash or check. It will also be used in the event that you forget to bring cash or check to your session OR you fail to give adequate notice of missing an appointment. In such a case you are authorizing me to charge your credit card for any therapy related fees. ***If for some reason you cannot pay for the session at our meeting time, we will not hold the session.*** However, you will still be responsible for payment for the session; *it will be regarded as a missed appointment* (see below). If the card charges are declined, this must be remedied before the next session can be scheduled and a $35 charge will be added if not remedied after two days.

**Missed, Cancelled, or Late Appointments:** You will be charged for a missed or cancelled appointment if you have failed to provide a minimum notice of **48 hours**. See the chart below:

| **Notice Given** | >48hrs | 48hrs>notice>24hrs | 24hrs>notice>12hrs | <12hrs |
|---|---|---|---|---|
| **Charge** | $0 | $40 | $80 | $160 |

There are a variety of ways to notify me, though by phone is preferred. Texts are the least preferred because they can be dropped or delayed. ***Illness is not an exception to this rule.*** If you are late, I will stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. **If late, *those using insurance*** will private pay for the portion of the hour that cannot be billed to insurance:

| **Delay** | <5min | 5-14min | 15-24min | >25min |
|---|---|---|---|---|
| **Charge** | $0 | $35 | $70 | $160 |

**Inclement Weather:** I will make reasonable and safe efforts to make it to the office in case of inclement weather (e.g., snow). If I make it to the office, I will assume that our appointment will be held and payment is your responsibility. If you are unable to attend in person, we will meet via video telehealth unless your insurance does not cover it.

**Insurance and Third Party Payments:** I am currently a provider for **Premera** (incl. Anthem), **Cigna,** and **First Choice Health** (incl. Kaiser PPO) and will submit claims accordingly. Otherwise, I do not file insurance claims for you or receive direct insurance payments, except for **Cigna, First Choice Health,** and **Premera**. [*I am opted out of Medicare*] If you wish to use your insurance, you must arrange for the provider to reimburse you directly. I am happy to provide you with a monthly statement that provides the required insurance codes. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to your provider, as well as knowing the benefits and limits of your policy. Please note that if you use insurance, a diagnosis will be required. **Note: Insurance** and other third party payers **will not pay for missed or late appointments. Complete payment** for services rendered and missed appointments **is your responsibility**.

**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, and you may terminate therapy at any time. In the event that you elect to end our time together, I strongly recommend a minimum of one final meeting to discuss your progress and your goals for the future (see "Termination of Treatment" below).

**Intake Process / Initial Consultation Services**: During the intake process, I will explore with you the nature of your concerns and will determine whether I can work with the problem as presented or a referral to another clinician would be more appropriate. The regular fee will be charged for the consultative services I provide during the intake process. You understand that until a plan of treatment has been developed and agreed upon by both counselor and client, all services provided are consultative in nature, and I will assume no obligation to provide continuing services to you. In the event I recommend services elsewhere, I will provide you with referral assistance. **Note: Use of insurance requires the submission of a mental health diagnosis.**

**Social Networking and Internet Searches:** At times I may conduct a web search on clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss it with me. I do not accept friend requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

**Confidentiality:** There is a legal privilege in the state of Washington protecting the confidentiality of the information that you share with me. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality.
There are legal **exceptions** to confidentiality. In the following situations, the information you have shared with me may be shared with others (please see the enclosed HIPAA form for a more complete list):

1) The Uniform Health Care Information Act may provide for disclosure of information to another health care provider who is serving you.
2) You may give written permission to share confidential information. If you wish to disclose to a third party, you must sign a *consent to release* form.
3) If you reveal that you are contemplating, planning, or have acted out a crime, I must report this.
4) If you reveal that you are planning to harm yourself or others, I must report this.
5) If you are a minor, I may discuss with your parents or guardians some of the information from counseling. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
6) If you and your spouse are both seeing me for marriage counseling, I may, at my discretion, discuss information with your spouse that you have revealed to me, unless you specifically indicate that certain information is confidential.
7) If you reveal that a child or adult has suffered abuse or neglect, I have an obligation (as do all professionals) to report this information.
8) If information you have revealed to me is subpoenaed, disclosure may be required by law.
9) As required under chapter 26.44 RCW.

When it is possible, we will discuss any exceptions to confidentiality as they arise.

**Clinical Consultation:** I regularly engage in clinical consultation, the goal of which is to increase my skills and improve my service to you. This allows me to gain other perspectives and ideas that may help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

**State Information:** Counselors practicing counseling for a fee must be registered or licensed with the department of health for the protection of the public health and safety. Licensing 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 counselors who would commit acts of unprofessional conduct. If you believe that I have been unethical in our work and still believe so after discussing your concern with me, you may contact the state:

**Department of Health—Counselor Programs**
**P.O. Box 47869**
**Olympia, WA 98504-7869**
**360.664.9098**

**Scheduling Appointments:** Appointments are generally made on a regular, **weekly basis** for an hour. In some cases, I will suggest more frequent appointments. Appointment times are automatically held for you from week to week. It is your responsibility to notify me of any changes in your schedule that prevent you from attending. ***Rescheduling when other openings in the week are available can prevent cancellation fees.***

**Termination of Treatment:** You may terminate treatment at any time without legal or financial obligation beyond payment for services already rendered and unpaid missed appointments. ***Please give a minimum of one week's notice.*** It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that might 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 you 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. Should you make contact with me at a later date requesting additional services, I may choose to see you on a consultative basis, or I may recommend that you seek services elsewhere. I also may terminate the treatment if I determine the therapy process to be unproductive and/or if I determine that you would be better served by other health or mental health practitioners. I will provide 30 days notice of intent to terminate to allow you to make other treatment arrangements.

**Thank you** for your interest in counseling with me.

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## TREATMENT AGREEMENT

I have read and understand the information in this form. Further, I have read the written statement entitled "Notice of Privacy Practices Regarding Protected Health Information." If there is anything I do not understand, I can ask my counselor. I continue my consent to treatment according to the policies presented in this form. *A signed copy of this form is available on request.*

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

**Insurance Authorization:**
I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services. I agree to pay according to the above terms.
**Client/Primary Subscriber signature required for insurance.**

_____ _____
Client Signature Date

_____ _____
Primary Subscriber Signature Date

_____ _____ _____ _____
Insurance Company Subscriber ID Group # Date of Birth
***(Be prepared to provide a copy of your insurance card, front and back.)***

☐ I am actively using my Medicare coverage

# Communications Policy

## CONTACTING ME

When you need to contact Fred DuMez-Matheson for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

**By phone (206.569.4937):** You may leave messages on voicemail, which is confidential. I will check these messages on a regular basis. Please limit your phone contacts to appointment scheduling and emergencies; barring prior arrangement, our work will take place face-to-face. There may be circumstances in which it is appropriate to conduct one or more scheduled sessions by phone or video. Unscheduled telephone conversations initiated by a client will result in a fee being charged on a prorated basis according to the client's established fee schedule.

**By e-mail (fredmathesontherapist@gmail.com):** If you wish to communicate with me by normal email or normal text message, please read and complete the Communication by Email, Text Message, and Other Non-Secure Means form included with these office policies, as **my e-mail is not secure**. My e-mail address is available to simplify contacts from new clients, to facilitate scheduling of appointments, and to send files such as PDFs or other digital documents. However, e-mail is not a viable means of communicating other information to me. Please note that e-mails will be printed and placed in your file. I do not respond in depth to e-mails from clients. If you require urgent contact, you may choose to schedule a session sooner than your previously scheduled appointment time, if available.

**Secure document portal (avagabondsjourney@faxtone.com):** This email is to be used solely to exchange private health information and/or financial documents. Communications outside of document exchange will not be responded to.

Please refrain from making contact with me using social media messaging systems such as Facebook, Twitter (X), or LinkedIn. These methods have very poor security and I am not prepared to watch them closely for important messages from clients. It is important that we be able to communicate and also keep the confidential space that is vital to therapy. Please speak with me about any concerns you have regarding my preferred communication methods.

## RESPONSE TIME

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can **expect a response within 48 hours** (weekends are excepted from this timeframe). I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town.

**EMERGENCY CONTACT**

If you are ever experiencing an emergency, including a mental health crisis, please call:

- General Emergencies – 911
- Crisis Line (Snohomish County) – 800-584-3578
- Crisis Line (King County) – 866-427-4747
- Teen Link – 866-833-6546 (Evenings 6-10pm)
- Domestic Violence – 800-562-6025

If you need to contact me about an emergency, the best method is:

- By phone (206.569.4937).
- If you cannot reach me by phone, please leave a voicemail.

Please note that SMS (normal phone text messages) are not designed for emergency contact. SMS text messages occasionally get delayed and on rare occasions may be lost. So, please refrain from using SMS as your sole method of communicating with me in emergencies.

# Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Fred DuMez-Matheson, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Fred DuMez-Matheson
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Fred DuMez-Matheson about ways to keep your communications safe and confidential.

## CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Fred DuMez-Matheson to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Client Signature Date

_____ _____

Second Client Signature (if applicable) Date

  

# Credit Card Payment Authorization Form

Sign and complete this form to authorize A Vagabond's Journey Counseling to debit your credit card as listed below.

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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 A Vagabond's Journey Counseling and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run as primary payment or in the event that you forget to bring another form of payment to your session. Credit cards will also be debited in the event that you fail to give adequate notice of missing an appointment. A receipt of credit card processing will be sent to the email provided below or, if you choose, by text to your mobile device.

---

**Please complete the information below:**

I, _____, authorize A Vagabond's Journey Counseling to charge my credit
(full name; please print)

card account indicated below. Fees accrued for services rendered or missed appointments or failure to provide payment at the time of service will be processed via credit card at the agreed upon counseling fee.

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 A Vagabond's Journey Counseling 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 _____

# Intake Form

**Date**_____

**Last Name** _____ **First Name(s)** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

Do I have permission to send mail to this address? Y / N

**E-mail Address**: _____

**Telephone:** Home _____ Cell _____ Work _____

☐ Male ☐ Female ☐ Couple Date of Birth ___/___/____ (Partner DOB ___/___/____ )

Is it acceptable to contact you at home by phone? Y / N By cell phone? Y / N

**If none of the above options is acceptable, how may I contact you?** _____

How did you hear of me? If you found me on the web, through what site?

_____

***Please check any current general issues or past issues that still affect you.***

☐ Anxiety
☐ Fears/phobias (type: _____)
☐ Sexual problems
☐ Separation/divorce
☐ Drug/alcohol use
☐ Anger
☐ Addiction
☐ Religious matters
☐ Health problems
☐ Thought patterns (type: _____)
☐ Death of someone close
  ☐ recently (when:_____)
  ☐ in the past
☐ Sexual assault/rape
  ☐ recently (when:_____)
  ☐ in the past
☐ Childhood abuse
☐ Sexual identity issues
☐ Pornography
☐ Other _____

☐ Depression
☐ Eating disorders
☐ Suicidal thoughts
☐ Finances
☐ Career Choices
☐ Self-Control
☐ Insomnia
☐ Work/Stress
☐ Cutting/Self-harm
☐ Pregnancy Issues
☐ Relationship Concerns
  ☐ family
  ☐ friend
  ☐ parent
  ☐ significant other
  ☐ roommate
☐ other: _____
☐ Academic Issues
☐ Conduct problems

## Your Current Functioning

**Please describe the particular issue(s) that have brought you to counseling. Briefly include any relevant information on when these problems began, how often they occur, and/or the severity of these issues.**

**What do you hope to get out of counseling?**

**Who provides you with social and emotional support? How do you describe your network of friends?**

**What do you do to relax and enjoy yourself?**

## Work and Education

**Please provide a brief history of your employment, including your current position if you are employed. Are you happy with your work now?**

**Describe your educational experience (last grade completed, grades, problems).**

# Family of Origin

**Who was present in your family during your childhood?**

| | Present entire childhood | Present part of childhood | Not present at all |
|---|---|---|---|
| **mother** | ☐ | ☐ | ☐ |
| **father** | ☐ | ☐ | ☐ |
| **stepmother** | ☐ | ☐ | ☐ |
| **stepfather** | ☐ | ☐ | ☐ |
| **brother(s)** | ☐ | ☐ | ☐ |
| **sister(s)** | ☐ | ☐ | ☐ |
| **other (specify)** | ☐ | ☐ | ☐ |

**Describe your parents:**

| | Father | Mother |
|---|---|---|
| Name | _____ | |
| Occupation | _____ | |
| Education | _____ | |
| General health | _____ | |

**Parents' current marital status:**
- ☐ married to each other
- ☐ separated for _____ years
- ☐ divorced for _____ years
- ☐ mother remarried ____ times
- ☐ father remarried _____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for _____ years
  your age at mother's death _____
- ☐ father deceased for _____ years
  your age at father's death _____

**Describe your childhood family experience:**
- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed phys./verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

**Age you left home: _____ Circumstances:**

**Special circumstances in childhood?**

## Immediate and Extended Family

**What is your current family structure (marital status, children, others living in home)? Also, describe any history of previous marriages, children, stepchildren, or other significant relationships.**

**Please mark any issues that are present in your family, including extended family:**

| | **Issue** | **Family member(s)** |
|---|---|---|
| _____ | Mental illness (incl. depression and anxiety) | _____ |
| _____ | Birth defects | _____ |
| _____ | Chronic illness | _____ |
| _____ | Hereditary illness | _____ |
| _____ | Alcoholism | _____ |
| _____ | Drug abuse | _____ |
| _____ | Physical abuse | _____ |
| _____ | Sexual abuse | _____ |
| _____ | Behavior problems | _____ |

## Medical Health / History

Are you currently under medical care? If yes, please explain/describe:

Do you have health concerns that are untreated at this time? If yes, please describe:

Name of primary physician: _____ Phone number: _____

## Medical Health / History (cont.)

Are you currently taking prescribed medications? **Y / N** Please explain/describe, including dosage:
_____
_____

List psychiatric/mental health medications you have taken in the past, including herbal substances:
_____
_____

Please list any time(s) in which you received care from a psychiatrist, psychologist, or counselor:

| Clinician | Location | Date | Nature of problem/ Diagnosis |
|---|---|---|---|

_____
_____

Are you or have you ever been suicidal? Briefly note dates and whether you have attempted suicide.

How often do you drink alcohol? _____ times per _____ (week, month, etc.)
How many drinks do you have each time you drink? _____
Has anyone (you or others) expressed concern about your use of alcohol?

Do you use other drugs/substances? _____ How often? _____ times per _____
Has anyone (you or others) expressed concern about your use of other drugs/substances?

Are you in a relationship in which you have been hit or threatened or forced to have sex? Is there anyone you're afraid of?

# Specific Symptoms

***Please rate your experience of the following specific symptoms using the key below. It is a lengthy list, but it can help you and your therapist to identify specific problems.***

*Never = 0; Seldom =1; Often = 2; Always = 3*

_____ Difficulty concentrating
_____ Vision or hearing problems
_____ Stealing
_____ Feeling helpless
_____ Eating binges
_____ Feeling hopeless
_____ Lying to others
_____ Sexual preoccupation
_____ Feelings of worthlessness
_____ Injuring self *List:* _____
_____ Memory loss/blackout
_____ Crying
_____ Weight gain/loss
_____ Anger
_____ Worrying
_____ Feeling afraid
_____ Withdrawing socially
_____ Feelings of self-doubt
_____ Nervous around others
_____ Seizures
_____ Missing classes
_____ Lack of energy
_____ Feeling uptight
_____ Lack of interest
_____ Guilt feelings
_____ Feeling out of control
_____ Suicidal thoughts

_____ Irritability
_____ Racing thoughts
_____ Decreased need for sleep
_____ Impulsivity
_____ Difficulty sleeping

_____ Shortness of breath
_____ Trembling/shaking
_____ Nausea
_____ Chest pain
_____ Panic attacks
_____ Dizziness/Faintness
_____ Sweating
_____ Numbness
_____ Fear of dying
_____ Palpitations
_____ Sensation of choking
_____ Hot flashes/chills
_____ Fear of "going crazy"

_____ Muscle tension/ache
_____ Frequent urination
_____ Easily startled
_____ Restlessness
_____ Trouble swallowing
_____ Dry mouth
_____ Feeling "on edge"

_____ Recurrent dreams
_____ Hallucinations
_____ Physiological reaction to trauma reminders
_____ Difficulty recalling aspects of past trauma
_____ Intrusive recollections
_____ Difficulty feeling emotions
_____ Avoidance of certain memories
_____ Distress to trauma reminders
_____ Flashbacks
_____ Lack of sense of future

_____ Physical symptoms *(e.g., headaches, digestive) Have you seen a health care provider for these?* _____

_____ Sexual functioning problems *Have you seen a health care provider for these?* _____

_____ Other: _____ _____ Other: _____

# Emergency Notification

**In case of emergency, notify:**

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

**OR**

Name: _____

Address: _____
_____
_____

Cell Phone: ( ) _____
Home Phone: ( ) _____

Relationship: _____

In the event of an emergency in which I _____am unable to
(Print Full Client Name)
communicate for myself, I grant Fred DuMez-Matheson, LMHC permission to contact the individuals listed above to inform them of my emergency and where I might be transported or otherwise taken care of.

Client Signature: _____

Date: _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Fred DuMez-Matheson.

Signature of Client *(or Legal Guardian):* _____ Date: _____

Signature of Client *(or Legal Guardian):* _____ Date: _____

**If a personal representative signs this acknowledgement on behalf of the client, please complete the following:**

Name of Personal Representative: _____

Relationship to Client: _____

---

**FOR OFFICE USE ONLY**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other *(Please specify)*-

_____

***This form does not constitute legal advice.***

# NOTICE OF PRIVACY PRACTICES INTRODUCTION

The privacy of your health information is important to me. I will not disclose your health information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A federal law, the Health Insurance Portability and Accountability Act, commonly known as HIPAA, requires that I inform you about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign an acknowledgement that you received it. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding the health information I maintain about you and a brief description of how you may exercise these rights.

## NOTICE OF PRIVACY PRACTICES

(effective October 1, 2014)

**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.**

### I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at www.avagabondsjourney.com.

### II. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

**A. USES AND DISCLOSURES RELATED TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS DO NOT REQUIRE YOUR PRIOR WRITTEN CONSENT. I may use and disclose your PHI without your consent for the following reasons:**

1. **For treatment.** I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. **For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

**B. CERTAIN OTHER USES AND DISCLOSURES DO NOT REQUIRE YOUR CONSENT. I may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Washington health and safety codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by Washington child abuse and neglect reporting laws. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by Washington elder/dependent adult abuse reporting laws. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

## C. 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 individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

## D. OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

In any other situation not described in Sections IIA, IIB, and IIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization

to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

## III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

### A. THE RIGHT TO SEE AND GET COPIES OF YOUR PHI.

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, ***you must request it in writing***. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you $35/hr for processing time. If you choose to have hard copies rather than digital, I will also charge not more than $.50 per page. Otherwise, the fee will include the cost of the digital media used to convey your PHI. Postage will be charged if you choose to have the documents sent to you by mail. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

### B. 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 disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

### C. THE RIGHT TO CHOOSE HOW I SEND YOUR PHI TO YOU.

It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

### D. THE RIGHT TO GET A LIST OF THE DISCLOSURES I HAVE MADE.

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. 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 cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

### E. THE RIGHT TO AMEND YOUR PHI.

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

### F. THE RIGHT TO GET THIS NOTICE BY EMAIL.

You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

## IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section V below. You may also 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. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

## V. 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: Fred DuMez-Matheson, 1501 N 200th St, Suite 105, Shoreline, WA 98133 / 206.569.4937 / fred@avagabondsjourney.com.

## VI. NOTIFICATIONS OF BREACHES

In the case of a breach, Fred DuMez-Matheson is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Fred DuMez-Matheson is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. Fred DuMez-Matheson bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

## VII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. Fred DuMez-Matheson may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

## VIII. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES; RIGHT OF ACCESS

To implement the 2013 HITECH Act, the Privacy Rule is amended such that Fred DuMez-Matheson is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring Fred DuMez-Matheson to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that Fred DuMez-Matheson must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct Fred DuMez-Matheson to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that Fred DuMez-Matheson may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

## IX. NOTICE OF PRIVACY PRACTICES

Fred DuMez-Matheson's Notice of Privacy Practices must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

## X. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on October 1, 2014.