***William Halter Therapy INC. P.S.***
*William Halter, MEd, LMHC*
*404 Bradley, Ste. 206*
*Richland, WA 99352*
*Phone: (509) 554-0588 Fax: (888) 277-6293*
*willhaltertherapy@gmail.com*

*CLIENT DATA WORKSHEET*

**THIS SHEET MUST BE FILLED IN COMPLETELY**

**Please Print Clearly** Readmit: ___Yes ___No

Date: _____ DOB: _____ Age: _____ Gender: _____

Client's First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

| Phone: | | Preferred | Messages OK | Text OK |
|---|---|---|---|---|
| Cell: | _____ | ☐ | ☐ | ☐ |
| Home: | _____ | ☐ | ☐ | ☐ |
| Work: | _____ | ☐ | ☐ | ☐ |

E-mail: _____

**Emergency Information** **In case of emergency, contact:**

Name (1): _____ Relationship: _____ Phone: _____ Work: _____

Address: _____ City: _____ State: _____ Zip: _____

Name (2): _____ Relationship: _____ Phone: _____ Work: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Psychiatrist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Current Medications: _____

Allergies: _____

Referral Source:

How did you hear of our clinic (or from whom)?

Relationship to referral source: _____

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*STATE REQUIRED DISCLOSURE STATEMENT*
Washington State Department of Licensing

## *Background*

*Education: M.Ed in Counseling Psychology, Washington State University*
*B.S. in Psychology, University of Idaho*

*Licensed Mental Health Counselor: LH00010838 (State License Number)*

*Type of Counseling: Primarily Individuals (ages 12 and up)*

*Counseling Methods: Cognitive-Behavioral*
*Solution Focused*
*Positive Psychology*

## *Philosophy*

*Life doesn't come with a manual and sometimes we find ourselves stuck and unable to move forward. Counseling is a collaborative process between individuals that works to help find tools so that each person can move forward toward the future that they envision. I utilize aspects from the following approaches to assist in helping in that process of moving forward as we work together and talk through the challenges that each person experiences.*

***Cognitive Behavioral Therapy (CBT)** works with the thoughts and patterns which are often developed through experiences of life that keep us from reaching our potential. This is done by exploring one's history can assist in recognizing patterns of behavior that work against us when coping with life stressors. While we do look at the past, the past is used to help us understand our current thoughts, feelings and behaviors.*

***Solution Focused Therapy (SFT)** holds that focusing only on problems is not an effective way of solving them. Instead, SFT targets clients' default **solution** patterns, evaluates them for efficacy, and modifies or replaces them with problem-solving approaches that work.*

***Positive Psychology** is the study of the strengths that enable individuals and communities to thrive. The field is founded on the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play.*
*We also will investigate options for improving nutritional intake, exercise routines, quality of sleep, physical health care and spiritual happiness, whatever you deem that to be. Treatment will be individualized to meet the needs of each client.*

## *Policies*

### *Confidentiality*

*It is a privilege to have been chosen to provide counseling services for you and/or your family. Out of respect for you, I uphold professional ethical standards that include the strictest of confidentiality as outlined by the Department of Licensing. Confidentiality is an important aspect of therapy. There are limits to confidentiality in the following situations:*

- *When permission is given by the client/parent to collaborate care. You may be asked to sign a release of information allowing me to disclose to persons outside the therapy session, such as your primary care provider or your psychiatrist. If this happens, you have the right to refuse to sign the release.*
- *When billing insurance companies require a diagnosis.*
- *When insurance companies require collaboration with a primary care physician.*
- *When there is a safety concern, such as Danger to Self, Danger to Someone Else, or Gravely Disabled. In such cases*

*Crisis Response or the Police may be notified; this is generally discussed prior to calling.*

- *When there are other safety issues involving minors or seniors then Child Protective Services or Adult Protective services will be contacted*
- *When there is a court hearing, testimony or case files may not be protected.*

***Illness***

*Therapy works best when it is regularly scheduled and attended. However, it is also important that you I remain healthy. If you have a fever, body aches, or chills in the last 48 hours, we can cancel, reschedule, or move to a virtual session. Please do not come into the office or waiting room. This policy is to keep you, your community, and your therapist healthy.*

***Fees/Billing***

*You are the customer for whom 1 am providing a professional service. However, you are ultimately responsible for the charges for services rendered. It is your responsibility to check with your insurance company to have a clear understanding of coverage for services. I will submit claims with your insurance company following appointments. Payment of co-pay/co-insurance or other charges are due at the time of service unless other arrangements have been made in advance, such as third party contractual payment from an insurance company.*

*Fees billed to your insurance company are established by rates as determined by each respective insurance carrier for mental health services and are comparable with similar mental health practitioners in Washington State.*

| *Regular Fees:* | *Insurance* | *Self Pay* |
|---|---|---|
| *Intake Evaluation (Initial Visit – Approx 75 minutes):* | $210 | $175 |
| *Individual Therapy (Most Sessions – Approx 50 minutes):* | $120 | $90 |
| *Late Cancellation/No Show* | $60 | $60 |

| *Other Fees:* | |
|---|---|
| *Court Testimony (Minimum 8 hrs):* | $120 *per hour* |
| *Report Writing and other consultations:* | $120 *per hour* |
| *Collateral Fee:* | $30 *per hour* |
| *Copy Fee (Based on WAC 246-08-400 at time of service):* | |

*No-show Policy & Cancellation Policy:*

*As I have only a set amount of time to schedule appointments, if you need to cancel your session, please do so 24-hours in advance so that I can waive your session fee and have the option to schedule a client who is in need during that time. If you cancel after 24 hours or no-show you will be billed for the session time at half of the full rate. If you have an emergency, please contact me as soon as possible so that I can offer an alternative time or mode of treatment (phone or video).*

*I authorize William Halter or any collection agencies used by William Halter to contact me by all contact information for billing activities or payment arrangements.*

## *Emergencies*

| | |
|---|---|
| *If you are in an Emergency situation please call:* | *911 or the nearest Emergency Room.* |
| *For after-hours Psychological Emergencies please call our local:* | *Crisis Response Unit: (509) 783-0500*<br>*Lourdes Counseling: (509) 943-9104*<br>*911* |
| *Non-Emergent - My confidential voice mail:* | *(509) 554-0588.* |

*I understand the contents of this disclosure statement and agree to its contents. I have been provided with access to Privacy Practices and Policies and Procedures*

*Client* _____ *Date* _____

*Parent/Guardian* _____ *Date* _____

*Therapist* _____ *Date* _____

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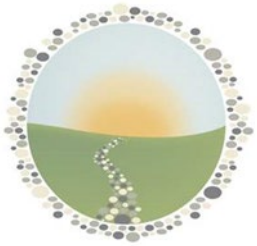

*FINANCIAL AGREEMENT*

*Client Name:* _____

*Payment Amount:* *Based on Current Fee Schedule* *Insurance Co-Pay Amount:* _____

| *Regular Fees:* | *Insurance* | *Self Pay* |
|---|---|---|
| *Intake Evaluation (Initial Visit – Approx 75 minutes):* | $210 | $175 |
| *Individual Therapy (Most Sessions – Approx 50 minutes):* | $120 | $90 |
| *Late Cancellation/No Show* | $60 | $60 |

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|---|---|
| *Court Testimony (Minimum 8 hrs):* | $120 *per hour* |
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| *Collateral Fee:* | $30 *per hour* |
| *Copy Fee (Based on WAC 246-08-400 at time of service):* | |

*Insurance Company Name:* _____

*Policy Holder Name:* _____ *Date of Birth:* _____

*Policy #:* _____ *Group #:* _____

*Employer Name:* _____

*Statement of Payment Agreement: I certify that the above information is true and correct, I authorize the above named clinician to furnish my Insurance Company, HMO, Managed Care Plan, Credit Bureau, or Contract Provider any or all information that the latter may request concerning my treatment for the purposes of billing.*

*Client:* _____ *Date:* _____

*Parent/Legal Guardian:* _____ *Date:* _____

*Other Treatment Team Members:* _____ *Date:* _____

*I understand that I am financially responsible to William Halter, MEd; for payment of services. That payment will be made at the time of service unless other arrangements are made. I understand that outstanding balances may be submitted to collections should I fail to pay the remaining balance when treatment is terminated I also understand a $60 no show fee may be assessed should I fail to give 24-hour notification of cancellations.*

*Signature of Financially Responsible Party:* _____ *Date:* _____

*Minors in Treatment (Under18 years): I give consent for William Halter, M.Ed., LMHC, to provide therapy to the above named client. I am the minor's legal guardian:*

*Parent/Guardian Signature:* _____ *Date:* _____

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## *NOTICE OF PRIVACY PRACTICES*

*The privacy of your information is important to me. I will maintain the privacy of your health information and will not disclose your information unless you advise me to do so or the law authorizes or requires me to do so. A federal law commonly known as HIPAA requires I take additional steps to keep you informed of how I use gathered information in order to provide health care services to you. As a part of this process, I am required to provide you with my Notice of Privacy Practices and request that you sign the written acknowledgment of either receipt or access.*

*The Notice of Privacy Practices describes how I may use and disclose your protected health information in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. This notice describes your rights regarding your health information and a brief description of how you may exercise these rights.*

*If you request I will provide a copy of my privacy practices, or if you prefer you may find them at:*
*http://www.willhaltertherapy.com/HelpfulForms.en.html*

*If you have questions about this policy feel free to contact William Halter.*

## *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 William Halter, M.Ed., LMHC*

_____ _____
*Signature of client (or personal representative.)* *Date*

*If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:*

*Personal Representative's Name: _____*

*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 of the following:*

- o*Individual refused to sign.*
- o*Communication barriers prohibited obtaining the acknowledgement*
- o*An emergency situation prevented us from obtaining acknowledgment*
- o*Other (please specify)*

*This form will be retained in your medical record.*

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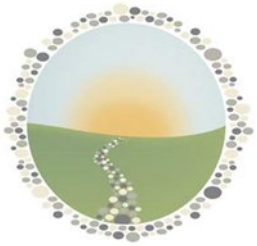

## *Telehealth Consent and Policies and Procedures*

*Telehealth involves the use of interactive 2-way video and audio communication (also known as Telemedicine) to conduct a "virtual office visit," as well as transmission of images, provision of ehealth including patient portals, and/or consumer-focused application. The information provided over telemedicine may be used for diagnosis, therapy, follow-up and/or education, and can include transmitting your medical records, medical images, audio and video.*

*Electronic systems used for Telehealth incorporate reasonable network and software security protocols and encryption to protect the confidentiality of Protected Health Information and include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption consistent with the Health Insurance Portability and Accountability Act (HIPAA). I currently utilize Doxy.Me as a secure platform for delivering telehealth services.*

***Potential Benefits:***

- *Improved access to convenient medical care.*
- *More efficient medical evaluation and management.*
- *Obtaining the expertise of a distant specialist.*

***Possible Risks:***

*As with any medical treatment, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:*

- *In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s)*
- *Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment*
- *In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information*

***Special Risks Associated with Personal Devices:***

*CARE Counseling cannot control the security of the computer, tablet, phone or other device you choose to use for Telehealth communication or the location where you choose to use it. Even though a platform is secured over the internet Viruses, Malware, Spyware, and other programs can be installed on the computer itself without a user's knowledge and could be used to record the audio and video of a Telehealth session without your knowledge. Unencrypted or poorly encrypted wireless networks could also allow someone to intercept the audio and video being transmitted over the network. CARE Counseling therefore recommends that you only use a privately-owned personal device with up to date antivirus software in a secure, private space. You assume all risks of your telemedicine session being recorded, seen and/or heard by unauthorized persons. The therapist nor the client will record the session(s) without the explicit, written consent of the other.*

***Safety Protocol***

*Your therapist will ask for your location address and ask you to scan the room you are in to show that it is secure and you are alone. If there are safety risks, the therapist will assess for safety and will develop a safety plan. If these risks exist and connection is lost, the therapist will call either your emergency contact on file and/or have a health and wellness check done to make sure you are safe.*

*In case of a mental health emergency, please call 911 or one of the following crisis services:*

*Crisis Response Unit: (509) 783-0500*
*Lourdes Counseling: (509) 943-9104*

***Termination of Telehealth Services***

*The therapist and the client will determine when telehealth services will be used and when meeting in person would be more appropriate. As mentioned in the potential benefits of telehealth, it would be recommended to use telehealth when there are*

*physical, environmental, and/or emotional reasons that prohibit or deter the client from attending sessions in person, thus telehealth improves accessibility. The therapist and client will determine when telehealth services will be terminated, which will depend on treatment goals and objectives, as well as accessibility needs.*

***Patient Consent to the Use of Telehealth***

*By signing this form, I agree that I am willing to undertake the risks associated with Telehealth in order to take advantage of the convenience it offers. I understand that I can revoke my consent to Telehealth at any time without affecting my right to future care or treatment. I understand and agree to the safety protocol and will work with my therapy to determine when telehealth will be completed.*

*I have read and understand the information provided above regarding Telehealth, have discussed it with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my medical/mental health care. Your signature below indicates that you have read and understood all of the information provided above and authorize your or your minor's therapist at CARE Counseling to use Telehealth in the course of your/your minor's assessment, diagnosis, and/or treatment.*

*Signature of Client or Parent/Legal Guardian of Client* *(Date)* _____

*Relationship to Client (if applicable)* _____

****This form may be signed electronically via the portal or above on a hard copy.*

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## *CREDIT CARD ON FILE POLICY*

*Thank you for choosing William Halter Therapy for your behavioral health needs. I am committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit.*

*To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, William Halter Therapy requests that all patients keep an active credit card on file. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility.*

*Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24 hour notice, missed co-payments, deductible and co-insurance, any non-covered services and/or denial of services.*

- *Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.*
- *When we receive the EOB, we will enter all pertinent payment information into our system. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be sent to you.*

*If the credit card we have on file for you changes, please notify us IMMEDIATELY by phone or email. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.*

*We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.*

*If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File. You may also pay for the visit with cash or a personal check.*

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*PRE-AUTHORIZED HEALTHCARE FORM*

*By signing below, I agree to all of William Halter Therapy's Credit Card on File Policy and I authorize William Halter Therapy to keep my signature and a valid credit/debit card number securely on-file in my account.*

*I allow William Halter Therapy to automatically charge my credit card for any outstanding balances. These may include: insurance denials for ANY reason (including no referral on file); missed or cancelled appointments; deductibles; co-insurances; partially paid claims. Missed or cancelled appointments without 24-hour notice will be charged the full fee at the time of the appointment.*

*If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give William Halter Therapy a new, valid credit card which I will allow them to key-in over the phone. Even though William Halter Therapy is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.*

*I understand that I am responsible for payment for all medical services provided to me by William Halter Therapy. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow William Halter Therapy to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to William Halter Therapy. Signature of Patient / Credit Card Holder (or Legal Guardian) Date Print Name of Person Signing Above Relationship to Patient*

*Name on Card:* _____

*Card Number:* _____

*Expiration Date:* _____ *CCV #:* _____ *Zip Code:* _____