Peter Weiss, MA, LMHC
2711 E. Madison St. Suite 211
Seattle, WA 98112
206-245-9975

Agreement for Services

Please read the following pages for information about the treatment process and my policies. After you have read this document in it's entirety, please fill out pages 6, 7, & 8.

Directions and Parking: My office is located 1/2 block up the hill from The Essential Bakery, on the same side of the street. Look for signs for "Kate's Day Spa" then look for a large door with a rounded top. The door handle will feel locked but push on the door and it will open. Suite 211 is upstairs and to the right. There is a waiting room inside the Suite so please come on in. Parking is free on the street and can be found South of E. Madison St., behind The Essential Bakery and around the neighborhood.

Appointments: Therapy appointments are 45 minutes in length for individual sessions, and either 60 or 90 min. for couples. The time is set exclusively for you.

Cancellation Policy: If you need to cancel an appointment, please do so by phone no later than 48 hours in advance in order to not be billed for the session. One session per year, I will make an exception for this policy. At times, I may need to reschedule our appointment due to emergencies. I also may need to cancel due to illness or time away from the office. I will contact you as soon as possible to cancel and reschedule appointments.

Fees: Therapy sessions are billed at $180 per 45-minute session for individual therapy, and $280 for a 1.5 hour session for couples therapy.

Please do not hesitate to ask if you need a sliding scale as I do work with individuals and couples at all income levels, and I have a certain number of slots available for these situations.

Insurance: I currently do not accept insurance. However if you do have insurance, your carrier may provide some coverage for mental health treatment with an out-of-network provider. I will provide you with a detailed monthly billing statement at the end of each month which has all of the important and necessary provider and procedure information which your insurance will need to process a claim. It is important that you find out exactly what mental health services your insurance policy covers.

Phone Calls: At times, you may feel a need to reach me by phone between our regularly scheduled therapy appointments. Phone calls to make or change appointments are expected. I will not bill you for phone calls during the week unless we talk for more than 5 minutes. I will bill you at a $160 per hour rate if we should talk longer than 5 minutes.

Email & Texting: I am available by email and texting only for exchanging information regarding scheduling. Personal health information should be limited, as email and texting are not secure.

Telemedicine (video calling): In some circumstances I do provide video calling for sessions. Charges for video sessions are the same as in-person sessions. Note that if there are any technical difficulties that temporarily disrupt or prevent video communication, the session is still billed. We will discuss before the session what hardware and software requirements are needed and it will be the patients responsibility to have that in order prior to the session.

Ethics & Accountability: I am a licensed counselor in the State of Washington. I am accountable for my work with you. If you have concerns about our work together, please discuss them with me. If your concerns are not able to be resolved or you feel that I have been unethical or unprofessional, you can contact the Department of Licensing in Olympia at (360) 753-1761.

Review of Records: I keep a record of the health care services that I provide to you which includes the date of sessions and payment details. You have a right to see and copy that record unless I feel that personal review of your record could be potentially harmful to you. You may also ask to correct that record. Records will not be seen outside of my office. If you wish for me not to take any clinical notes please feel free to make this request and I will do so.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how I may use or disclose your protected health information, with whom that information may be shared, and my obligations to protect this information. This notice also describes your rights to access and amend your protected health information. “Protected health information” (PHI) includes information that I have created or received regarding your health care or payment for you health services. It includes both your medical records and personal information such as your name, social security number, address and phone number. I am required by law to maintain the privacy of your health information and to provide you with this notice of my legal duties and privacy practices with respect to your health information. I am also required to comply with the terms of our current Notice of Privacy Practices.

THIS NOTICE COVERS THE PRIVACY PRACTICES FOR Peter Weiss, MA, LMHC YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION: RIGHT TO INSPECT AND COPY

You have the right to request and opportunity to inspect or copy health information used to make decisions about your care-whether they are decisions about your treatment or payment of your care. You must submit your request in writing. If you request a copy of the information, I may charge a fee for the cost of copying, mailing and supplies associated with your request. I may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access.

RIGHT TO AMMEND

For as long as I keep your records about you, you have the right to request me to amend any health information used to make decisions about your care-whether they are decisions about your treatment or payment of your care. Requests for an amendment must be submitted in writing telling me why you believe the information is incorrect or inaccurate. While I accept requests for amendments, I am not required to amend the record.

RIGHT TO AN ACCOUNTING OF DISCLOSURE

You may request that I provide you with an accounting of disclosures I have made of your health information. This right applies to disclosure made for purposes other than treatment, payment, and health care operations as described in this Notice of Privacy Practices. You must submit your request in writing. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003. The first accounting you request within a twelve-month period will be free. For additional requests during the same 12-month period, I will charge you for the costs of providing the accounting. I will notify you of the amount I will charge and you may choose to withdraw of modify your request before I incur any costs.

RIGHT TO REQUEST RESTRICTIONS

You may ask me not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing. In your request, you must tell me (1) what information you want restricted; (2) whether you want to restrict my use, disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosure to your spouse; and (4) and expiration date, I am not required to agree to a restriction that you may request. If I do agree, I will honor your request unless the restricted health information is needed to provide you with emergency treatment.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You may request that I contact you using alternative means or at an alternative location. I will accommodate reasonable requests, when possible. For example, you may request that I contact you only at a specific phone number other than you home phone. I will accommodate all reasonable requests, when possible.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have a right to obtain a paper copy of this Notice of Privacy Practices at any time.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT REQUIRE YOUR AUTHORIZATION

Except in the situations listed below, I will use and disclose your PHI only with your written authorization. In some situations, federal and state laws provide special protections for substance abuse and HIV information and require authorization from you before disclosure. In these situations, I will contact you for the necessary authorization. If you sign an authorization, you may revoke it at any time in writing, although this may not affect information that I disclose

before you revoked the authorization. This PHI is strictly confidential and released only in conformance with the requirements of state and federal law.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION.

EMERGENCIES

I may use and disclose your PHI in an emergency treatment situation. For example, I may provide your health information to a crisis outreach worker who may be working with you when your care manager is not available.

AS REQUIRED BY LAW

I may disclose your PHI when required to do so by federal, state or local law. I also may disclose your PHI in response to a subpoena, discovery request, or other lawful process. For example, if you are involuntarily committed, the hospital may request your PHI.

PUBLIC HEALTH ACTIVITIES

I may disclose PHI to an authorized public health authority to protect public health and safety and to prevent or control disease, injury or disability.

HEALTH OVERSIGHT ACTIVITIES

I may disclose your PHI to Health Oversight Agencies for certain activities such as audits, examinations, investigations, inspections and licensure.

LAW ENFORCEMENT

I may make disclosure of your PHI when the law requires that we report information about victims of abuse, neglect or domestic violence, or when ordered in a judicial or administrative proceeding.

MILITARY AND VETERANS

If you a member of the armed forces, I may disclose your health information as required by military command authorities.

CORRECTIONAL FACILITIES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may disclose health information about you to the correctional institution of law enforcement official.

WORKERS' COMPENSATION

I may disclose health information about you to comply with the Workers' Compensation Law.

NEXT OF KIN, ATTORNEY, GUARDIAN OR CONSERVATOR

I may use or disclose your health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for you care: of your location, general condition or death. For example, I f you are in an emergency situation, I may disclose you health information to your next of kin, guardian or conservator.

APPOINTMENT REMINDERS

I may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or services at our facility.

TREATMENT ALTERNATIVES AND SERVICES

I may use and disclose you PHI to tell you about or recommend possible treatment options or services that may be of interest to you. Fro example, I would send you a letter identifying other treatment options.

CORONERS AND FUNERAL DIRECTORS

I may disclose your PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. I may disclose PHI to funeral directors as authorized by law.

CHANGES TO THIS NOTICE

I reserve the right to change the terms of our Notice of Privacy Practices. I also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information I already have about you as well as any health information I receive in the future. I will post a copy of the current Notice of Privacy Practices at our main office and at each site where I Provide care. You may also obtain a copy of the current Notice of Privacy Practices by calling me and requesting that a copy be sent to you in the mail or by asking for one any time, you are at my office.

This notice is effective in its entirety as of April 14, 2003

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Clinician Disclosure Statement

Degree/Certifications:
I have a Master's Degree in Mental Health Counseling from Argosy University, Seattle, (2003) and I am a doctoral candidate at the Institute of Contemporary Psychoanalysis in Los Angeles, California.

Methods & Philosophy of Therapy:
Primary methods of therapy are individual and couples therapies, using psychoanalytic, psychodynamic, behavioral, and cognitive-behavioral approaches. For some cases of Obsessive-Compulsive Disorder I use a tool of cognitive-behavioral therapy called Exposure and Response Prevention, an evidence-based technique which I have found to be very helpful for some of my patients. I am informed by the EFT, PACT, Gottman, and other relational methods for couples therapy. I believe that there is no one therapeutic modality which reaches the vast range of issues and personalities which are treated with psychotherapy. Therefore I pull from a range of therapeutic orientations, choosing the theory which fits the client and their present needs. I believe that my role as a therapist changes based upon the client and their needs, and can move from a wide range of positions.

Experience:
I have over 15 years of experience working in clinical and therapeutic settings.

I have been provided with a copy of, and understand, my Clinician's Disclosure Information and the extent of confidentiality provided by RCW 18.130.180

Client or Guardian Signature Client Name (print) Date

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Consent for Treatment

I have received the following information from Peter Weiss:

Counselor Disclosure, which includes Washington State License Number, Counseling Philosophy, Methods, Techniques, Counselor's Education, Training and Experience.
Billing information including client's cost per session and billing practices.
Client's rights--State of Washington Department of Health.

Information on confidentiality and HIPPA

I consent to mental health services (individual or couples therapy provided by this licensed therapist). I have received information on confidentiality, payment, and a therapist/client disclosure form about Peter Weiss' professional training, experience and philosophy.

If client is under the age of 13, a parent or legal guardian must authorize for treatment.

Client Name (please print) _____

Client
Signature: _____

Parent/Guardian
Signature:_____Date:_____

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Contact Information

Client Name: _____

Client Date of Birth: _____

Previously given Diagnosis(es):_____

Parent/Guardian Name(s): (if a minor)

Parent :_____Phone: _____

Parent:_____Phone:_____

Client Phone:_____

Client Email:_____

Client Address: _____

_____

Emergency Contact:_____Phone:_____