John Jordy, M.Ed., LMHC
Washington State Licensed Mental Health Counselor #5876
12 Bellwether Way, Ste. 223 Bellingham, WA 98225 Phone: 360.255-0772 Fax: 360-255-0773

TERMS OF SERVICE / DISCLOSURE STATEMENT

Effective February 15, 2016

I am pleased that you have selected me as your counselor. I intend to have our time together be a helpful and positive experience for you. I believe clear and direct communication is an important part of this goal. This document is designed to ensure that you understand our professional relationship.

Please read carefully and ask if you have any questions.

CONFIDENTIALITY AND PRIVACY:
As your counselor, I will keep confidential anything you say to me, with a few exceptions as required by law. Usually confidentiality may be waived if your or someone else's safety is considered to be at risk. I am part of a clinical consultation group which meets to facilitate good care. While I may discuss your case with this group, I will not disclose your identifying information.

A copy of the Notice of Privacy Practices is provided in your packet. If you have any questions about this policy, you can discuss them with me.

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit it to your insurance carrier.

FEES AND PAYMENT:
My rate for individual counseling services is $135 per 45-50 minute hour and $185.00 for initial assessment. Couples and family therapy, groups, consultation, training services, and court attendance may be billed at different rates and in accordance with my contract with your insurance company.

I will bill your insurance company for our sessions and if known, will collect the copay/coinsurance fee at the beginning of each session. I will be paid by the insurance company according to their contracted amount for covered services. You are responsible for determining the specifics of your insurance coverage, especially tracking the session limits as well as procuring relevant paperwork, and coverage such as physician referrals, as your insurer may require. It is very important that you call your insurance company and determine your mental health benefit before your first visit.

Please note that you are responsible for all charges not paid by your insurance company. Any portion not paid by your insurance company will be reflected in your monthly billing statement from me and is due within 2 weeks of receipt of your billing statement. If you have a question about your account, please call immediately so this can be addressed.

Please call myself or my billing service, Kristi Peters 360-920-0036, with any questions.

Account balances which have been billed to you and remain unpaid beyond <u>60 days</u> may result in your account being turned over to a collections agency and the termination of treatment with a referral to another provider.

By signing this document, you agree to pay each invoice in full unless an alternative payment agreement has been made in writing and signed.

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CANCELLATIONS:
In the event that you are unable to keep an appointment, you must notify me 48 hours in advance (unless there is a reasonable emergency). If I do not receive such notice, you will be responsible for paying the full fee for the missed session. Your insurance company will not pay for missed sessions.

If you need to cancel or reschedule you can leave a message on my voice mail at **(360) 255-0772.** Also, please remember to leave your home and work phone numbers with every message so that I can get back to you even if I am not in the office.

OUR RELATIONSHIP:
Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

PHONE & EMAIL CONTACT:
Please do not use Email as a form of contact. I check it sporadically and it is not confidential. If you need to reach me between sessions during normal working hours, 9-5, Monday-Friday, I can be reached by phone at **(360) 255-0772.** Typically, you will get voice mail, which I check at least by 6pm each business day, and I will return your call within 24 hours. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If a contact of more than 5 minutes is necessary during normal business hours, you may be charged at my usual hourly rate.

EMERGENCIES:
If you feel the need for emergency help, you may call the **Crisis Line (staffed by professional therapists) at 1-800-584-3578.** In the case of life threatening emergency, please call **911**, or go to the **Emergency Room**. Please note that repeated use of emergency services usually suggests that outpatient care is insufficient and alternative treatment will need to be discussed (i.e., hospitalization).

RELATIONSHIP TO OTHER AGENCIES:
I am an independent private practitioner, though I have associations in other agencies and services including The Stress Clinic (Director), the associates, staff or practitioners have no supervisory relationship or responsibility for my services in any way. All treatment decisions remain with you and me, as the counselor and client.

COMPLAINTS:
If at any time, for any reason, you are dissatisfied with my services, please let me know. If I am not able to resolve your concern, you may report your complaint to Dept. of Health, Health Professions Quality Assurance Division, P.O. Box 47869, Olympia WA 98504, or call (360) 236-4902.

Consent for Therapeutic Services
Your signature below indicates that you have read and understand this disclosure. Your signature indicates your understanding and agreement with its contents.

Two copies of this form will be provided. Please bring the signed copy to your first appointment.

_____ _____

Signature of Client Date

_____ _____

John Jordy, M.Ed., LMHC Date

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CLIENT INTAKE FORM

Patient Name:_____ Social Security #:__ __ __ - __ __ - __ __ __ __

Mailing Address:_____

City/State/Zip_____

Home Phone #_____ Work #_____ Cell # _____

OK to leave message? *YES/NO* *YES/NO* *YES/NO*

Date of Birth:_____ Referred by:_____

Sex: FEMALE / MALE / _____ Primary Care Physician:_____

Employer / School_____ Position/Grade_____

Employer Address_____

Emergency contact_____ Phone # _____

If visit is related to auto accident: Date of Accident:_____ State: _____

PRIMARY INSURANCE

Insurance Co.:_____

Policy ID Number: _____
(*this may be a social security #)*

Group Number: _____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth: _____

SECONDARY INSURANCE

Insurance Co.:_____

Policy ID Number:_____
(this may be a social security #)

Group Number:_____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth:_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT

I hereby authorize John Jordy, M.Ed., to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to: John Jordy, M.Ed. I acknowledge that I have read or been offered the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.

_____ _____
Signature Date

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CLIENT INTAKE FORM

PERSONAL INFORMATION

Where were you born/raised? _____

Are you currently practicing a religion / faith system? _____

What, if any, religious / faith traditions were important in your upbringing? _____

_____

Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

MEDICAL HISTORY

LIST ALL PREVIOUS AND CURRENT ***Prescription*** MEDICATIONS:

Drug Name/Purpose	Strength	Times/Day	Approximate start/end date	Results/effectiveness/side effects

ALL ***OTHER*** CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Please list all current health care providers: _____

_____

_____

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CLIENT INTAKE FORM

PERSONAL INFORMATION

Current medical (non-psychiatric) illnesses, problems, issues. Please be as complete as possible:

_____

_____

_____

Previous medical illnesses, problems, and surgeries (include dates):

_____

_____

_____

Allergies to medicines: _____

Alcohol/Drug/Tobacco/Caffeine use:

Past: _____

Present:_____

MENTAL HEALTH HISTORY

Have you had mental health problems in the past (please explain)? _____

_____

_____

Have you sought treatment for this or other mental health problems? Was it helpful? _____

_____

Were you ever hospitalized for psychiatric reasons? If so, when and where?

_____

Have any of your relatives had problems with their mental health? If so, please describe: _____

_____

FAMILY SITUATION

RELATIONSHIP STATUS: single involved engaged cohabitating
married separated divorced widowed

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CLIENT INTAKE FORM

PERSONAL INFORMATION

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

Others living with you; age and relationship: _____

Your sources of social/emotional support (family, friends, spiritual community, etc.):

_____

_____

Current sources of income (circle all that apply)

Employment Retirement Disability Family Savings/Investments Other:_____

EMPLOYMENT: (circle all that apply)

Full time Part Time Current Occupation: _____

Retired Disabled Student Homemaker

Past Occupations: _____

GOALS FOR THERAPY / EVALUATION

What would you like to see happen as a result of your work here?_____

_____

_____

_____

_____

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Notice of Privacy Practices Regarding Protected Health Information

To our clients: *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for us to disclose your PHI to other Pacific Harbor Psychology therapists and/or other outside entities for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

- ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations*****:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your Psychotherapy Notes—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

We do not release your private health information for marketing or as part of a sale of information. (In situations where that do happen, your authorization would be required.)

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has been abused or neglected, she/he is required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that a vulnerable adult has been abandoned, abused, financially exploited, sexually or physically assaulted or neglected, she/he must immediately report it to the appropriate authorities.
- **Health Oversight:** If the State Department of Health subpoenas your therapist or your PHI as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

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- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This does not apply when you are being evaluated for a third party or for the court.)

- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If we are treating you under a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

- ***Right to opt out of receiving fundraising communications.***

- ***Right to restrict disclosure*** of your private health information to a health plan when you have paid out of pocket, privately, for the health service.

- ***Right to be notified*** if there has been a breach of your protected health information.

V. Therapist's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way we have handled your privacy rights, you may contact our Privacy Officer, 12 Bellwether Way, Suite 223, Bellingham, WA 98225, 360-255-2505 x100.

You may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. 200 Independence Avenue, S.W., Washington, DC 20201 (877) 696-6775.

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Directions from I-5 Southbound

- Exit **Bellis Fair/Meridian (Exit 256**)
- Go West on Meridian (turn right off freeway ramp to **Squalicum Way.**
- Turn right onto Squalicum Parkway
- Continue all the way to the harbor and as it turns sharply to your left it will turn into **Roeder Ave.** Continue on Roeder Avenue to **Bellwether Way.**
- Turn right onto Bellwether Way
- Proceed to stop sign.

You may either drive straight thru to outside upper parking lot, or turn right and then immediately left into the underground parking garage. Pacific Harbor is located in the **Bayview Center Building** Use the yellow elevators to the 2nd floor from the parking garage, or enter thru the front of the Bayview Center Building and take the elevator to the 2nd floor. We are in Suite 223.

Directions from I-5 Northbound

- Exit **Lakeway Drive (Exit 253)**
- Turn right off ramp
- Right at the traffic light onto Lakeway Drive.
- Continue on Lakeway Drive which angles into **Holly Street.**
- Veer right onto Holly Street and continue through downtown Bellingham to **"F" Street.**
- Turn left onto "F" Street, (cross the railroad tracks)
- Turn right onto **Roeder Ave.** Continue on Roeder Avenue to **Bellwether Way.**
- Turn left onto Bellwether Way
- Proceed to stop sign.

You may either drive straight thru to outside upper parking lot, or turn right and then immediately left into the free underground parking garage. Pacific Harbor is located in the **Bayview Center Building** Use the yellow elevators to the 2nd floor from the parking garage, or enter thru the front of the Bayview Center Building and take the elevator to the 2nd floor. We are in Suite 223.

HANDICAP PARKING IS LOCATED IN THE PARKING GARAGE NEAR THE YELLOW ELEVATOR.