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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CHILD AND FAMILY INTAKE FORM

Patient Name:_____ Social Security #:_____

Mailing Address:_____

City/State/Zip_____

Home Phone #_____message ok y/n Other Phone # _____message ok y/n

Date of Birth:_____ Referred by:_____

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

Child lives with: MOTHER/FATHER/BOTH OTHER (Describe): _____

Mothers Name: _____ SS # _____ Phone: _____

Fathers Name: _____ SS # _____ Phone: _____

Emergency contact_____ Phone # _____

PRIMARY INSURANCE

Insurance Co.:_____

Policy Number: _____

Group Number:_____

Customer Service Phone Number:

_____

Policy Holder's Name:

_____

Relationship to client:_____

Policy Holder date of birth:_____

Policy Holder Social Sec #:_____

SECONDARY INSURANCE

Insurance Co.:_____

Policy Number:_____

Group Number:_____

Customer Service Phone Number:

_____

Policy Holder's Name:

_____

Relationship to client: _____

Policy Holder date of birth:_____

Policy Holder Social Sec #:_____

PERSON RESPONSIBLE FOR PAYMENT:

Name: _____ Relationship to patient:_____

Date of Birth: _____ Drivers License #: _____

Mailing Address: _____

Social Security number: _____ Home Phone: _____

Employer: _____Position:_____Work Phone: _____

I hereby authorize direct payment from my insurance company to my provider. I understand that I am responsible for all costs of medical treatment. 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.**

_____ _____

Signed (Person responsible for payment) Date

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CHILD'S MEDICAL HISTORY

Is your child taking medication? YES / NO
ALL CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Has your child ever had any of the following?

Visual problems	YES/NO	Broken Bones	YES/NO
Hearing problems	YES/NO	Head Injury	YES/NO
Allergies	YES/NO	Serious infections	YES/NO
Problems with coordination	YES/NO	Soiling	YES/NO
Weight loss	YES/NO	Bedwetting	YES/NO
Speech problems	YES/NO	Chronic illness	YES/NO
Seizures	YES/NO	Other:	

List any illness or injuries for which the child required hospitalization or surgical operation:

ILLNESS	DOCTOR	DATE	HOSPITAL

FAMILY SITUATION

CURRENT FAMILY STATUS: Single parent involved engaged cohabitating married
Separated divorced widowed remarried
MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

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

MOTHER'S EDUCATION: _____ AGE: _____
EMPLOYER: _____ OCCUPATION: _____
FATHER'S EDUCATION: _____ AGE: _____
EMPLOYER: _____ OCCUPATION: _____
Are any family members experiencing significant medical problems? YES ? NO
If yes, please describe: _____
Specify child's Alcohol/Drug/Tobacco/Caffeine use:
Past: _____
Present:_____
MENTAL HEALTH HISTORY
Has your child had mental health problems in the past (please explain)?
_____
_____
Has your child sought treatment for this or other mental health problems? Was it helpful? _____

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_____

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

_____

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

Drug Name	Strength	Times/Day	Currently Using?	Results

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

_____

GOALS FOR THERAPY

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

_____

_____

_____

DEVELOPMENTAL HISTORY

Pregnancy

During the pregnancy, did the mother experience any difficulties (such as German Measles, RH incompatibility, false labor, etc.)? If yes, please explain: _____

Were any drugs (prescribed or non-prescribed), alcohol or tobacco taken during pregnancy?

_____

Were there any problems with other pregnancies, (miscarriage, difficult delivery)? Please explain:

Delivery

Duration of pregnancy: _____ Duration of labor: _____Birth Weight: _____
Describe any difficulties with the delivery (Caesarian section, breech birth, etc.):

_____

Following birth, did the infant have any difficulties (such as trouble starting to breathe, infections, etc.)?

Development

How old was the child when he/she:
Smiled _____ sat without support_____ stood _____
walked without support_____ used single words (other than mama, dada) _____
Combined two words into simple phrases_____ spoke in short sentences _____
Was bladder trained (day) _____ (night) _____ was bowel trained _____
Comment on how you found the child to look after:

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As an infant _____ as a toddler _____
Was the child a cuddly infant or toddler?

Preschool History

Name of Program For how Long

List any preschool programs your child has attended: _____
_____
List any daycare centers your child has attended: _____
_____
Has a private babysitter cared for your child? YES/NO
Has your child's behavior been of any concern at the preschool or daycare? YES/NO
If yes, what have the concerns been?

School History

Name of present school: _____
Teacher: _____Grade Level _____

City Grade Level

Please list other schools attended: _____
_____
Has your child's behavior been of any concern at school? If yes, please explain: _____
_____
Has your child needed any special help at school? If yes, please explain: _____

General Information

Has the child experienced any serious upset? YES/NO If yes, what kind: _____
_____
Has the child suffered any significant losses? YES/NO If Yes, please explain: _____
_____
Is the child clingy? YES/NO Comments? _____
_____
Any problems with eating or appetite? YES/NO Please explain: _____
_____
Does the child have any particular fears? YES/NO Comments: _____
_____
Any problems with sleeping? YES/NO Comments: _____
_____
Any problems with discipline? YES/NO If yes, please describe: _____
_____
How active is the child? _____
_____
Please add any information you feel would be helpful:
_____
_____
_____

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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.