



## NOTICE OF OFFICE & PRIVACY PRACTICE

### GENERAL

Counseling is a client/ provider collaboration. Therefore, it is important that you are informed of the process, treatment, and fee expectations. Please read this notice and discuss any questions that you may have with me at any time.

I am an Advanced Practice RN (Clinical Nurse Specialist) with a master's degree in Psychiatric Nursing. I specialize in the treatment of trauma information, eg. those life experiences that continue to be disturbing in present time and the more easily recognized major trauma experiences. My theoretical orientation is Cognitive/ Behavioral and Psychodynamic with a primary specialization in providing the Eye Movement Desensitization & Reprocessing (EMDR) Therapy model. I am a Senior Trainer /Facilitator/Consultant for the EMDR Institute, Inc. I have been trained personally by Francine Shapiro, PhD, the originator and developer of EMDR Therapy.

Two to three single sessions (45 minutes /client hour) will be required for the initial evaluation process. If EMDR is the appropriate treatment, at times I will recommend a double session (90 minutes). My experience is that most people get the most efficient amount of benefit within the double session. However, this can be adjusted to client needs and/or desires. Weekly sessions are typical but again this is a flexible item.

### FEE AGREEMENT

The fee is \$150.00 per single session and \$300.00 per double session. Fees are due at the time of service. Cash, check, money order or credit cards are accepted at the time of service. There is a \$5 service fee for use of a credit card. Cancellations are gratefully accepted 24 hours prior to the appointment time. You will be charged for late cancellations or "no shows".

## PRIVACY PRACTICES

In accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA), this notice is to inform you of your rights regarding your records and any possible disclosure of your records.

Under federal law, I am required to:

1. Protect the privacy of your Personal Health Information (PHI).
2. Provide you with this Notice of Privacy Practices explaining my duties and practices regarding your PHI.
3. Follow the Practices and Procedures set forth in this notice.

Your PHI will be kept securely in a locked file. Your records are not kept on a computer data base. Your records will be retained for 7 years following the end of treatment with me and discarded by shredding at the end of the 7 years. Your PHI may only be released under the following circumstances:

1. Washington State Law requires me to notify law enforcement officials if I suspect that a child or dependant adult is being abused or is in imminent danger from acts by you; you pose an imminent risk of danger to yourself, another person or property; you are unable to care for your own basic needs.
2. I may be required to disclose specific information about you in the course of any legal proceeding in response to an order of the court or administrative agency, and, in certain cases, in response to a subpoena, discovery request or other lawful request.
3. In the event of an unpaid account, typical information for insurance billing will be submitted to an authorized collection agency.

Except for the situations already described, I will disclose your PHI only with your written authorization. You may revoke this authorization at any time after signing. This will not affect any previously disclosed information.

When I attend professional consultation groups, I may discuss client information for educational purposes only and always without any identification of the client.

You have the right to:

1. Request restrictions. We will discuss these if any problems are associated with your request .

2. Request a copy of your PHI. Please request in writing and there will be a nominal fee for this production. At times this request may be inappropriate and denied. You will be notified in writing. You may appeal that decision in writing and that will be included in your PHI.
3. Request specific instructions regarding phone or other communications.

HIPAA requires:

Confirmation that you have received this Notice and it must be retained in your file. Please sign and date the confirmation (done at the time of appointment in the office). Thank you for your time and consideration in meeting these federal and state requirements.



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