

Mark Tucker, MS, LMHC
1155 North State St. Suite 322 Bellingham, WA 98225
Privacy Practices, Disclosure of Confidential Information,
Counselor Disclosure & Consent to Services Form

Counselor Name: Mark Tucker, MS, LMHC
Primary Contact Number: (360) 594-7566

License Number: LH60091770
Crisis Hotline: 866-427-4747

Education & Experience:

In 2006 I earned my Bachelor of Arts degree in Psychology from Western Washington University. In 2007 I received my Masters in Science through the Mental Health Counseling Program, also from Western Washington University. I have worked as a mental health counselor since 2007, primarily at Unity Health Center and in private practice. I am a Licensed Mental Health Counselor; my license number is LH60091770. I know American Sign Language and I am knowledgeable about Deaf Culture.

I work with adults, families, and couples. I am eclectic and collaborative in my approach, utilizing a range of therapeutic styles such as Cognitive Behavior Therapy, Motivational Interviewing, and Sensorimotor Psychotherapy. I work to integrate one's body, emotions, and thoughts to process the past and/or approach the present in new, more effective ways. I use communication and attachment principles to help enhance interpersonal relationships between couples and family members. I would be happy to discuss which approach would work best for you. I encourage you to let me know what you find useful or not to help create effective sessions. Remember you have the right to refuse treatment or decline any suggestions made. Also, you can request a referral to a different therapist or discontinue therapy at any time.

Appointments/Fees/Cancellation Policy:

Intake appointments are \$160. Allow 1 hour for an intake appointment. Individual counseling sessions are 50 minutes long or shorter if discussed previously. Sessions generally occur on a weekly basis. The standard rate for individual therapy is \$120/hr. Please provide at least 24 hour notice for cancellation or reschedule. A no show or cancellation on same day as appointment will result in a charge of my set fee.

Privacy Practices & Disclosure of Confidential Information:

Your treatment here is confidential. Information about you (including the fact that you have been seen here) will not be released unless you give written permission to do so. Clients that are 13 or older are considered adults and, by completing a Release of Information (ROI) form, they determine what level of information is provided to others, including parents and guardians. Unless there is a suicide risk or ideation, a client 13 or older can choose to NOT complete an ROI and they will receive the same level of confidentiality as any other adult. Parents of clients age 13-17 may be notified if the client is indicating suicidal risk or serious ideation even if there is a limited ROI or if no ROI exists. Records or information pertaining to children under 13 years of age require a parent or legal guardian's written authorization to be released. Furthermore, for clients under age 13, both parents have full access to records regardless of marriage or custody status.

To help ensure the best treatment for my clients, I participate in consultation groups. It is considered "best practice" to consult with licensed colleagues or with other professionals. Information discussed at that time is for the purpose of treatment planning and will remain confidential. Specific identifying information is never disclosed. Please inform me if you do NOT want your case discussed during consultation or supervision.

Confidentiality cannot be assured for electronic communication such as cell phones, e-mails, and faxing. If you choose to communicate with me by these electronic means, I cannot be held responsible for breach of confidentiality. I do provide encrypted emails if you would like.

Since I reside and work in the community, there may be times when you see me in public settings. In an effort to respect your confidentiality, I will not greet you in public unless you greet me first. Please keep in mind that if you choose to greet me in public and talk about your sessions, there is a chance that your confidential information will be overheard by other members of the community. It is up to you to determine if you are comfortable with this.

Certain information may be released without your authorization under the following legal circumstances:

1. The receipt of a legitimate subpoena or court order, unless you file a protection order within 14 days of the subpoena.
2. If ordered by a judge or other judicial officers.
3. In the event of a medical emergency.
4. The receipt of information that suggests child or elder abuse or neglect has occurred. I am obligated to report any such information to child or adult protective services (CPS/APS).
5. If I have reason to believe that you may be a danger to yourself and to others, that you are unable to care for your basic needs, that you may be abusing a child or adult dependent, that you are planning to commit a felony, or that you are HIV positive and may be engaging in behavior that could infect others, I am required by law to release that information. In the event of threat or harm to someone, if that threat is perceived to be serious, the proper individuals must be contacted.

Grievance Procedures:

Counselors practicing for a fee must be registered or certified with the Washington State Department of Licensing (DOL) for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you are dissatisfied with the services you receive from your counselor, or if you believe there has been a violation of your confidentiality you are encouraged to call the counselor directly to discuss this. If you feel any past or present counselor has been unethical or unprofessional, you can contact the Washington State Department of Health (DOH) at 360.236.4700 or access online forms and information at www.doh.wa.gov/hsqa

Consent to Services:

I have been provided with a copy of this document about my rights and responsibilities. I have read and understand the information provided and have been given an opportunity to ask any questions I may have. I agree to participate; I am personally responsible for my experience and I understand that I may discontinue these services at any time. A parent or legal guardian for a minor child under the age of 13 must sign this form.

Client Name: _____ **Client Signature:** _____ **Date:** _____

Adult Name: _____ **Adult Signature:** _____ **Date:** _____

Relationship to the client: _____

INTAKE SHEET

Date: _____ Form completed by self parent guardian spouse

Client Name: _____

Personal Pronoun [optional] _____ Referred by _____

Street Address _____

City _____ Zip _____

Can we leave you a phone message? Circle Yes or No

Phone: Home _____ Cell _____ Work _____

Yes No

Yes No

Yes No

Date of Birth: _____ Age _____ Social Security Number _____

Primary Care Physician _____

Marital Status: single married partnered divorced widowed

Education: highest grade completed _____ degree _____

Employer: _____ Occupation: _____

full-time part-time retired

Person responsible for copayments, coinsurance, deductibles, and/or payment in full:

(if different than client's)

Name: _____ Relationship to client: _____

Address _____ Phone _____

Social Security Number _____ Date of Birth _____

Please provide Insurance card(s) at first appointment.

PRIMARY INSURANCE COMPANY _____

Member's #ID: _____ Date of Birth _____

Subscriber's Name _____ Social Security _____

(if different than client's)

Subscriber's Address _____ Employer _____

SECONDARY INSURANCE COMPANY _____

Member's #ID: _____ Date of Birth _____

Subscriber's Name _____ Social Security _____

(if different than client's)

Subscriber's Address _____ Employer _____

Therapist Use Only: ICD-10: _____ **Date Submitted:** _____

Provider Initials _____

Client Name: _____

Emergency Contact:

Name: _____ Relationship to client: _____

Phone: Home _____ Work _____ Cell _____

If client is a student:

Grade: _____ School: _____

School Counselor _____ Teacher(s) _____

Please list any other persons residing in home

Name	Age	Relationship to client

If client is a minor, please list any Parent(s) or sibling(s) not residing with client

Name	Age	Relationship to client

Payment and Insurance billing:

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company previously noted. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company.

I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Client or Authorized Person's Signature: _____

Relationship to Client: _____

For your information, your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes in order to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately, to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.

Name _____ Date _____

Height	Weight

Please list all medical specialists the client is seeing or has seen for the last year.

Name	Reason

Describe any current or past medical problems, or recent changes in physical condition. Make sure you note issues such as Thyroid , Diabetes, Fibromyalgia, Neurological Conditions, etc.

Any past hospitalizations? Yes No
If yes, please provide a brief explanation of the reason and the outcome.

Current Medication:

Medication Name	Dose	Frequency	Taking it for:

Previous Mental Health Medications:

Medication Name	Outcome

Please list all allergies.

Mental Health History

Please provide the name, reason, and results of any past counselors and/or psychiatrist you have met.

Name	Reason	Result

Yes, in the past I/Client have been hospitalized for mental health reasons.

Please provide brief explanation of all past hospitalizations:

Diagnosis	Myself	Bio	Others whose diagnosis has impacted me	Please describe your current experience with the diagnosis and any current concerns you have. Briefly describe symptoms, how you know you are having more problems. We will go in more detail during the first session.
Depression				
Bipolar				
ADHD/ADD				
Alcoholism/ Addiction				
General Anx				
Social Anxiety				
OCD or Pho-				
PTSD				
Other:				
Other:				

When thinking about the reason you/client are seeing me, how do you best explain the origins of the issue, how have you tried to work with it, and what results you have had? I understand this can be a very long answer. Please provide a brief explanation that we can expand on during our first few sessions.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

WASHINGTON NOTICE FORM

Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Examples of Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

The providers of Associates In Mental Health may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions.

PHI refers to information in your health record that could identify you.

Treatment is when a provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when a provider consults with another health care provider, such as your family physician or another mental health provider.

Payment is when provider obtains reimbursement for your healthcare. Examples of payment are when provider discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of provider's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

Use applies only to activities within a provider's office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure applies to activities outside of provider's office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Provider may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when a provider is asked for information for purposes outside of treatment, payment and health care operations, provider will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) the provider has relied 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

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

Child Abuse. If provider has reasonable cause to believe that a child has suffered abuse or neglect, provider is required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

Adult and Domestic Abuse. If provider has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, provider must immediately report the abuse to the Washington Department of Social and Health Services.

Sexual or Physical Assault. If provider has reason to suspect that sexual or physical assault has occurred, provider must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

Health Oversight. If the Washington Licensing Board subpoenas provider as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed providers, provider must comply with its orders. This could include disclosing your relevant mental health information.

Judicial or Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about the professional services that provider has provided to you and the records thereof, such information is privileged under state law, and provider will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform provider that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety. Provider may disclose your confidential mental health information to any person without authorization if provider reasonably believes 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 you file a worker's compensation claim, with certain exceptions, provider must make available, at any stage of the proceedings, all mental health information in their possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

IV. Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization. Regarding all other uses and disclosures for which an authorization or opportunity to agree or object is not required, including specialized government functions, please see HIPAA 164.512.

V. Patient's Rights

Receive, read, and ask questions about this Notice. You have the right to request and receive a paper copy of the most current Notice of Privacy Practices for Protected Health Information (Washington Notice Form) from your provider.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. You must deliver this request in writing to your provider. However, your provider is not required to agree to a restriction you request but will comply with any request granted.

Cancel prior authorizations. You have the right to cancel prior authorizations to use or disclose health information by giving written revocation to your provider. Your revocation does not affect information that has already been released. It also does not affect any action taken before your provider has your revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are receiving treatment. Upon your written request, your provider will send your PHI to another address.

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in your provider's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. Upon your request, your provider will discuss with you the details of the request and denial process.

Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your provider may deny your request. On your request, your provider will discuss with you the details of the amendment

process. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). This will not include disclosures to third-party payers. You may obtain this information without charge once every 12 months. Your provider will notify you of the cost involved if you request this information more than once in 12 months.

The following patient rights are required by the Omnibus HIPPA Final Rule, which was published in January, 2013.

Right to Request Non-disclosure. You have the right to request that AMH *not* disclose information to your insurance company regarding your treatment *for sessions that you pay for privately.*

Right to be Notified. You have the right to be notified by AMH in the event that there are any breaches of you PHI.

VI. Provider's Duties

Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

Your provider reserves the right to change the privacy policies and practices described in this Notice. Unless your provider notifies you of such changes, however, your provider is required to abide by the terms currently in effect.

Your provider has the right to change his/her practices regarding the protected health information he/she maintains. If your provider makes changes and you are an active patient in his/her practice, he/she will provide you with a copy of the updated Notice at your first visit after the change. You may always receive the most recent copy of this Notice by calling your provider and asking for it or by visiting your provider's office to pick one up.

VII. To ask for Help or Report a Grievance

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Letisha Stokes, Office Manager Associates in Mental Health 1116 Key Street, suite 204 Bellingham, WA 98225 360-715-2488

If you believe your privacy rights have been violated, you may discuss your concerns with your provider or the above noted person. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VIII. Website

Associates In Mental Health has a website that provides information about your provider. For your benefit, this Notice is available on the website at this address: www.amhinfo.com.

IV. Effective Date

This notice went into effect on April 14, 2003.

_____/_____/_____
Signature of Patient or legally authorized individual Date

Relationship (self, parent, legal guardian, personal representative)

Printed Name

WASHINGTON NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I keep a record of the health care services I provide you. The Washington Notice Form describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge:

- receipt of the Washington Notice Form of Privacy Practices that went into effect April 14, 2003.**

- I chose not to receive a copy of the Washington Notice Form of Privacy Practices that went into effect on April 14, 2003,**

Signature of Patient or legally authorized individual

Relationship
(self, parent, legal guardian,
personal representative)

Printed Name

Date

(Notation, if any, by staff)

Staff Signature

Date

This form will be retained in your medical record.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ authorize Mark Tucker, LMHC
(your name) 1116 Key St , suite 1021, Bellingham WA, 98225

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record
- Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

- Unsecured email.
- SMS text message (i.e. traditional text messaging) or other type of "text message."
- Other media. Describe: _____.

TERMINATION

- This authorization will terminate _____ days after the date listed below.
- OR
- This authorization will terminate when the following event occurs: _____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that Mark Tucker, LMHC makes available the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:

- *Encrypted email by Virtu; <https://www.virtu.com>*

(Signature of client)

Date

CLIENT'S COPY Washington Notice Form

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Printed Name

Mark Tucker, MS, LMHC
1155 North State St. Suite 322 Bellingham, WA 98225
Privacy Practices, Disclosure of Confidential Information,
Counselor Disclosure & Consent to Services Form

Counselor Name: Mark Tucker, MS, LMHC
Primary Contact Number: (360) 594-7566

License Number: LH60091770
Crisis Hotline: 866-427-4747

Education & Experience:

In 2006 I earned my Bachelor of Arts degree in Psychology from Western Washington University. In 2007 I received my Masters in Science through the Mental Health Counseling Program, also from Western Washington University. I have worked as a mental health counselor since 2007, primarily at Unity Health Center and in private practice. I am a Licensed Mental Health Counselor; my license number is LH60091770. I know American Sign Language and I am knowledgeable about Deaf Culture.

I work with adults, families, and couples. I am eclectic and collaborative in my approach, utilizing a range of therapeutic styles such as Cognitive Behavior Therapy, Motivational Interviewing, and Sensorimotor Psychotherapy. I work to integrate one's body, emotions, and thoughts to process the past and/or approach the present in new, more effective ways. I use communication and attachment principles to help enhance interpersonal relationships between couples and family members. I would be happy to discuss which approach would work best for you. I encourage you to let me know what you find useful or not to help create effective sessions. Remember you have the right to refuse treatment or decline any suggestions made. Also, you can request a referral to a different therapist or discontinue therapy at any time.

Appointments/Fees/Cancellation Policy:

Intake appointments are \$160. Allow 1 hour for an intake appointment. Individual counseling sessions are 50 minutes long or shorter if discussed previously. Sessions generally occur on a weekly basis. The standard rate for individual therapy is \$120/hr. Please provide at least 24 hour notice for cancellation or reschedule. A no show or cancellation on same day as appointment will result in a charge of my set fee.

Privacy Practices & Disclosure of Confidential Information:

Your treatment here is confidential. Information about you (including the fact that you have been seen here) will not be released unless you give written permission to do so. Clients that are 13 or older are considered adults and, by completing a Release of Information (ROI) form, they determine what level of information is provided to others, including parents and guardians. Unless there is a suicide risk or ideation, a client 13 or older can choose to NOT complete an ROI and they will receive the same level of confidentiality as any other adult. Parents of clients age 13-17 may be notified if the client is indicating suicidal risk or serious ideation even if there is a limited ROI or if no ROI exists. Records or information pertaining to children under 13 years of age require a parent or legal guardian's written authorization to be released. Furthermore, for clients under age 13, both parents have full access to records regardless of marriage or custody status.

To help ensure the best treatment for my clients, I participate in consultation groups. It is considered "best practice" to consult with licensed colleagues or with other professionals. Information discussed at that time is for the purpose of treatment planning and will remain confidential. Specific identifying information is never disclosed. Please inform me if you do NOT want your case discussed during consultation or supervision.

Confidentiality cannot be assured for electronic communication such as cell phones, e-mails, and faxing. If you choose to communicate with me by these electronic means, I cannot be held responsible for breach of confidentiality. I do provide encrypted emails if you would like.

Client's Copy

Since I reside and work in the community, there may be times when you see me in public settings. In an effort to respect your confidentiality, I will not greet you in public unless you greet me first. Please keep in mind that if you choose to greet me in public and talk about your sessions, there is a chance that your confidential information will be overheard by other members of the community. It is up to you to determine if you are comfortable with this.

Certain information may be released without your authorization under the following legal circumstances:

1. The receipt of a legitimate subpoena or court order, unless you file a protection order within 14 days of the subpoena.
2. If ordered by a judge or other judicial officers.
3. In the event of a medical emergency.
4. The receipt of information that suggests child or elder abuse or neglect has occurred. I am obligated to report any such information to child or adult protective services (CPS/APS).
5. If I have reason to believe that you may be a danger to yourself and to others, that you are unable to care for your basic needs, that you may be abusing a child or adult dependent, that you are planning to commit a felony, or that you are HIV positive and may be engaging in behavior that could infect others, I am required by law to release that information. In the event of threat or harm to someone, if that threat is perceived to be serious, the proper individuals must be contacted.

Grievance Procedures:

Counselors practicing for a fee must be registered or certified with the Washington State Department of Licensing (DOL) for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you are dissatisfied with the services you receive from your counselor, or if you believe there has been a violation of your confidentiality you are encouraged to call the counselor directly to discuss this. If you feel any past or present counselor has been unethical or unprofessional, you can contact the Washington State Department of Health (DOH) at 360.236.4700 or access online forms and information at www.doh.wa.gov/hsqa

Consent to Services:

I have been provided with a copy of this document about my rights and responsibilities. I have read and understand the information provided and have been given an opportunity to ask any questions I may have. I agree to participate; I am personally responsible for my experience and I understand that I may discontinue these services at any time. A parent or legal guardian for a minor child under the age of 13 must sign this form.

Client Name: _____ **Client Signature:** _____ **Date:** _____

Adult Name: _____ **Adult Signature:** _____ **Date:** _____

Relationship to the client: _____