



Curran Otis, MA, LMHCA, CCTP
Tranquil Waters Counseling LLC
Professional Counseling for Individuals
3810 166th Place NE
Suite 201A
Arlington, WA 98223
(360) 674-0787

To New Patients: This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason, you are unable to complete the paperwork before our session, I will have copies in my office and we will use your session time to complete the paperwork.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I look forward to meeting with you.

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Checklist for completing this paperwork:

- o Please print your name in the space provided on this Page (Page1).
- o Read through the Disclosure Statement on pages 2 through 5. Sign on page 5.
 - o Read Acknowledgement of Receipt of Notice of Privacy Practices and Financial Agreement on pages 6 through12. Sign on page 12
- o Read through and sign the Video and Audio Recording Release on page 13.
- o Complete the Credit Card Authorization Form on page 14.
- o Initial all pages in lower right-hand corner to indicate that you have read and understand the information provided.

Client Name: _____

(please print)

DISCLOSURE STATEMENT

Counselor Training, Counseling Orientation, General Information, and Counseling Fees

Licenses and Training:

I hold a Master of Arts Degree in Clinical Mental Health Counseling and a Master of Arts Degree in Forensic Psychology from The Chicago School of Professional Psychology. I hold a Bachelor of Arts Degree in Psychology from Northwest Nazarene University. I am credentialed as a Washington State Licensed Mental Health Counselor Associate (MC60889599) and I'm Supervised by Hannah Smith (LH0010370). Hannah can be reached by email at hannah@potentialfinders.com or by phone (206) 676-2701. My private practice *Tranquil Waters Counseling LLC* is affiliated with and practices collaboratively at Seattle Christian Counseling, PLLC.

Counseling Approach:

I work from a Person-Centered Therapy, Existential Therapy, and Cognitive Behavioral Therapy perspective.

Person-centered therapy focuses on using the therapeutic relationship to encourage growth during our sessions. This means the therapeutic relationship is the engine that drives the counseling process and I see your life experience as providing the wisdom you need to overcome the challenges you face.

Existential therapy means that we interpret and understand meaning in our lives through the experiences we face. Often times, when we worry, it steals the joy from life itself. This means we will work to connect you to your relationship as a child of God and how He sees you through His eyes. This makes everything worthwhile.

Cognitive-Behavioral Therapy means I hope to encourage you to think more positively about your life, your relationships, your interests, and who you are as a person and human being. I will be your guide to bring you to that place.

Fees:

Intake Session (90 minutes): \$140

53-minute session: \$120

Payment is due at time of service in the form of cash, check, or debit/credit card. Processing payments through credit/debit will incur up to a 3.75% fee added. If payment is returned due to insufficient funds, the client will be charged for the fees. You may file a claim with your insurance for my services as a Clinical Mental Health Counselor. Please note I am an Out of Network Provider. I am not certified on any specific insurance panels. I will offer you support to submit to your insurance. You will need to ensure your information is accurate. I

cannot guarantee you will be reimbursed. In most cases, your session fee will apply to your out of network deductible.

Appointments and Cancellations/No Show Policy

Our first appointment will be 90 minutes long and then 53 minutes for following sessions, unless otherwise agreed upon. You may determine how often you would like to meet based on your personal needs. Once we have determined that you feel you have reached your goals in session, we will have one last meeting to ensure you have appropriate supports in the community to continue your progress.

Please note all appointments that need to be cancelled must be done with three days (72-hour notice). E-mail and text messages are not adequate notice. **Missed appointments for whatever reason will be charged a fee equal to the session missed.** More than three missed appointments without notice, within a two-month period, will impact your ability to continue with services and will be referred out to another provider of your choice. In the event I am unable to contact you after three attempts over a three-week period, I will end our clinical work. Not arriving on-time for scheduled sessions without notice will reduce the amount of time we are able to meet together and therefore reduce the ability of therapy to make a difference in your life.. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Termination of Treatment: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment more than 60 days. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

In the event that you choose to stop attending sessions on a consistent basis, more than two missed sessions in a monthly period for any reason, except unexpected illness or emergencies, I will send you a letter informing you that this will impact your ability to continue to receive counseling services. Your time is reserved for. If no contact has been made within 2 weeks without an appointment scheduled in the office, the therapeutic relationship will be considered terminated and a new intake session, at regular fee, will be required if services are to resume.

Testifying in Court: If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$200 per hour for

preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

State Mandated Disclosure: I have broad discretion to release any information that I deem relevant in situations where I believe my patient or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Consultations: I regularly consult with other professionals regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

State Registration: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (a) to provide protection for public health and safety, and (b) to empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure titled “Counseling or Hypnotherapy Patients” lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs

PO Box 47869

Olympia WA 98504-7869

(360) 664-9098



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Phone Contact and Emergencies

Please call during business hours at (360) 674-0787. They are Mondays through Thursdays from 11 AM to 7 PM. This is for your benefit as a client and mine as a Clinician. I do actively practice self-care and encourage you to do the same. Please limit phone conversations to appointment scheduling and emergencies.

Emergencies:

In the event of a medical crisis after business hours, please contact 911 or proceed to your nearest Emergency Department.

In the event of an emergency and you cannot reach me, please call one of the following numbers for help:

General Emergencies: 911

Crisis Clinic: (800) 244-5767 or (206) 461-3222

I have read and understand the information in this form.

Date

Client Signature

Date

Curran Otis, LMHCA, CCTP

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and, as applicable, RCW Chapter 70.02 entitled “Medical Records - Health Care Access and Disclosure.” Please review it carefully.

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

Protected health information means individually identifiable health information:

- Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- In Washington State, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose (RCW 70.02.030(6)). Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create, and store are the property of health care provider. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;

- Ask us to change your health information. You may give us this request in writing. 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.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI.** Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made.** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on _____, 20_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

Curran Otis keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information



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about it by contacting our Privacy Officer. Written requests should be made to the Privacy Officer at the following address:

Curran Otis, LMHCA, CCTP

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Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity shall not be liable for the acts or omissions of others.

AUTHORIZATION TO RELEASE INFORMATION – IF APPLICABLE: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity’s charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity’s treatment or charges, including medical service companies, insurance companies, workmen’s compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for all charges not paid by insurance. I understand this amount is due at the beginning of the session.

INSURANCE COVERAGE – IF APPLICABLE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered



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Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance. I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

Client Signature (or Parent/Guardian)

Date

Printed name if signed on behalf of Client

Relationship (parent, legal guardian, representative)

VIDEO AND AUDIO RECORDING RELEASE

As an additional support for your counseling process it is sometimes beneficial to use video feedback as part of our work together. This means that I may ask to video or audio record you during specific dialogues, exercises, or during entire sessions. This will give us the option to play back these recordings in session to help you see patterns of behavior in yourself or your significant other (if applicable). Because it usually takes some time to setup a video camera or audio recorder, I'm requesting that we do the paperwork for this on the front end so that we can devote as much time to working on the issues that bring you into counseling. By viewing the video or listening to the audio recording in session, it allows us to "stop action" and process how you might approach an issue in a more productive way. It also allows you to witness your progress with your counselor and/or your relationship.

In addition to in-session use, I occasionally may use the video footage or audio recording to receive consultation from other health care professionals that I consult with. This may occur during time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission and it will be deleted when it is no longer needed for these purposes.

These recordings are the property of **Curran Otis, MA, Licensed Mental Health Counselor Associate** and will remain solely in my possession throughout the course of your counseling and until they are destroyed. Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems at all times to ensure maximum confidentiality.

I _____ hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.

In no way, will the refusal to grant consent for this video or audio recording effect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect.

Client _____ Date _____
(signature) (printed name)

Counselor _____ Date _____



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CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Seattle Christian Counseling, PLLC** to debit your credit card as listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with **Seattle Christian Counseling, PLLC**, and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I _____ (full name printed) authorize **Seattle Christian Counseling, PLLC.**, to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of \$120 per 53-minute session for individuals and couples and charged up to 3.7% plus \$0.15 for electronic processing of the charge. This is the exact same fee that I am charged by my credit card processing company

Billing Address _____ Phone # _____
 City, State, Zip _____ Email _____

<p>Account Type: Mark an (X) next to Card Type</p> <p> <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover </p> <p>Cardholder Name _____</p> <p>Account Number _____</p> <p>Expiration Date _____</p> <p>CVV2 (3 Digit on back of Visa/MC, 4 Digit on front of AMEX) _____</p>

I authorize
**Seattle
 Christian**

Counseling, PLLC, to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE: _____ DATE: _____