



PO Box 5 • Naches, WA 98937 • 509.658-2993
Email: brfr@bethelridge.org • Website: bethelridge.org

Dear Client,

Counseling is a professional relationship where a client is seeking answers to troublesome problems. Counselors first need to know and understand the nature of the problem. Counselors must take into account other factors affecting the problem. Together the client and counselor develop a new way of thinking, acting, and planning.

You can expect first an assessment interview where your goals for counseling are heard and understood. There may also need to be assessment testing. Then a prescribed plan is formulated to achieve the goals you and I have discussed. This plan includes verbal feedback from the diagnostic phase together with methods and time expectations.

I have been in private practice as a Social Worker (MSW) since 1972. I chose a degree in social work because of its comprehensive study of individuals, families and societal relationships. A Master in Social Work (MSW) and, in particular, the Licensed Clinical Social Worker (LCSW), is more recognized by medical professionals and insurance companies. I received my formal training at Multnomah School of the Bible, and was a pastor for one year. I attended Trinity College/BA Degree, and the University of Missouri/MSW. Some of my Postgraduate studies include The Gottman Institute, courses in Chemical Dependency, Residential Treatment of Adolescence, Behavior and Emotive Theory, Single Parenting, and Psychological Testing. My clinical experience has been working with families and teenagers in crisis at the Flying H Youth Ranch as well as a private counseling practice for over thirty-five years.

As a Licensed Clinical Social Worker (#LW00004987) for the state of Washington, I agree with and adhere to the laws regulating counselors. Please read the materials from our state entitled *Counseling or Hypnotherapy Clients* included in this packet. "Counselors practicing counseling 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 of Health does not include a recognition of any practice standards nor necessarily imply the effectiveness of the treatment." Especially important to me (and you) are the protections this law offers for confidentiality. To release counseling information without your written consent would violate the counseling ethics of this law as well as my own personal ethical and moral code. However, this law requires that in two situations I must report to authorities. First when there is clear indication that someone may be harmed; and second when a child or dependent person is being sexually or physically victimized.

You are beginning what I hope will be a meaningful counseling experience. Therefore, it is my aim and your right to select a counselor who best suits your individual needs and purposes. I am committed to your long-term best interest.

With Sincerity of Purpose,
Gregg Hires



PO Box 5 • Naches, WA 98937-0005 • 509.658.2993

Office Use _____ RX _____
 Email brfr@bethelridge.org Website: bethelridge.org

Client INTAKE		Today's Date		MALE	FEMALE
Last Name:		Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>
First Name:		Date _____		Date _____	Date _____
Address:		MI:	SS#:		
City:		Date of Birth:	Email:		
State:		Minor <input type="checkbox"/>	Home Phone:		
Employer:		ZIP:	Work Phone:		
Referred to Counseling by:		Cell Phone:			

EMERGENCY CONTACT

Last Name:	First Name:	Phone:
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INSURANCE INFORMATION: PRIMARY ATTACH COPY OF INSURANCE CARD FRONT AND BACK

Insured Name:	Relationship :	Date of Birth:	SS#:
Insurance Company:	Mailing Address:		
Ins Company Address:	Physical Address:		
City:	State:	ZIP:	City:
Policy No:	Grp No:	Employer:	Empl Phone#

Insurance Information: Secondary Attach copy of Insurance card FRONT and BACK

Insured Name:	Relationship:	DOB:	SS#:
Insurance Company:	Mailing Address:		
Ins Company Address:	Physical Address:		
City:	State:	ZIP:	City:
Policy No:	Grp No:	Employer:	Empl Phone#

LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

_____ Date _____ Signature of Guarantor _____

MEDICARE -- LIFETIME AUTHORIZATION	
I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for any services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.	
_____ Date _____	_____ Signature of Guarantor _____



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Gregg Hires, LCSW • Glenna Hires, RC

Counseling Agreement

*Sign two forms: **BRFR OFFICE COPY***

Thank you for your interest in counseling with Bethel Ridge Family Resources. I look forward to this time to serve you and I am committed to your best interest. In order to be as clear as possible about the counseling you will be receiving, please read through this new client packet and sign and date those pages as indicated.

Description of Counseling

I, as a counselor, will be talking with you about what you think, feel and the choices you make. You will learn how the things you believe and feel are affecting your choices. Change can happen as you view life and choose differently. Counseling may include the recommendation of various materials, evaluation tools and possible exercises/assignments.

Clinical/Office Setting: Usually a 50 minute session unless otherwise scheduled. Sessions are located at Selah Family Medicine or Bethel Ridge Retreat.

Intensive Setting: Located at Bethel Ridge Retreat, 136 and 138 Flying H Loop, Naches, WA, 98937. Counseling is provided in extended blocks of time in a private mountain home or bed and breakfast setting. Individuals, married couples and families are able to receive counseling over a scheduled number of days in a quiet secluded setting. Many programming opportunities are offered to reinforce learning and develop new patterns of relating.

Doctrinal Statement

I believe there is a God who created us. We are spiritual beings in need of a relationship with Him. He loves us and has provided a way for us to know and experience a loving relationship with Him. The Bible describes God, Jesus and the Holy Spirit clearly. Creation also helps us know God. God, the Creator knows all about life and reveals this in the Bible. As a counselor, this doctrine is foundational to my thinking and counsel.

Confidentiality

Washington State laws provide client confidentiality in counseling sessions. Without your written consent, I cannot, and will not, release any information regarding you and or your counseling time. Exception: See attached Washington State Department of Health publication, *Counseling or Hypnotherapy Clients*, Confidentiality Statement, pgs. 1 and 2.

Fees

Our typical office fee is \$150 for a fifty minute session. New client diagnostic intake fees are \$240. However, we will work with your particular financial and insurance situation; and a sliding scale is available where applicable. Non insured clients will be billed at the same rate and will also receive the same provider portion discount that insured clients receive. At times I do extended sessions and the fee is adjusted accordingly. We attempt to work with you and any medical / insurance benefits you may have. If you are uninsured, you may request an application for a scholarship to help cover the fees. Fees may then be adjusted to the sliding fee based on your IRS 1040 gross income.

Adjusted Fee (if qualified)

I agree to pay the following fee for regular office visits as determined from the sliding fee scale. _____

Insurance Payments

You need to be aware that we are not accepted by all insurance companies as a *preferred* or *in network provider*. You will need to check with your insurance company regarding your specific benefits. You may need to get special authorization or a referral from your primary care doctor. ***You are responsible for payment if your insurance does not cover services provided.*** We will bill your insurance directly and notify you about any unpaid balance that is your responsibility. Any insurance questions may be directed to our billing company, Medical Management at 469-1903 or toll free at 1-877-813-1638.

Missed Appointments

I ask that you do everything possible to avoid cancellations. Therefore, with the exception of emergencies, cancellations with less than 24 hours notice are subject to be charged to you at ***half the hourly rate***. Your insurance company will not reimburse for missed appointments. Please call our office at least 24 hours in advance of a cancellation. This will allow us to schedule someone with an urgent need to be seen.

Phone Call Consultation and E-mail – Teleconference Appointments

It may be necessary for you to call me after hours; and I want to be able to meet your need. Calls and emails will be charged upon the length of the time spent conferencing. This may not be reimbursed by insurance companies. Therefore, you will be personally responsible for non-reimbursed charges. The fee will be computed by the hourly rate. Please know that I would like to be available for you. However, with our Counseling Retreat sessions in the evenings and weekends, it is best for us to work through your issues during scheduled office visits.

I have read and understand the above material.

Signature

Date

Please print name



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I have read and understand the above material.

Signature

Date

Please print name



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Client Symptom / Status – Please, Print Clearly

CLIENT INFORMATION

Client Name: _____

Client Reasons for Counseling / Desired Goals (results)

CURRENT SYMPTOMS

Affect/Energy

- ___ depressed mood
- ___ diminished energy
- ___ diminished interest
- ___ increased irritability
- ___ feelings of guilt
- ___ feelings of worthlessness
- ___ inability to concentrate
- ___ inability to make decisions
- ___ other _____

Anxiety

- ___ generalized fear
- ___ shortness of breath
- ___ depersonalization
- ___ chest pains
- ___ hot/cold flashes
- ___ fears of dying
- ___ fear of going crazy
- ___ other _____

Sleep Disturbance

- ___ difficulty falling asleep
- ___ early morning awakening
- ___ restless sleep
- ___ excessive sleep
- ___ nightmares
- ___ night terrors
- ___ other _____

Eating

- ___ increased appetite
- ___ decreased appetite
- ___ weight gain
- ___ weight loss
- ___ purging
- ___ other _____

Avoidance Symptoms

- ___ fear of specific places
- ___ fear of social situations
- ___ constriction of lifestyle
- ___ other _____

PTSD Symptoms

- ___ intrusive memories
- ___ hypervigilance
- ___ distress from triggers
- ___ numbing
- ___ other _____

Alcohol/Drug Use (Write “R” for regular; “O” for occasional; “I” for infrequent; “N” for never)

___ alcohol ___ cocaine ___ marijuana ___ methamphetamine ___ opiates ___ other

specify use of other drugs _____

CURRENT MENTAL STATUS: Instructions: Please check *all* that apply

Thought process: ___ intact ___ circumstantial ___ tangential ___ flight of ideas ___ loose associations
Hallucinations: ___ none ___ auditory ___ visual ___ olfactory ___ command
Delusions: ___ none ___ persecutory ___ grandiose
Memory: ___ intact ___ impaired ___ immediate ___ recent ___ remote
Judgement: ___ intact ___ impaired ___ mild ___ moderate ___ severe
Suicidality: ___ not present ___ ideation ___ contemplation ___ plan ___ activity
Homicidality: ___ not present ___ ideation ___ contemplation ___ plan ___ activity
Impulse Control: ___ within normal limits ___ impaired

Other: _____

For Office Use Only:

CURRENT DIAGNOSIS (include DSM-IV numeric code)

Axis I _____
Axis II _____
Axis III _____
Axis IV (psychosocial stressors) _____
MEDS / Prescribing Physician _____

Total number of sessions completed for current calendar year
___ individual ___ couples ___ family ___ group ___ med. management

CURRENT TREATMENT PLAN

Instructions: Please document treatment goals, interventions, & time frames to address current diagnosis and symptoms.

Treatment Goal	Intervention	Time Frame
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Number/types of sessions being requested of complete treatment (subject to contractual limits)

Are you communicating with patient's PCP regarding their treatment? ___ Yes ___ No
If yes, how? ___ copy of intake ___ phone ___ progress notes ___ treatment summary

Signature of Mental Health Provider _____ Date: _____

Gregg Hires, LCSW
Administrative Office: 130 Flying H Loop, Naches, WA 98937 -- 658-2993



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Client History

Today's Date _____

Name _____ Date of Birth _____

Home Phone _____ Email _____

Spouse _____ Date of Birth _____ Anniversary Date: _____

Employer _____ Occupation _____

Work Phone _____ Cell Phone _____

Personal History

Your Marital History/Significant Relationships

Your Spouse's Marital History/Significant Relationships

Children/Dependents #Boys _____ #Girls _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Additional Children: _____

Client's Family History

Father's Name _____ Age (if living) _____ Occupation _____ Marital Status _____

Mother's Name _____ Age (if living) _____ Occupation _____ Marital Status _____

Guardian's Name (if applicable) _____ Relationship _____

Reason for guardianship _____ Date of guardianship _____

Siblings # ***Brothers*** _____ # ***Sisters*** _____

Name _____ Age _____ Relationship _____ Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

More than four siblings? Yes _____ No _____

Names: _____

Has anyone in your immediate family been hospitalized or received some form of professional help for psychological problems? If so, please specify who, when they received help, and the nature of the problem.

Occupational History

What positions have you held in the past?

Does your present work satisfy you, if not, please explain.

Briefly list any additional information that you think would be helpful for your counselor to know.



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NOTICE OF PRIVACY PRACTICES (MEDICAL NON-PROFIT VERSION)

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

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable counseling information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your counseling information is used. “HIPAA” provides penalties for covered entities that misuse personal counseling information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your counseling information and how we may use and disclose your counseling information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- ◆ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- ◆ **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- ◆ **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified counseling information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected counseling information, which you can exercise by presenting a written request to the Privacy Officer:

- ◆ The right to request restrictions on certain uses and disclosures of protected counseling information, including those related to disclosures to family members, other relatives, close personal friends, or any

other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- ◆ The right to reasonable requests to receive confidential communications of protected counseling information from us by alternative means or at alternative locations.
- ◆ The right to inspect and copy your protected counseling information.
- ◆ The right to amend your protected counseling information.
- ◆ The right to receive an accounting of disclosures of protected counseling information.
- ◆ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected counseling information and to provide you with notice of our legal duties and privacy practices with respect to protected counseling information.

This notice is effective as of April 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected counseling information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to the written complaint with our office or with the Department of Health and Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA
Or to file a complaint:

Please contact Bethel Ridge Family Resources
PO Box 5
Naches, WA 98937
509-658-2993

or

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected counseling information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my counseling information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Relationship to Client: _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date	Initials:
<i>Reason:</i>	



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CLIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected counseling information. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ◆ Obtain payment from third-party payers.
- ◆ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my counseling information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Client Name: _____

Signature: _____

Relationship to Client: _____

Date: _____



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Permission for Digitally Recording and Videotaping Therapy Sessions

As a primary tool in the *Gottman Method Couples Therapy*, and in order to augment your therapy work, I use videotape feedback as part of the Therapy sessions. This means that I may ask to videotape you during specific dialogues or exercises, or during entire sessions. We will play back these tapes in session to help you see patterns of behavior between the two of you and to help you process conflicts. By viewing the videotape in session, it allows us to “stop action” and process how you might approach a conflict in a more productive way. It also allows you to witness your progress as your relationship becomes more satisfying to both of you.

In addition to in-session use, I may wish to use the videotape to receive consultation from Drs. John or Julie Gottman or a Gottman institute senior clinician. This may occur during the 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 in consultations will remain completely confidential within the Gottman Institute clinical staff. The videotape will be used for no other purpose without your written permission.

These tapes are my property and will remain solely in my possession during the course of your therapy. Copies may be sent to the Gottman Institute for the purposes noted above. Should you wish to review these tapes for any reason, we will arrange a session to do so. These materials will remain in locked facilities at all times.

Client Name: _____

Signature: _____ **Date:** _____

Client Name: _____

Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Gregg Hires, LCSW, Bethel Ridge Family Resources

Counseling or Hypnotherapy Clients

Client and Counselor Responsibilities and Rights

Counselors must provide disclosure information to each client in accordance with chapter 18.19 RCW prior to implementation of a treatment plan. The disclosure information must be specific to the type of counseling service offered; in language that can be easily understood by the client; and contain sufficient detail to enable the client to make an informed decision whether or not to accept treatment from the disclosing counselor.

If you have concerns about being dependent upon your counselor or hypnotherapist, talk to him or her about it. Remember, you are going to that person to seek assistance that helps you learn how to control your own life. You can and should ask questions if you don't fully understand what your counselor or hypnotherapist is doing or plans to do.

Requirement for Registration of Licensure

Your counselor or hypnotherapist must be either registered under chapter 18.19 RCW or certified under chapter 18.224 RCW through the Washington State Department of Health unless otherwise exempt. To be registered, a person fills out an application and pays a fee. To become licensed, a person fills out an application form and pays a fee, but he/she must also show proof of appropriate education and training. There are some people who do not need to be either registered or certified because they are exempt from the law. You should ask your counselor or hypnotherapist if he/she is registered or licensed and discuss his/her qualifications to be your counselor or hypnotherapist.

Definitions

Counseling means using therapeutic techniques to help another person deal with mental, emotional and behavioral problems or to develop human awareness and potential. A registered or certified counselor is a person who gets paid for providing counseling services.

Confidentiality

Your counselor or hypnotherapist cannot disclose any information you've told them during a counseling session except as authorized by RCW 18.19.180:

- 1) With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;
- 2) That a person registered or certified under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;
- 3) If the person is a minor, and the information acquired by the person registered or certified under this chapter indicates that the minor was the victim or subject of a crime, the person registered or certified may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
- 4) If the person waives the privilege by bringing charges against the person registered or certified under this chapter;
- 5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or
- 6) As required under chapter 26.44 RCW

Assurance of Professional Conduct

Thousands of people in the counseling or hypnotherapy professions practice their skills with competence and treat their clients in a professional manner. If you and the counselor agree to the course of treatment and the counselor deviates from the agreed treatment, you have the right to question the change and to end the counseling if that seems appropriate to you.

We want you to know that there are acts that would be considered unprofessional conduct. If any of the following situations occur during your course of treatment, you are encouraged to contact the Department of Health at the address or phone number in this article to find out how to file a complaint against the offending counselor or hypnotherapist. The following situations are not identified to alarm you, but are identified so you can be an informed consumer of counseling or hypnotherapy services. The conduct, acts or conditions listed below give you a general idea of the kinds of behavior that could be considered a violation of law as defined in RCW 18.130.180.

- 1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceeding in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
- 2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
- 3) All advertising which is false, fraudulent, or misleading;
- 4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

- 5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
- 6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
- 7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
- 8) Failure to cooperate with the disciplining authority by:
 - (a) Not furnishing any papers or documents;
 - (b) Not furnishing in writing of all and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
 - (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceedings; or
 - (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
- 9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
- 10) Aiding or abetting an unlicensed person to practice when a license is required;
- 11) Violations of rules established by any health agency;
- 12) Practice beyond the scope of practice as defined by law or rule;
- 13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
- 14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
- 15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;
- 16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
- 17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96 RCW;
- 18) The procuring, or aiding or abetting in procuring, a criminal abortion;
- 19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand of the disciplining authority
- 20) The willful betrayal of a practitioner-patient privilege as recognized by law;
- 21) Violation of chapter 19.68 RCW;
- 22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him/her from providing evidence in a disciplinary proceeding;
- 23) Current misuse of:
 - (a) Alcohol;
 - (b) Controlled substances;
 - (c) Legend drugs
- 24) Abuse of a client or patient or sexual contact with a client or patient;
- 25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

This article should not be considered as the final source of information. If you want more information about the law regulating counselors and hypnotherapists or want to file a complaint, please write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington 98504-7869. If you want to contact someone by phone to discuss the law or talk about a possible complaint, call (360) 236-4700 Monday through Friday, 8:00a.m. to 5:00p.m.

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Record of Disclosure

Bethel Ridge Family Resources has provided me with a New Client Packet which includes:

- Letter of Welcome (NCP1)
- Client Intake Insurance Information (MM) (NCP2)
- Counseling Agreement (NCP3a/b)
- Client Symptom Status (NCP4)*
- Client History (NCP5)
- Notice of Privacy Practices (NCP 6, HIPPA)*
- Notice of Privacy Statement and Acknowledgement (NCP7, HIPPA)*
- Client Consent Form (NCP 8, HIPPA)*
- Permission for Digitally Recording and Videotaping Therapy Sessions (NCP9)*
- Counseling or Hypnotherapy Clients (by Washington State) (NCP10)
- Record of Disclosure (NCP11)

Client is to keep:

- Letter of Welcome
- Counseling Agreement (client copy)
- Notice of Privacy Practices*
- Counseling or Hypnotherapy Clients

BRFR to received signed copies of

- Counseling Agreement (brfr copy)
- Client Intake Insurance Information
- Client Symptom Status
- Client History
- Privacy Statement and Acknowledgement*
- Client Consent Form*
- Permission for Digitally Recording and Videotaping Therapy Sessions*
- Record of Disclosure

I have read and understand the information provided

Signed _____

Date _____

Witnessed by counselor _____ Date

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