RYAN A. LEWIS, M.A., LMHC
Psychotherapist

Informed Consent For Treatment, Disclosures, Payment Information, & Privacy Rights

Washington State Department of Health Credential Number: LH 60321405
NPI#1649516097
Ryan Lewis Counseling & Psychotherapy
600 First Ave. Suite 601, Seattle, WA 98104
206.467.4080
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The information contained on this sheet is offered to ensure that you are given all the necessary information to make an informed decision in regards to counseling and/ or consultation services. Do not hesitate to mention if you have any questions, need clarification, or if anything is unacceptable to you.

Confidentiality

Your counseling or consultation sessions are confidential, meaning that **no one** (including your partner, physician, or parent unless you are a minor) will be able to obtain information about you from me. This includes others that may pay for you to receive services from me. If you would like someone else to speak with me, I will be unable to communicate with him or her until you sign a release of information form. One exception to this is if you are participating in an assessment paid for and mandated by a third party. You should note that the other mandating party may have rights to this information. If you have asked me to help you get reimbursement from your insurance for our sessions, I will disclose to the company a diagnosis for your treatment and number of sessions attended. Occasionally insurers request additional information. I will discuss such requests with you prior to responding to them. There are particular situations in which I would need to, and in most cases legally mandated, break confidentiality. These include if you are planning to harm yourself or someone else, if you are fully unable to take care of yourself, if you are aware of current sexual or physical abuse of a child, or under direct order of a court judge. **Specific to child therapy, I will not testify in court in regards to my therapy with your child, unless mandated by the court, such as part of a child custody dispute.**

Emergencies

I am available until 6pm on most office days by calling my office number for brief phone calls. My email address is not a crisis resource; it is not checked regularly, and it is only to be used for scheduling or cancellations. If I am unavailable at the time you call, I will return your phone call as soon as possible. If you need immediate assistance or emergency care, please call the area **24-hour crisis line** at **866.427.4747.** Also, in case of emergency you may call **911** or walk into the nearest Emergency Room or your local Urgent Care Center. When on vacation or otherwise unavailable for extended periods of time, I will arrange for another mental health provider to cover client emergencies. In such a case, referral information will be available on my office voicemail.

Fees

Our payment agreement is $185/Individual - $225/Couples per 50-minute session; $225/Individual - $250/Couples per 75-minute session. For a complete list of fees and payment terms, please also review the terms detailed in the fees, payment & insurance document. I do not charge for brief phone calls to discuss scheduling or cancellations; however, if you need phone consultation, I will charge my regular fee. This includes any time spent consulting over the phone, email, or via the Internet. If you have coverage through a health insurance plan, you may try and get reimbursement directly through your insurance company. However, I currently to do not work with any insurance boards. I may be able to submit electronic insurance claims on your behalf. I require full payment before each session begins. I accept cash, checks, debit, credit, HSA & FSA cards. I will charge a $25 check return fee should your check not clear. If you want to try and get reimbursement through your insurance plan, please let me know and I will give you all the necessary paperwork—this includes: an invoice from me detailing the dates of service, a diagnostic code, and my counseling credentials number (see fees, payment & insurance document). You will be responsible for filing the claim directly with your insurance provider. Cancellations must be made within 24 hours of your next appointment, so that your scheduled time can be used by others seeking services. If you do not cancel within 24 hours, you will be charged my full rates.

Treatment

It is my philosophy that counseling, psychotherapy and coaching is a joint effort. Your active participation is a key factor for successful outcome. We will jointly create a plan for treatment based on your needs and goals. At times, individuals can experience discomfort as a result of our work together. These difficulties typically subside as our work together progresses. However, it is important that you share any discomfort during our sessions. Please feel invited to bring up any needs, requests, concerns, or questions at any time. Remember, you always have the right to request changes in, or to refuse, treatment at any time.

I understand, agree to the above terms and consent for treatment.

_____ _____

Signature of Client Date Clinician's Signature: Ryan A. Lewis, MA, LMHC / Date

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NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact Ryan A. Lewis at 206.467.4080. Or write to: 600 First Ave. Suite 601, Seattle, WA 98104.

WHO WILL FOLLOW THIS NOTICE.
This notice describes the information privacy practices followed by my employees, staff and other office personnel. Your privacy is protected by law. I serve as my own Privacy Officer.

YOUR HEALTH INFORMATION:
This notice applies to the information and records I have about your health, health status, and the health care and service you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I am required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.
I may use and disclose health information for the following purposes:

For Treatment: I may use health information about you to provide you with clinical treatment or services. I may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For Health Care Operations, consultation, and supervision: I may use and disclose health information about you in order to run my office more efficiently and to make sure that you and our other patients receive quality care. For example, I may use your health information to evaluate my performance in caring for you through consolation and supervision. I may also disclose your health information to health plans that provide you insurance coverage (should you try and seek reimbursement) and other health care providers that care for you. My disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Appointment Reminders: We will determine your appointment together. It is your responsibility to remember your appointments. I do not send reminders at this time.

Treatment Alternatives: I may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: I may tell you about health-related products or services that may be of interest to you.

SPECIAL SITUATIONS
I may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

Child Abuse: I am required to report all suspected cases of physical and/or sexual abuse or neglect of children to the Department of Human Services (DHS).

Elder Abuse: I am required to report suspected cases of elder abuse or neglect to the Senior & Disabled Services Division.

Serious Threat to Health or Safety: I may use and disclose health information about you when necessary to prevent a clear and substantial risk of harm being inflicted by you on yourself or another person. When there is a clear and substantial risk of harm to another individual I am required to warn law enforcement officials and the intended victim.

Workers' Compensation: If you file a worker's compensation claim, this constitutes authorization for me to release relevant mental health records to involved parties and officials.

Health Oversight Activities: I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, I may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose health information about you in response to a subpoena.

Law Enforcement: I may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable: I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Research: If you were to sign a consent form to participate in a research study, I might use and disclose health information about you for research projects that are subject to the approval process specified in the consent form. This does not apply to you if you have not been asked to participate in a research study.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION
I will not obtain, use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give me Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, I will no longer obtain, use or disclose information about you for the reasons covered by your written Authorization, but I cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Ryan A. Lewis, MA in order to inspect and/or copy records of your health information. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.

Right to Amend: If you believe health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, request, complete and submit a CLINICAL RECORD AMENDMENT/CORRECTION FORM to Ryan A. Lewis, MA.

I may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that I did not create.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures I have made based on your written authorization. To obtain this list, you must submit your request in writing to Ryan A. Lewis, MA. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free.

For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION to Ryan A. Lewis, MA.

Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL

COMMUNICATION to Ryan A. Lewis, MA. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE
I reserve the right to change this notice, and to make the revised or changed notice effective for clinical information I already have about you as well as any information I receive in the future. I will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with my office, contact Ryan A. Lewis, MA, LMHC, 206.467.4080, 600 First Ave. Suite 601, Seattle, WA 98104. If you request assistance filling out the complaint forms, someone will be assigned to help you. You will not be penalized for filing a complaint. You will be asked to state that these policies have been explained to you and that you have been offered a copy of this policy before you consent to treatment. If you have any questions about my privacy practices, please ask for clarification. If you require further clarification at any time please contact me.

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