ROBERT E. DEEBLE, MA, LMHC

FOLKTOWN
COUNSELING • COMMUNITY • ART MENTORING

1900 Dock Place #3, Seattle WA 98107

DISCLOSURE

To new clients:

Thank you for contacting me for therapy.

This packet includes forms for you to fill out for your first session. It also includes a disclosure form to give you a little bit more about how I practice as your counselor. My purpose in providing these forms in advance is to preserve our first session from unnecessarily paperwork. If you are unable to complete the paperwork I have copies in my office that you can complete during the session.

Regarding forms: the info form is a "protected" word document, open it as a read only file, fill it out, then save it under your own name and email it back. The disclosure packet is a pdf file and requires Adobe Acrobat software on your computer.

I look forward to working with you,

Robert E. Deeble, MA, LMHC
Licensed Therapist & Clinical Supervisor
1900 Dock Pl., Ste. 3, Seattle, WA 98107
Email: Robert@folktowncounseling.com
www.folktowncounseling.com • (206) 274-5889

THIS PACKET INCLUDES:

Attachment One: ***Welcome Letter, Disclosure Statement, Privacy & Financial Policy*** provides you with basic information about me and my counseling practice, rates and policies. Included in this packet is a ***Credit Card Authorization*** allows a backup form of payment for missed sessions or for amounts not covered by insurance payments.

Attachment Two: the ***Info Form (attached separately)*** provides me with basic information about you.

CHECKLIST FOR COMPLETING PAPERWORK:

- Complete the **Info Form** (in MS Word) to email it to: Robert@folktowncounseling.com prior to your appointment.
- Read, sign and date the **Disclosure Packet** & **Credit Card Form** and bring it with you for your first appointment.

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General: Asking for counseling can be difficult. I would like to help you in this process by letting you know what you can expect from me as your counselor and the services I provide. I also wish to clarify my administrative policies to avoid misunderstandings. The State of Washington requires counselors to provide their clients with certain information. You will find all of this information in this statement.

Please read through all the material provided and let me know if I can answer any questions for you. Counseling will be provided on the condition that the counselee (client/patient) understands and accepts these conditions.

Robert E. Deeble, LMHC, Counselor | Clinical Supervisor:
Licensed Mental Health Counselor: LH60090293
National Provider Identification Number (NPI): 1124257795 (group) /1861541765 (individual)
Bachelors of Liberal Arts, Azusa Pacific University, 1989
Masters in Counseling Psychology, The Seattle School of Psychology and Theology 2006

Contacting me: Please enter **206-274-5889** into your phone; this is my office number and simultaneously dials my cell. If in Crisis: call 911, Seattle Crisis Center (206) 461-3222, or the King County Crisis Clinic: (800) 244-5767 ***then*** alert me to your situation. If I do not pick up please leave a message. Please keep Email to scheduling concerns.

Door Code: The code to enter the building during business hours is 32764

Therapeutic Approach and the Counseling Process: My psychotherapy practice is based on a psychodynamic modality (sometimes referred to as existential or humanistic psychotherapy) that examines the relationship between client and therapist as the primary agent of change for the client. This approach relies heavily on analyzing transference and counter-transference in therapy and at times may include some self-disclosure by the therapist for the benefit of the client. I attempt to use those encounters to help a client better understand their self within a relational context. It is these relational patterns that develop in the counseling relationship that I believe allow a patient to gain a better awareness of him or herself and develop greater insight into the nature of their problem(s). As your counselor I try to *explore* your concerns, assist you in uncovering deeper issues that may be of influence in your life and to discover with you relational patterns that occur as you interact with me on a consistent basis. I strive to view the lives of my clients with a sense of curiosity over any one clinical or scientific position, having said that, my counseling approach is based off psychodynamic, existential and modern psychoanalytic theory.

Choosing a counselor: You should choose one counselor who best suits your needs within a season of time. As professional ethics dictates I do not knowingly counsel clients who are in multiple counseling relationships. Please advise me if you are currently in treatment or wish to pursue treatment with a different professional.

Confidentiality: As your counselor I am committed to the strictest ethical standards of confidentiality. Your identity and ongoing therapy will be kept strictly confidential with the following exceptions:

1. Child Abuse: If I have reasonable cause to believe a child has suffered neglect or abuse, I am required by law to report it to the Washington Department of Social and Health Services. The requirement does include current and past offenses committed. It does include past abuse you suffered if children are currently in danger from the same offender that abused you.
2. Threat of harm to self or others by law may need to be reported to family and or appropriate mental health or law enforcement professionals. I may disclose your confidential mental health information to any person if I reasonably believe disclosure will avoid or minimize imminent danger to your health or safety, or that of any other individual. I may seek hospitalization for you, contact someone else who can provide protection, and/or contact the potential victim or the police.

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- *Confidentiality continued*

3. Adult and Domestic Abuse: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I am required by law to report it to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must report it to the appropriate law enforcement agency and DSHS.

4. Case records and testimony may be subpoenaed by court order.

5. Periodic professional consultation (described below).

Scheduling of Appointments: I work, at the minimum, on a weekly basis with clients. Once we agree to a regular day and hour this will become your hour that I reserve for you each week. You are responsible for payment of that hour. No-shows or late starts are charged at the full hourly rate.

Fees: I accept cash, check or credit card at the time service or by a monthly fee paid on the first session of each month. I am in network with Premera, Lifewise, Foundation, Blue Cross/Blue Shield, Heritage & Kaiser PPO and when out of network my services are available for reimbursement by most insurance carriers. When clients use credit cards I charge a service fee of approximately 4 %.

• My standard fee for individual counseling (53 min.) is $160 and $175 for couples counseling (53 min.). I am in-network with Premera, Lifewise, Foundation, Blue Cross/Blue Shield, Heritage & Kaiser PPO and contracted with them for their individual service rates. Please note I do not bill insurance for couples counseling.

• For clients in which I do not bill insurance I offer a discount of $20 for individual therapy when paying at the time of service.

• I offer monthly discounts for individual and couples therapy for clients who pre-pay on the first session of each month. The monthly option, which has a built in discount, has no cancellations. This is designed to consistently budget for therapy and fosters a better environment for ongoing work. Should therapy end prior to the end of the month the unused portion of the fee will be refunded.

Initial consultations. I do not offer free initial consultations. Your first session will be charged at the rate we agree to in our first visit. An initial consultation will not commit you towards further sessions.

Canceling and rescheduling: As a part of a mutual commitment to holding a therapy hour for you each week, I charge for all cancelled or missed appointments at the full session rate (unless special arrangements have been made far in advance). I will try to offer a time to reschedule your hour at no additional charge if there is an available hour within the same week. For clients who have me bill their insurance, the cancellation fee is $125, and can not billed to your insurance. I offer phone or video sessions when transportation or health issues are factors in keeping your appointment.

Duration and Termination: our work is considered an ongoing relationship unless you state upfront a specific time frame to be in therapy. The duration of the work depends on when you feel ready to transition out of therapy. Often clients feel anxious about telling their counselor that they are ready to discontinue, please feel free to discuss this with me even if you see it as a temporary pause. Ending treatment is as important as starting treatment so I encourage you to discuss this in session. I am also happy to provide referrals to further your treatment.

Legal Proceedings: I strongly protect therapy from legal proceedings that can develop between couple clients or parents of minors. Notes taken for couples counseling are considered a "combined record" and require both parties to sign a release form before releasing. In choosing to work with me as your counselor I ask that you avoid using therapy in legal proceedings. If I am asked to participate in legal matters for courtroom appearances, release of records,

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depositions, expert testimony, etc. I bill at $295 per hour. Travel and preparation time will be billed at the same rate.
Professional Consultation: To maintain a clearer perspective for the clients I serve; I keep regular clinical consultation with other professionals. "Identifying information" is not shared in these consultations except under a crisis situation. Your agreement to this disclosure grants me permission to disclose information for the purpose of clinical consultation.

Medications: I aim to be holistic in my practice and believe that certain psychological problems have a physical component. I may advise my clients to seek medical consultation in addition to our work. Despite having a clinical familiarity with medications and natural remedies, I cannot prescribe or provide medication. I can, at your discretion, work in cooperation or refer other medical providers and professionals for you in your best interest.

1. **CONFIDENTIALITY**: I understand and accept the statement on confidentiality. INITIAL ___

2. **INDIVIDUAL COUNSELING & DISCOUNTS: (check one)**.
   - ☐ $160 Fee per individual session (w/billing to insurance)
   - ☐ Discounted to: $140 per session when making payment at time of service
   - ☐ Discounted to: $ 540 per month when prepaid monthly

   COUPLES COUNSELING & DISCOUNTS: (check one).
   - ☐ $175 Fee per couples session
   - ☐ Discounted to: $ 650 per month when prepaid monthly

Payment at the Time of Service is made at the end of each weekly session. I provide a statement at the end of each month for clients to submit to insurance for partial reimbursement. 48 hours advance notice is required to cancel an appointment.

Monthly Pre-Payment is paid on the first session of each month. This is designed to consistently budget for therapy and fosters a better environment for ongoing work. The monthly payment remains the same regardless of a 4-week or 5-week month and allows therapist and client to use vacation or sick leave without a cancellation fee or refund. Should counseling terminate mid-month, the unused portion of your payment will be refunded. A statement is provided at the end of each month to submit to insurance.

Insurance: it is your responsibility to know "how much your insurance will pay for counseling and whether you have met your deductible." Clients are responsible for payment regardless of insurance reimbursement. I am in network with Premera, Lifewise, Foundation, Blue Cross/Blue Shield, Heritage & Kaiser PPO.

3. THIS DISCLOSURE: I (we) have read this disclosure form and have been provided a copy of these counseling policies as mandated by the State of Washington. I understand its terms, and agree that my counseling with Robert E. Deeble, will be subject to such terms and conditions. INITIAL ____

4. EMAIL & VOICEMAIL CORRESPONDENCE: Be aware that I cannot guarantee that information transmitted by either email or voicemail will not be intercepted or read by other parties. By initializing below you agree not to hold Robert Deeble / Folktown Counseling LLC responsible for any breach of confidentiality that may occur by information contained in either email or voicemail correspondence. INITIAL ____

_____ _____ _____ _____

Client Date Client (couple) Date

_____ _____

Counselor Date

ROBERT E. DEEBLE, MA, LMHC

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Credit Card Payment Authorization Form

Sign and complete this form to authorize Robert E. Deeble / Folktown Counseling LLC. 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 Folktown Counseling LLC 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 payment to your session, or for sessions not paid for by insurance carriers. Credit cards may also be debited in the event that you fail to give adequate notice by phone or email to cancel a scheduled 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 authorize Folktown Counseling LLC to charge my credit card

account (indicated below) for fees accrued with missed appointments, failure to provide payment at the time of service, or for sessions not paid for by insurance carriers. Payment will be processed at the time-of-service rate specified in your disclosure form + an additional 4% for the fee that I am charged by my credit card processing company. For credit card charge-backs, a fee of $25 will be assessed to your account.

Billing Address: **City:**

State: **ZIP:**

Phone#: **Email:**

Account Type: Drop Down

Cardholder Name:

Account Number:
(Number to be entered securely to Squareup's digital customer database (the number on this form will be blacked out).

Expiration Date: **CVV:**

SIGNATURE **DATE**

I authorize Folktown Counseling to charge the credit card indicated in this authorization form according to the terms outlined above. This authorization is for the 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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. / USES AND DISCLOSURES:

TREATMENT – Your health information may be used by our providers and staff members or may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

PAYMENT – Your health information may be used to seek payment from your health plan, other sources of coverage such an automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS – Your health information may be used as necessary to support the day-to-day activities and management of ROBERT DEEBLE LMHC / FOLKTOWN COUNSELING For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.

LAW ENFORCEMENT – Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting. For example, any known or reasonably suspected cases of child abuse or neglect, any known or suspected intentions of harming oneself (suicide), and/or any known or suspected intentions of harming others.

PUBLIC HEALTH REPORTING – Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

BUSINESS ASSOCIATES – The following companies may have access to your Protected Health Information for the purpose of carrying out Treatment, Payment, and/or Health Care Operations: Prestige Medical Billing Company, Inc., Sharefile, Compuhealth, Billflash, Squaeup, Jamy Potts, Doxy.me, and in-office affiliates/associates Kevin Klevjer, Kelsey Watkins, Susan Ward, Denise Wallace, Allison Keeker, Phil Farish.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION – Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure or use of your information, you may submit a written revocation of the authorization. However, your decision to revoke your authorization will not affect or undo any disclosure or use that occurred before you notified this practice of your decision.

ADDITIONAL USES OF INFORMATION:
APPOINTMENT REMINDERS – When applicable, your health information will be used by our staff to call / send you appointment reminders.

INFORMATION ABOUT TREATMENT – Your health information may be used to send you information on the treatment and management of your health condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS - YOU HAVE CERTAIN RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS. THESE INCLUDE:
The right to request restrictions on the disclosure and use of your protected health information; The right to receive confidential communications concerning your medical condition and treatment; The right to inspect and copy your protected health information; The right to request an amendment or to submit corrections to your protected health information; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice.

PROVIDER / OFFICE DUTIES – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. These revised policies and practices will be applied to all protected health information we maintain.

RIGHT TO INSPECT PROTECTED HEALTH INFORMATION – As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your individual practitioner or the front office. If you request a copy of your records, the following fees will be assessed: $26 Clerical fee, $1.17 per page fee for the first 30 pages and then $0.88 per page for any pages 31 and over. This fee must be paid prior to the copies being released.

COMPLAINTS AND CONTACT PERSON – If you would like to submit a comment or complaint about our privacy practices or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Robert Deeble LMHC, Folktown Counseling 1900 Dock Place Seattle WA 98117. Or you may also contact: Office for Civil Rights-U.S. Dept of Health and Human Services 90 7th St, Suite 4-100, San Francisco, CA 94103. Phone (800) 368-1019 FAX (202) 619-3818. Email ocrmail@hhs.gov

Financial Policy / Insurance Billing
Robert Deeble, LMHC, Folktown Counseling.

INSURANCE VERIFICATIONS - Before the initial office visit, my billing company may contact your insurance company to determine specific benefits. We will inquire if there is a deductible, co-pay, co-insurance, what services are covered, and whether or not a referral or prior authorization is necessary.

The information we receive is not a guarantee of your actual benefits and is subject to final processing by your insurance company. You are responsible for all fees not covered by the insurance company.

PAYMENT ARRANGEMENTS – Any unpaid balance from your treatment will be applied to the credit card number you provided in the Credit Authorization Form. In the event that the card information you provided is no longer current, please update that information or discuss other payment options. Treatment interruption may occur if unpaid balances persist without other arrangements being made.

PRIVATE BILLINGS - For clients without insurance coverage, full payment is due at time of service. All clients are quoted a fee for the office visit and are expected to pay at the time of the appointment. My financial policy does offer a fee at time of service discount if you do not have insurance or do not wish to utilize your insurance.

FORMS OF PAYMENT – In addition to cash or check, we kindly accept credit cards for payment of services. There will be a $35.00 fee for checks returned for insufficient funds. For credit card charge-backs, a fee of $25 will be assessed to your account.

COLLECTION NOTICE – I understand that any and all accounts that become 120 days delinquent are subject to collections.

Insurance Company:_____ ID#:_____

Subscriber Name:_____ Group#:_____

_____I certify that I am eligible for benefits under my prepaid health benefit plan. In the event that I am later found to be ineligible or in consideration of being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees then in effect.

_____I understand that all Co-pays, co-insurances, deductibles and non-covered services will be due at the time of service unless other payment arrangements are made with the provider or billing company directly.

_____I grant permission to Prestige Medical Billing Co., Inc. to submit claims on my behalf to my insurance carrier for services provided by Robert Deeble, LMHC / Folktown Counseling.

_____I authorize the release of any medical or other information necessary to process my claims.

_____I authorize payment of medical benefits to Robert Deeble, LMHC / Folktown Counseling directly from my insurance carrier

CLIENT FEE SCHEDULE

Psychiatric diagnostic interview (90791)	$200.00
Individual Session 30 min. (90832)	$75.00 – 16-37 minutes
Individual Session 45 min. (90834)	$112.50 – 38-52 minutes
Individual Session 60 min. (90837)	$160.00 – 53-60 minutes
Family Session w/ Patient Present (90847)	$175.00 – 60 minutes
Family Session w/out Patient Present (90846)	$175.00 – 60 minutes
Interactive Complexity Add On	$15.00
Prolonged Services Code	$100.00 – 30-74 adt, min
Couples Counseling	$175.00

SERVICES NOT COVERED BY INSURANCE

Forms and letters outside of appointment in increments of 15 min.	$150.00/hour, billed
Letters for attorneys billed at separate rate	$250.00/hour
Clerical fee for searching/handling records, per WAC	$26.00
Pages 1-30 (copying fee), per WAC	$1.17 per page
Pages 31+ (copying fee), per WAC	$0.88 per page
Editing of confidential information, per WAC	$150.00/hour
Returned check fee, plus original amount due	$35.00
No show or late cancel fee for follow-up clinic visits	equivalent to your appointment charge

I have read and understood the above information and have been provided with a copy at my request.

Patient Signature or Parent/Guardian (if under 18 years of age) **DATE**

Patient Name **Patient D.O.B.**