Bellevue Family Counseling, LLC
1601 116th Ave NE, Ste. 102 & 111
Bellevue, WA 98004
Main 425-947-5030
Fax 425-454-1476

Disclosure of Information, Policies & Client Agreement

Your rights as a client in counseling and coaching
Therapists and counselors practicing for a fee in the State of Washington must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration or Licensure of a counselor with the Department does not include recognition of any practice standards nor necessarily imply the effectiveness of any treatment.

If you feel we have behaved in an unprofessional or unethical manner, please advise us so that the problems can be addressed and resolved. If you believe that does not resolve the issue, you may contact the Department of Health.

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia WA 98504-7857

Confidentiality
As a client you have privileged communications under state law. We will hold all communication with you in strict confidence and will not share information about you without your written consent. However, by law there are certain exceptions to your rights of confidentiality. These are:

1. If we believe you are likely to do harm to yourself or another person.
2. If we believe that you may be physically or sexually abusing or neglecting a minor or vulnerable adult, or if you report the possible abuse or neglect of a child.
3. If we receive a subpoena to provide information.

Appointments & Fees
Each session lasts 50 minutes unless we arrange in advance for a longer time. The scheduled time for your session is set aside for you. If you miss a session without canceling or if you cancel with less than 24 hour notice, we will bill you in full for that time.

Bellevue Family Counseling's session fees are $130 per 50 minute session and prorated for longer times. These rates are the same for the initial evaluation, subsequent 50 minute sessions and for any work we do outside of session to support your progress in counseling or coaching. Rates for legal services are different. These rates are posted on the websites in the Appointment/Forms section. Bellevue Family Counseling, LLC accepts cash or checks, Visa/MC, Discover, Amex and Pay Pal.

Payment & Insurance Reimbursement
Bellevue Family Counseling, LLC collects session fees at the end of each session. We may be able to submit a claim to your insurance company on your behalf or upon request you may be provided with a detailed receipt. Monthly statements are sent to you if you have a balance due. There will be a 1.5% or $25.00 charge on unpaid balances more than 60 days old. If the bill becomes more than 90 days past due it will be sent to a collection agency.

I have read the Disclosure of Information, policies & client agreement; I understand and agree to its terms and conditions, including:

☐ I hereby authorize my provider to consult with other providers employed by Bellevue Family Counseling, LLC as well as with any contracted Washington State approved supervisors as specified by the Washington State Department of Health. Your confidentiality will be protected per HIPPA guidelines.

☐ I understand and agree that Bellevue Family Counseling, LLC, does not take or maintain any session notes beyond what is legally required under Washington State Law.

☐ I hereby grant permission to Bellevue Family Counseling, LLC, to communicate with me via email and texting. I understand that email and texting is not considered a secure form of communication; I understand and accept this risk.

IF FILING AN INSURANCE CLAIM / SEEKING REIMBURSEMENT

If you would like Bellevue Family Counseling, LLC to file a claim with your insurance company, we will take down information from your insurance card and file your claim as a courtesy. However; it is your responsibility to understand the behavioral health benefits of your insurance policy including deductible and copy amounts. Unless Bellevue Family Counseling, LLC is on the provider list at your insurance company, we will collect our full fee up front. Session fees or any co pays are due at the time of service regardless of the coverage of your insurance policy. Note: Parent coaching it not covered by any insurance company.

If the insurance company denies reimbursement for any reason, please note that you are responsible for the balance. You will receive a copy of the same explanation of benefits that we receive from the insurance company. If they deny the claim, it is your responsibility to negotiate reimbursement from your insurance company. Monthly statements are sent to you if you have a balance due. There will be a 1.5% or $25.00 charge on unpaid balances more than 60 days old. If the bill becomes more than 90 days past due it will be sent to a collections agency.

☐ ***I understand that I am responsible for paying for any services not reimbursed by my insurance company within ninety days of the date of service. I assign directly to Bellevue Family Counseling, LLC all insurance benefits otherwise payable to me for services rendered. I further authorize Bellevue Family Counseling, LLC to release all information necessary to secure payment of benefits.***

____ Date: __________________
Client Signature

____ Date: __________________
Additional Client Signature or Parent / Guardian

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Acknowledgement Receipt: Notice of Privacy Practices

Records

Bellevue Family Counseling, LLC keeps a record of the health care services provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02. 120. 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 in writing or unless the law authorizes or compels us to do so.**

Viewing Your Records

You may see your record or get more information about it by contacting our privacy officer, Marlon Familton at his voice mail 425-417-4700. Written requests should be made to the following address:

Bellevue Family Counseling, LLC
1601 116th Ave NE, Ste. 102
Bellevue, WA 98004

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. This is available on the forms page of our website.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_______________________________________ ________________
Client or legally authorized individual signature Date

_______________________________________ ________________
Client or legally authorized individual signature Date

____
Print name if signed on behalf of the client
(parent, legal guardian, personal representative)
.
This form will be retained in your medical record.

(RCW 70.02.120, 45 CFR 164.520)

This page updated on June 29, 2019

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New Client Questionnaire

Today's Date: ____________________

Client Name: ____ Date of Birth: ____________________

Address: ____

City: __________________________________ State: ____________ Zip: ____________________

Phone: ___________________________Email Address: ____

If here for **Relationship Counseling?**- Partner's name _________________________________

Phone: __________________________ Email Address: ____________________________________

If here for **Child Therapy?** - Parent's name: ____

Phone: __________________________ Email Address: ____________________________________

Other Child: ____ Birth date: ______________________

Other Child: ____ Birth date: ______________________

Emergency contact Name: ____________________________________ Phone: __________________

Please describe the general problem you are seeking help for today: ______________________________

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Insurance Information*

**We request payment up front for our services. If you provide insurance information below, Bellevue Family Counseling, LLC will bill your insurance company directly as a courtesy. Reimbursement from your insurance company is not guaranteed.*

Name of insurance company: _____________________ ID Number: ___________________________

Insurance Provider Phone: _______________________ Group Number: _________________________

Name of subscriber (*if different than client*): ____________________________Birth date: __________

Coverage details: ____

______________________________________ _______/_______/_______

Client Signature Date

____

Client Signature

Counselor: