



Bellevue Family Counseling, LLC  
1601 116<sup>th</sup> 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**

Payments are due at the end of each session unless prior arrangements have been made. 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 understand my confidentiality will be protected per HIPPA guidelines. As necessary, 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.
  - 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 including emailing payment receipts for services. I understand that email and texting is not considered a secure form of communication; I understand and accept this risk.
  - I understand that appointments not cancelled at least 24 hours from the scheduled time will be charged at the full session rate.
- 

**IF FILING AN INSURANCE CLAIM / SEEKING REIMBURSEMENT**

If Bellevue Family Counseling, LLC is contracted with your insurance company we will collect any out-of-pocket amount per your policy and submit a claim for the balance. **If we are out-of-network with your insurance company, we will collect payment at the end of the session.** Upon processing your payment, you will be provided with a detailed receipt that will allow you to submit a claim directly. It is your responsibility to know and understand the behavioral health benefits of your policy.

Note: Parent coaching is not covered by any insurance company.

If the insurance company denies reimbursement for any reason, 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 collection 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*



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

**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 116<sup>th</sup> 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 February 6, 2020



Bellevue Family Counseling, LLC  
1601 116<sup>th</sup> Ave NE, Ste. 102  
Bellevue, WA 98004  
Main 425-947-5030  
Fax 425-454-1476

## New Client Questionnaire

Date: \_\_\_\_\_

Name of client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Who else is attending today? \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

If here for Child Therapy? Parent's name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Other Child: \_\_\_\_\_ Birth date: \_\_\_\_\_ May see counselor?

Other Child: \_\_\_\_\_ Birth date: \_\_\_\_\_ May see counselor?

Emergency contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### Insurance Information\*

Name of person responsible for session fees: \_\_\_\_\_

Email address to send receipts: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of subscriber (if different than client): \_\_\_\_\_ Birth date: \_\_\_\_\_

Coverage details: \_\_\_\_\_

Counselor: \_\_\_\_\_