

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## **Disclosure of Information & Policies and Client Agreement & Good Faith Estimate of Charges**

In accordance with the Washington Administrative Code and the revised Code of Washington, the following Client Disclosure Information is provided for the client and must be signed by both the client(s) and counselor. The client's signature indicates that she/he has read and understands the information.

### **Introduction**

I am a licensed mental health counselor (#LH60330781), and I am nationally certified as a sex therapist through the American Association of Sexuality Educators, Counselors and Therapists (AASECT). I earned my Master of Arts in Psychology from LIOS Graduate College of Saybrook University. My practice includes work with couples, families and individuals of all ages.

### **Counseling Approach**

My approach to psychotherapy is systemic; I view people and their behavior within the larger context of their families and cultures. I will consider the impact of your relationships, past and present, on the issues you face, and I will consider the well being of the others in your life as we work together.

#### *What you can expect:*

I will treat you with respect. I will hold you capable, believing that your strengths are up to the challenge of addressing your relationship problems. It would be a disservice to you for me to water down therapy to meet your limitations.

I will always seek to reach the best parts of you, and I will challenge those parts to come forward. I will expect you to grow in your ability to honestly look at your darker motivations and to confront yourself about them. Only the best part of us can talk about the worst parts; the worst parts will always pretend they are not there.

In couples counseling, the relationship itself is not my client. I will not do whatever it takes to keep you together. I work with two individuals, each of whose best interests are my concern. While I believe that most people will benefit from staying in their relationship and working through gridlock toward previously unimagined intimacy, I am not afraid to walk people right to the brink of separation. Often, this journey to the edge is transformative and is, in itself, the solution.

As a rule, I do not work individually with clients if they see me for couple therapy. This policy maintains the balanced relationship with both people. It also serves to prevent me from having any information that has not been shared with the absent partner. Please only come to a couple session alone if it has pre-authorized.

I will fiercely protect your privacy. Confidentiality is always important in therapy, and I take this obligation very seriously. The fact that you are a client and the details of your situation are

completely confidential except for very specific exceptions outlined in my disclosure statement. To further protect your privacy, I will not acknowledge you unless you acknowledge me first if I see you in a public setting.

If you have needs beyond those which I can treat with my training and experience, I will let you know and will make an appropriate referral.

I do not provide after-hours availability. If you are in crisis, you should go the emergency room or call the crisis clinic at 206-461-3222.

### *My Training:*

I graduated with a Master of Arts Degree in Psychology with an emphasis in Systems Counseling from LIOS Graduate College of Saybrook University, and I earned a Certificate in Sex Therapy from the University of Michigan. I completed an intensive externship in Emotionally Focused Couples Therapy (EFT) as well as 5 days of clinical workshop in the Crucible® Intimacy and Desire approach. I have training in and use a blend of a variety of models in my work with clients, including:

- **Sex Therapy**, a rigorous training that helps individuals and couples with issues of sexual dysfunction, sexual addiction and sexual abuse.
- Crucible® Couples Therapy, an approach that views emotional gridlock as inevitable in long term relationships. It then transforms this impasse into an opportunity for the growth of both individuals, increasing their capacity for a much stronger and more intimate partnership.
- EFT, a research backed approach that digs below the surface to find the underlying needs that are not being met and shift the negative patterns that keep people stuck.
- Bowenian Therapy, an approach that strengthens our own self in relation to our families and important others. It is an approach that builds our ability to self-soothe and self-confront, allowing for an increased ability to participate in fulfilling relationships.
- Narrative Therapy, an approach that challenges the limiting stories we carry about ourselves and helps us see the more empowering threads throughout our lives. It is an approach that frees us to choose the roles and stories that we want to live.
- Solution Focused Therapy, an approach that focuses on what is already working in our lives and finding ways to create more of that. It is an approach that opens up our dreams for our lives and encourages us to reach for them.

### **Social Media and the Internet**

\_\_\_\_\_ I keep a business Facebook Page, a Google + profile and a LinkedIn profile (and possibly more, over time) to share my blog posts, practice updates and other information about my business. I do not recommend that you, as a client, connect with me through social media because it creates a greater likelihood of compromised client confidentiality. That being said, I accept all requests and do not take responsibility for filtering requests made by clients. If you elect to “friend”, “like”, “follow”, or otherwise connect with me through the internet or social media, you acknowledge that this compromise is made by your own consent.

You may find my psychology practice on business review sites like Yelp, Healthgrades, Yahoo Local, etc. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites,

please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my clients. Of course, you have the right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If you have concerns about therapy with me, we should discuss them.

### **Communication with me**

\_\_\_\_\_When you need to contact me, the best method is to email me at [change@jessazimmerman.com](mailto:change@jessazimmerman.com) or call me at 206-919-9488. I answer messages as time allows. Texts are only for scheduling purposes.

### **Appointments and Cancellations**

\_\_\_\_\_If you miss a scheduled session with less than **forty-eight hour notice** or if you arrive at a couple's session without your partner without prior arrangement, you will be charged for that session unless we can schedule that appointment within the same week. This does not include weekends. Exceptions may be made, at my discretion, for emergencies.

### **Automatic Termination After 60 Days**

\_\_\_\_\_If more than 60 days have transpired since your last therapy appointment, it will be assumed that you are choosing to terminate therapy. Your file will be closed, and our current episodic treatment will be terminated. You can re-establish therapy at any time by contacting me or by participating in another therapy session.

### **Confidentiality**

Conversation between you and me will not be disclosed without written permission.

The following situations are exceptions to your right of confidentiality:

- If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.
- If you reveal that you have committed or are contemplating the commission of a crime, I may report that to appropriate authorities.
- If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective Services, a state agency.
- If you are currently in litigation or become involved in litigation during the treatment process or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that process. Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation, so that I can exercise due caution so as to protect

your privacy.

If you are seeing me in couples or family therapy, and you, your partner or another family member should happen to see me in an individual session, information shared with me in that meeting may be shared by me in a couple or family session if I believe it to be in the best interest of the work we are doing together. Your signature on this document constitutes a release to this kind of disclosure.

If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner) I will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together.

In some cases it will be useful to the therapy for me to discuss your situation with others such as your physician, your former therapist, your attorney, etc. In such cases, I will seek your written permission for this exchange of information.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed in formal or informal sessions with my colleagues or with other professionals. During these consultations, neither your last name nor other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services and I will thank them for the referral. I will not discuss your situation with them unless I have your written permission.

Please review my *Notice of Privacy Practices* for the most current legal description of private healthcare information and exceptions and exclusions per HIPAA regulations. I request that you do not subpoena me, or my records, in any family court action.

### **Client Records**

I keep record of the health care services I provide. You may ask to see and copy that record. You may ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it by request. There will be a fee for the copying of the clinical file.

I ascribe and adhere to the Code of Ethics of the American Psychological Association, the American Association of Sexuality Educators, Counselors and Therapists and the American Association for Marriage and Family Therapy.

### **Quality of Service**

If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that this does not resolve the issue, you may contact the following agency:

The Department of Health  
Examining Board of Psychology  
P. O. Box 47869  
Olympia, WA 98504-7869  
360/236-4700

**Client Consent to Treatment**

I have read or have had satisfactorily explained to me Jessa Zimmerman’s Disclosure of Information, Policies, and Client Agreement and understand it. I have asked any questions that I had about this statement, and about statements regarding fees and payment policies. (For clients under the age of 13, consent must be given and this form must be signed by a parent or legal guardian.) I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above with Jessa Zimmerman and understand that I have the right to terminate counseling at any time. My signature below indicates that I have received a copy of this agreement.

\_\_\_\_\_  
Client Signature

Date

\_\_\_\_\_  
Jessa Zimmerman, MA

Date

**FEE AGREEMENT AND GOOD FAITH ESTIMATE OF CHARGES**

Appointments are either 50 minutes or 80 minutes long and are billed at the rate of:

Counseling sessions: \$200 for 50 minutes, \$320 for 80 minutes

Any work pertaining to legal proceedings: \$500 per hour

*Rates are subject to change; they are evaluated periodically and may be adjusted up to 10%.*

**Good Faith Estimate of Charges:**

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Based upon a fee of \$200 per 50 minute visit, if you attend one psychotherapy visit every other week, your estimated charge would be \$400 for two visits provided over the course of one month;

\$800 for four visits over two months; or \$1200 for 6 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Based upon a fee of \$320 per 80 minute visit, if you attend one psychotherapy visit every other week, your estimated charge would be \$680 for two visits provided over the course of one month; \$1280 for four visits over two months; or \$1920 for 6 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

**Service Codes:** Diagnosis code Z63.0 for relational distress; CPT service code: 90847 family/couple therapy with the patient present.

**Cancellation:** You are asked to cancel any appointment at least 48 hours in advance. The full session fee will be charged for missed appointments and cancellations with less than 48 hour notice. Exceptions may be made, at my discretion, for emergencies.

**Delinquent Payment:** You are responsible for your account and are expected to pay for all services you receive.

\_\_\_\_\_ **Insurance:** I am a cash only practice. I do not work with any insurance as an out of network or in network provider. If you require a statement of proof of services, I can provide one for you. I do not provide additional information to insurance companies such as W-9s, complete out of network provider approval forms, or provide clinical reviews or superbills.

Sessions end on time, even if we are in the middle of something. This allows me to be on time for all of my clients.

Emergency and professional consultation telephone sessions are billed at the same rate, in quarter hour segments, after the first 5 minutes.

\_\_\_\_\_ Please call or text me (206-919-9488) if you are running late. I will wait for 20 minutes without hearing from you before considering it a no show, and the session fee will still be owed.

For telehealth sessions, payment, via payment portal, must be completed prior to the beginning of the online therapy session. In addition, full session fees apply despite any technical difficulties that may arise

This contract is exclusively with Jessa Zimmerman, MA. (TIN 46-5669324, NPI # 1710264122) My work with you is as an independent practitioner and not in affiliation with any group practice, or other practitioner in this, or any other, building. Individual mental health practitioners assume no liability or responsibility for any other practitioner or group working in this office or building.

I (we) agree to pay the fees as listed above per psychotherapy session with Jessa Zimmerman, MA.

Having read the above contract, I understand my responsibilities for payment. My (our) signature(s) confirms acceptance of the above items and constitutes informed consent for psychotherapy without exception.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

#### HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include the Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical records-- Health Care Access and Disclosure." Please review it carefully.**

I understand that your personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

The law protects the privacy of the health information I create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations. State law requires me to get your authorization to disclose this information for payment purposes.

*Protected Health Information (PHI):*

*Protected health information means individually identifiable health information, which is : transmitted by electronic means, maintained in any means described in the definition of electronic media; or transmitted or maintained in any other form or medium.*

**Examples of use and disclosures of Protected Health Information for *Treatment, Payment, and Health Operations* are:**

**Treatment:**

- information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of the treatment team will be recorded in your medical record and used to help decide what care may be right for you.
- I may also provide information to others providing you care. This will help them stay informed about your care.

**Payment:**

- In Washington State, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. I will have you sign another form “Assignment of Benefits” or a similar form for this purpose (RCW 70.02.030(b)). Health plans need information from me for your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

**Health care operations:**

- I may use your medical records to assess quality and improve services.
- I may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services.
- I may use and disclose your information to conduct and arrange for services, including:
  - medical review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

**Your health information rights.**

The health and billing records I create and store are the property of Jessa Zimmerman, MA. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask me to restrict certain uses and disclosures. You must deliver this request in writing to me. I am not required to grant that request. But I will comply with any request granted;
- Request and receive from me a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. I have a form available for this type of request.
- Have me review a denial of access to your health information—except in certain circumstances.
- Ask me to change your health information. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, I will give you a list of disclosures of your health information. The list will not include disclosures to 3rd party payers. You may receive this information without charge once every 12 months. I will notify you of the cost involved if you request this information more than once every twelve months.
- As that your health information be given to you by another means or at another location. Please sign, date, and give me your request in writing.
- Cancel prior authorizations to sue or disclose health information by giving me a written revocation. Your revocation does not effect information that has already been released. It also does not effect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

**Psychotherapy notes:**



These are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record. *Psychotherapy notes* excludes medication prescriptions and monitoring, counseling session start and stop times, the modalities or frequencies of treatment provided, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes is required except if used by the originator of the notes for treatment, to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, if the notes are to be used in the course of training students, trainees or practitioners in mental health; to defend a legal action or any other legal proceeding brought forth by the patient; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by the law.

### **My responsibilities.**

I am required to:

- \* Keep your protected health information private.
- \* Give you this notice.
- \* Follow the terms of this Notice.

I have the right to change my practices regarding the protected health information I maintain. If I make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it.

### **To ask for help or to make a complaint.**

If you have questions, want more information, or want to report a problem about the handling of your protected health information, contact Jessa Zimmerman, PO Box 2427, Vashon, WA 98070.

If you believe your privacy rights have been violated, you may discuss your concerns with the Privacy Officer. You may send a written complaint to the Washington State Department of Health at: 510 4th Ave. W., Suite 404, Seattle, WA 98119.

You may also file a complaint with the U.S. Secretary of Health and Human Services.

I respect your right to file a complaint with me or to the Secretary of HHS, and I will not retaliate against you.

### **Other disclosures and uses of Protected Health Information.**

#### **Notification of family and others.**

Unless you object, I may release health information about you to a friend or family member who is involved in your medical care. I may also give information to someone who helps pay for your care. I may tell your family or friends your condition and that you are in a hospital. In addition, I may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, I will not use or disclose it.

#### **Other use or disclosure of your Protected Health Information without your authorization is:**

- With medical researchers—if the research has been approved and has policies to protect the privacy of your health information. I may also share information with medical researchers preparing to conduct a research project.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To comply with Workers' Compensations Laws if you have made workers' compensation claims.
- For Public Health and Safety Purposes as allowed or required by law:
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - to public health or legal authorities.
  - to protect public health and safety
  - to prevent or control disease, injury, or disability
  - to report vital statistics such births or deaths.
- To report suspected abuse or neglect to public authorities.
- To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For law enforcement purposes such as when I receive a subpoena, court order, or other legal process, or you are a victim of a crime.
- For health and safety oversight activities. For example we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, I may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For work related conditions that could effect employee health. For example, an employer may ask me to assess health risk on a job site.
- To the military authorities of U.S. and foreign military personal. For example, the law may require me to provide information necessary to a military mission.
- In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- For specialized government function. For example, I may share information for national security purposes.

### **Specialized Authorizations**

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, I will contact you to secure the required authorizations to comply with federal and state laws such as:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse treatment Records (RCW 70.96S.150)
- Mental Health Services for Minors (RCS 71.05.390-690)
- Communicable and Certain other Diseases Confidentiality (WAC 246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

If I need your health information for any reason that has not been described in this notice, I will ask for your written authorization before using or disclosing any identifiable health information about you. More important, if you choose to sign an authorization to disclose information, you may revoke that authorization at a later time to stop any future use and disclosure.

### **Other uses and Disclosures of Protected Health Information**

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: 08/1/2010