

Sean Orpen, M.S., LMFT

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PSYCHOTHERAPY SERVICES AGREEMENT WITH SEAN ORPEN, M.S., LMFT INC.

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Welcome to Sean Orpen, M.S., LMFT Inc. This document contains important information about our professional services and business policies. It also contains information about our policies and practices to protect the privacy of your health information. Please read it carefully and discuss any questions you may have with me. When you sign this document, you will be stating that I provided you with this information and it will represent an agreement between us.

Office Location:

My office is located at 2711 E Madison St. (Suite 211), Seattle, Washington, 98112. There is usually ample street parking on E. Madison St and the surrounding areas. There are also local coffee shops, restaurants, and bakeries within a short walking distance from the office. Enter the main doors on the north side of the building and proceed up the stairs on your right. Turn right at the top of the stairs and pass the first door on your right; when you pass the first door you will come upon a waiting room on your right. Please have a seat there, and I will be with you at your appointment time. Do not knock on my door, as I may be in session with someone else.

Psychotherapy Services: Psychotherapy varies depending on the therapist, the client and the client's particular situations and goals. There are many different methods I may use to deal with your particular situations and goals. In order for therapy to have the best outcome you will have to invest energy in the process and work actively on things we talk about both during and between our sessions.

Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of your life. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your situation and needs and we will discuss goals you want to work towards. I will offer you some information so that you will have an idea of what our work together will be like if you decide to continue the therapy with me. During this time, we can both decide if I am the best person to provide the services you need. Psychotherapy can involve a significant investment of time, energy and money, so it is important that you select a therapist you are comfortable working with. If at any time you have questions about any aspect of our work together, please discuss them with me. If you decide that you do not want to continue in therapy with me, please tell me if you want me to help you try to find another therapist or other appropriate resources and I will do so.

Sessions: I generally schedule 50- or 90-minute sessions with clients once per week at a time we agree on. If you arrive late for an appointment, we will only be able to meet for the remaining time of our scheduled 50 minutes. Generally, there is a great deal of variability in the duration of treatment clients seek. Depending on need and preference, some people seek and attend sessions for a week or two, while others see benefit from receiving services for a few months or a few years. I will work with you to help identify and clarify your goals for therapy in order to maximize the use of our time together.

If you ever need to cancel a scheduled therapy session, please do so at least 24 hours in advance. If you do not cancel a scheduled appointment with at least 48 hours notice or if you fail to attend a scheduled session, you will be expected to pay the full fee for that session, unless we both agree that you were unable to attend due to circumstances beyond your control. Insurance companies will not reimburse for canceled or missed appointments so you will be fully responsible for the charges for such sessions. If you normally use insurance, the full fee for such sessions is the full fee that your insurance company allows for a therapy session and not just your usual copayment amount.

Professional Fees: My fee is \$120 for a 50 minute session. We do provide sliding fee scale options, but with limited availability. In addition to our regular sessions, I charge \$120 per hour for other professional services you may need, though I will break down the hourly cost into 15-minute increments if I work for periods of less than one hour. Other services include telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other professional service that you may request. **Sean Orpen M.S., LMFT Inc. does not get involved in legal proceedings, nor custody disputes.** If such situations arise, clients will be referred to other licensed therapists for services and continuity of care.

Billing and Payments: You will be expected to pay the full fee at the time of service. I accept payments by check, cash, or credit card. Payment schedules for other professional services will be agreed to when they are requested. Sean Orpen M.S., LMFT Inc. utilizes HIPPA compliant medical clearinghouses like "Office Ally" and "TherapyNotes" for billing and claim submission to insurance companies accepted by this practice. Note that by signing this form you acknowledge and agree to the use of such programs by your therapist for both billing and case file management (e.g., progress note storage). A personal receipt can be provided if you wish to submit your claim yourself and would be responsible for therapist's full fee, as determined by your specific insurance company, at date of service.

If you make a payment by check and your check does not clear due to insufficient funds or any other reason, you will be expected to reimburse us in full for any related bank fees that we are charged as a result.

Insurance Reimbursement: Sean Orpen M.S., LMFT Inc. is paneled with some insurance companies, but can provide receipts in order for clients to submit claims for "out of network" reimbursement. **You will be responsible for submitting claims in order to receive reimbursement from insurance companies or employee benefit programs if "out of network". For those insurance panels that are accepted, you should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis as well as demographic information. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record.** In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by insurance contract]. I will provide you with a copy of any report I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your carrier.

Contacting Me: I am not always immediately available by phone as I turn off my phone when in session with clients. Calls go to my voicemail when I am unavailable, which I check regularly on weekdays. I will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours). If you are difficult to reach, please leave times you will be available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance. At times when I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

If you are in an emergency situation, you should either call me and if you get my voicemail, follow the instructions for emergencies, or immediately call the your local emergency services at 911 or call or go to the nearest hospital emergency room and tell them what is happening. I will get back to you as soon as I possibly can in such situations, but I may not be able to get back to you immediately in all cases. Therefore, if you can't wait for me to return your call

because of your situation, or if you do call me and follow my voicemail instructions for emergencies and you do not hear back from me within 5 to 10 minutes, you should immediately call 911 or the nearest emergency room and tell them what is happening.

Professional Records: The laws and standards of my profession require that I keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing unless I believe that seeing them would be emotionally damaging, in which case I will send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to people who are not mental health professionals. Therefore, if you want to see your records, I recommend that you review them with me so we can discuss the contents. We reserve the right to charge you for the costs of copying and sending your records if you request them.

Confidentiality: In general, the law protects the privacy of all communication between a client and a psychologist. I can only release information about your treatment to others if you sign a written authorization form. You can revoke any such authorizations at any time in writing. However, in the following situations your authorization is not required for me to release information:

- a. Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
- b. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses and habitual use of alcohol.
- c. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
- d. Therapist's duty to report the misconduct of mental health or health care professionals.
- e. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
- f. Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
- g. Therapist's duty to release records if subpoenaed by the courts.
- h. Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.)

While I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

Other Client Rights: If you want, I will discuss with you more details about any of the following:

- You have the right to request and receive from me confidential communication of your protected health information by alternate means or at alternative locations. For example, you can request that I send any correspondences to an address other than your home address if you don't want a family member to know that you are in therapy with me.
- You have the right to request that I change information in your record. I require such requests in writing along with your reasons for your requested changes. I may deny your request for legal reasons depending on nature of request.

- You generally have the right to receive an accounting of any disclosures I have made of your protected health information, which did not require your authorization. If you want, I will discuss with you more details about this process.
- If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, I would like you to inform me as soon as possible so we can try to resolve your concerns. If you prefer to discuss your concerns with someone else, you may contact the Secretary of the U.S. Department of Health and Human Services.

Conclusion and Signatures: I reserve the right to change my policies, practices and procedures described in this document. I will notify you in writing of any significant changes. By signing below you are indicating that you have received and read the information in this document, you have discussed the contents with me to your satisfaction, and you agree to abide by its terms during the course of our professional relationship. If you would like a copy of this document, please ask me for one.

| | | |
|---|--------------------|---------------|
| _____ Client 1 - Print Name | _____ Signature | _____ Date |
| _____ Client 2 - Print Name | _____ Signature | _____ Date |
| <u>Sean Orpen, M.S., LMFT</u> Licensed Marriage and Family Therapist | _____ Signature | _____ Date |

FINANCIAL POLICY AGREEMENT

The following schedule summarizes our fees for service:

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|--|---|
| Individual/Couple/Family Therapy (50 minute session) | \$120/session |
| Case Management/Consultation | \$120/hour (Billed in 15 minute increments) |

Reduced fee services are available on a limited basis.

Under the terms of the agreement, the patient or patient's legal guardian is responsible for full payment for services.

Although we only bill some forms of insurance directly, if you are utilizing health insurance benefits or an employee benefits plan, we will be glad to provide a detailed receipt to provide to your insurance company for reimbursement. **You will be responsible for submitting claims for reimbursement from your individual health care plan.** Therapeutic services might be covered in full, or in part, by your health insurance or employee benefits plan. **Please check your coverage carefully by asking the following questions:**

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the coverage amount per therapy session?
- Is approval required from my primary care physician in order for services to be covered?

Full payment is due at the time of service.

Cancelled or missed appointments with less than 24 hours notice are billed at the fee and must be paid in full by the next session.

In addition to our regular sessions, I charge \$120 per hour for other professional services you may need, though I will break down the hourly cost into 15-minute increments if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals you have authorized. It is agreed and understood that any charges incurred are the sole responsibility of the patient and/or the responsible party signed below. Any past due balance older than 30 days will be subject to a late charge of 1.5% per month. It is agreed and understood that if this obligation should become delinquent that you, the patient or responsible party, agree to pay collection costs, attorney's fees, and any costs associated with placing your account with a collection agency and/or an attorney for litigation.

I have read the policy statement and agree to these policies. I hereby guarantee payment of charges for psychological services and understand that should insurance fail to pay for this psychological treatment that I will be responsible for payment.

I agree to pay Sean Orpen M.S., LMFT Inc. the following fee _____ for services rendered.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE REVIEWS HOW HEALTH-RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED UNDER THE FEDERAL HIPPA ACT

MY OBLIGATIONS: I am required by law to do the following: 1) To maintain the privacy of protected health information. "Health information" refers to your name, address, date of birth, social security number, insurance information, and other identifiable data. 2) To provide you this notice of my legal duties and privacy practices regarding health information about you. 3) To follow the terms of my notice that is currently in effect.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways I may use and disclose Health Information that identifies you.

Benefit Verification: I will obtain verbal permission from you at the time of your telephoned, treatment inquiry to use your Personal Health Information. This will allow my office to verify the financial liabilities under your health insurance plan prior to setting up your first appointment.

Payments: I may use and disclose Health Information so that I or others may bill and receive payment from you, your insurance company, or a third party for treatment and services you received. For example, I may give your health plan information so that they will pay for your treatment. I will receive written permission from you to release this information at the initial intake session.

Use of Electronic Means to Contact You: Unless otherwise specified, I may use and disclose Health Information (e.g., your telephone number) to contact you by telephone or voice-mail in order to return a message or relay information to you. This is a restricted use if you specifically state not to make such contact—for example, if you want me to contact you via your home or cell phone numbers but not via the telephone at your place of employment.

SPECIAL SITUATIONS: The following are special situations in which your Personal Health Information may be used or disclosed.

As Required by Law: I will disclose Health Information when required to do so by federal, state, or local law, including disclosure to the U.S. Department of Health and Human Services.

To Avert a Serious Threat to Health or Public Safety: I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. However, disclosures in these regards will be made only to someone who may be able to help prevent the threat and only will involve discussion about issues relevant to the threat.

Business Associates: I may disclose Health Information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. "Business associates" may refer to other persons or companies that I may contract with in order to help me with my business. For instance, my IT/Computer Consultant, the company that helps me with my Office Billing program, or individuals who may help with Transcription. All of my business associates are obligated to protect the privacy of your information as well as others' and are not allowed to use, or disclose, any information other than what they need to perform their functions for me.

Health Oversight Activities: I may disclose Health Information for purposes of health oversight regarding health-care delivery as authorized by law. These oversight activities may include, for example, insurance audits, investigations, or inspections. These activities are necessary for some insurance companies that monitor the quality of the therapeutic delivery of services to those individuals covered under their plans. Likewise, federal or state

agencies may perform the same function/purpose for those clients receiving Medical Assistance or Medicaid. In addition, these latter instances are necessary for the government to monitor the health care system, relevant government programs, licensure activities, and compliance with civil rights laws and other applicable laws.

Lawsuits and Other Disputes: If you are involved in a lawsuit or a dispute, I may disclose Health Information in response to a court order if signed by a judge. Any other disclosures of Health Information in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute, must have your written permission.

Law Enforcement/Protective Services: As a mandated reporter, I may be required, by law, to release Health Information to appropriate law enforcement or protective services officials as it relates to certain injuries, actions, or situations, involving children, teenagers, and vulnerable adults

National Security: I may disclose your Health Information under certain circumstances to authorized federal officials for national security and intelligence activities. For example, threats to the life of the President of the United States or other authorized persons or heads-of-state.

YOUR RIGHTS: You have the following rights regarding Health Information I have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be issued to receive payment for your care. This includes billing-related records, but it does not include your Intake Report, Psychotherapy Summary Notes, or other clinical reports. To and inspect and receive copy of these types of Health Information, you must make your request in writing and sign a Release of Information indicating what documents you are requesting.

Right to Amend: If you feel that Health Information I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by my office. To request an amendment, it must be in writing, accompanied by a reason that supports your request for an amendment. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. I may also deny your request for amendment if it is directed at amending information that a) was not created by me; b) is not part of the Health Information kept by or for my practice; c) is not part of the information which you would be permitted to inspect and copy; or d) is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures I make on your behalf for billing purposes. Yet, this request must be in writing.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information I use or disclose for payment-related matters. You also have the right to request a limit on the Health Information I disclose to someone involved in your care—unless the information is needed in an emergency situation. This request needs to be made in writing.

Right to a Paper Copy of This Notice: You have the right to request a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: I reserve the right to change this Notice and to make the new notice apply to the Health Information I already have as well as any information I receive in the future.

QUESTIONS/COMPLAINTS: If you have any questions about this Notice, please feel free to contact me. I can be reached at (360) 525-4266. In addition, if you believe that your Privacy Rights have been violated, you may file a complaint in writing, without penalty, to me or with the Secretary of the U.S. Department of Health and Human Services.

