Peter J. Sanderson
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LMFT, MHP, CMHS

South Sound Psychotherapy, LLC
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Client Disclosure Agreement, Privacy Practices Notification, and Consent for Treatment

This document gives you information about me and my practice, as well as explains our rights and responsibilities as part of our therapeutic working relationship. Washington state law requires all counselors to disclose certain information to you, which is provided here. If you have questions, please discuss them with me.

Your Right to Know: Counselors practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards or necessarily imply the effectiveness of any treatment.

Confidentiality: Client confidentiality is a vital component of psychotherapy. It is extremely important that clients feel secure that what they discuss in therapy will not be shared. There are three circumstances in which a therapist is required to report confidential information to state public welfare officials. These are when the therapist has a reasonable suspicion of the occurrence of:

1. Child abuse
2. Physical abuse of an elder or dependent adult living in the home
3. Expressed intent to harm oneself or another person

Right to Choose: You have the right to choose a counselor/therapist who best suits your needs and purposes. At any time feel free to discuss with me any questions you have regarding my qualifications, practice, course of treatment and/or intervention techniques, or any other issues or questions you may have regarding our work together.

Education, Training and Experience:

ANTIOCH UNIVERSITY SEATTLE
SEATTLE, WA 2003-2006
MA- Psychology, 2006 Couple, Child, and Family Therapy

THE EVERGREEN STATE COLLEGE
OLYMPIA, WA 2000-2003
BA, 2003 Emphasis in Psychology and Sociology

Additional training in Dialectical Behavior Therapy, Motivational Interviewing, Multisystemic Therapy, Trauma-Focused Cognitive Behavioral Therapy, Emotionally Focused Couples Therapy, and Cognitive Processing Therapy.
My professional roles have included Supervisor, Therapist, Social Worker, and Case Manager. Experience included family and individual therapy, skills coaching, and community support with teenagers and their families in the community, and in Juvenile Rehabilitation institutions; On-call availability to client families; Treatment planning, outcome assessment, identification of natural supports, and coordination with community resources.

Theoretical Orientation: My therapeutic interventions and methodologies are based primarily on Family Systems Therapy and Cognitive-Behavioral Therapy.

Course of Treatment: To be agreed upon with the client.

Client Responsibility for Choice of Treatment: You have the right to decided whether to engage in any course of treatment and to decide whether that treatment is suitable for your needs. I encourage you to discuss with me your goals for therapy, and the treatment. Clients have the right to request a change of therapy, referral to another therapist, or other referral sources, or to discontinue therapy. If you do wish to terminate therapy, I encourage you to discuss your decision and reason for termination at the beginning of a regularly scheduled session. I hope you will discuss any dissatisfaction or questions with the therapeutic

process and consider it of therapeutic value that the counseling relationship and issues be dealt with in a straightforward manner and in the best of your and my ability.

Fees: My standard fee is $110.00 per 55 minute appointment and $130.00 for the assessment/ intake appointment). At times, appointments may be scheduled to be shorter or longer in duration. At those times, the fee will be prorated according to our agreed upon fee schedule. I also offer limited negotiated cash discounts. Requested report writing and other requested work related to your treatment outside of our scheduled sessions will be charged at the same rate as office sessions.

My fee for court-related services, including such services as testimony, deposition, time away from my practice, travel expenses, preparation, and other expenses involved, is $110.00 per hour.

Payment for Service: All charges are due and payable at the time of your appointment, unless other arrangements have been made in advance of the session.

Appointment: Making and keeping appointments is important to the therapeutic process. If it is necessary to cancel an appointment, please give 24 hours notice in order to avoid being charged for the session.

Emergencies and Non-Scheduled Contact. In case of emergency, I cannot guarantee my availability. You may leave a message for me at (360) 402-0992 at any time, but I may not receive it until days later. If it is an emergency and I am not available, you may call 911, or the Crisis Clinic at 360-586-2600.

Concerns about Provisions of Service: I am licensed to practice in the State of Washington. I am committed to the highest quality of professional and regulatory ethics and standards of practice. The purpose of the law regulating counselors and the Counselor Credentialing Act is to: a) provide protection for public health and safety; and b) to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. You may obtain a list of acts of unprofessional conduct under RCW 18.130.180 at http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130.180. You may also obtain the list or file a complaint with HSQA Complaint Intake, P.O. Box 47857, Olympia, WA 98504-7857, 360-236-4700; Email: HSQAComplaintIntake@doh.wa.gov.

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. PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of my professional practice, I maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosure. "Protected health information" (PHI) is information about you, including demographic information, that may identify or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payments for the provision of health care.

Your Rights Regarding Your PHI

The following are your rights regarding PHI I maintain about you.

- *Right of Access to Inspect and Copy*. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that I maintain. I may charge a reasonable cost-based fee for copies.
- *Right to Amend.* If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree with the amendment.
- *Right to an Accounting of Disclosures.* You have the right to request a copy of the required accounting of disclosures that I make of your PHI.
- *Right to Request Restrictions.* You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. I am not required to agree with your request.
- *Right to Request Confidential Communication*. You have the right to request that I communicate with you in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making those requests.
- *Right to a Copy of this Notice.* You have the right to a copy of this notice.

- *Right of Complaint.* You have the right to file a complaint in writing with me or with the Secretary of the Department of Health if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

My Uses and Disclosure of PHI for Treatment, Payment and Health Care Operations

Treatment. I may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, I may disclose your PHI to others with your permission.

Payment. I may use your PHI in connection with billing statements I send you and my system of tracking charges and credits to your account. In addition, but with your authorization, I may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage and remaining availability, as well as to submit claims for payment and to disclose PHI for medical necessity and quality assurance reviews.

Health Care Operations. I may use and disclose your PHI for health care operations of my professional practice in support of the functions of treatment and payment. Such disclosure would be with business associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist me in my delivery of your health care.

Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. I also must make disclosure to the Secretary of the Department of Health for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose your PHI to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me (such as a third-party payer).

Threat to Health or Safety. I may disclose your PHI when necessary to minimize an imminent danger to the health and safety of you or any other individual.

Appointment Reminders. I may use your PHI to contact you to remind you of your appointments with me.

Business Associates. I may disclose your PHI to my licensure supervisors and business associates that are contracted by me to perform health care operations, or payment activities on my behalf which may involve their collection, or disclosure or use of your PHI. My contact with them must require them to safeguard the privacy of you PHI.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will also disclose your PHI if (1) you and I have each been notified in writing at least fourteen days in advance of subpoena or other legal demand, identify the PHI sought, and the date by which a protective order must be obtained to avoid my compliance. (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurance that you received notice of an opportunity to have limited or quashed the discovery demand and (4) such time has elapsed.

Uses and Disclosures of PHI with Your Witness Authorization
I will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This Notice
This Notice of Privacy Practices informs you how I may use and disclose your protected health information (PHI) and your rights regarding your PHI; I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect your PHI. I am required to abide by the terms of this notice of Privacy Practices.

I reserve the right to change the terms of my Notice to Privacy Practice at any time. Any new Notice of Privacy Practice will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by providing you a copy upon your request or providing a copy to you at your next appointment.

Contact Information

I am my own Privacy Officer, so if you have any questions about this Notice of Privacy Practices, please contact me.
My contact information is: Peter J. Sanderson, LMFT MHP CMHS; South Sound Psychotherapy, LLC; 2142 West Railroad Avenue-Shelton, WA 98584; (360) 427-0853

Complaints regarding privacy

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this notice. I will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of the Department of Health.

By signing this document, I confirm that I have read the above information, disclosure statement and Privacy Practice Notice and received a copy the documents. I further confirm that I have had the opportunity to discuss this information with Peter J. Sanderson, LMFT MHP CMHS, and that I understand its content. By signing this document, I also agree to participate in and receive counseling from Peter J. Sanderson, LMFT MHP CMHS of South Sound Psychotherapy, LLC.

______________________________	______________________________	____________________
Print Name	Signature	Date
______________________________	______________________________	____________________
Parent (if client is under 13)	Signature	Date

Fee Agreement

The standard fee is $110.00 per 55 minute appointment and $130.00 for the assessment/intake appointment.
No shows and cancellations made with less than 24-hours' notice are billed at the full hourly rate and payment is required at the next scheduled appointment or within 15 days, whichever comes first. I agree to pay for court-related services at the rate of $110.00 per hour, as described to me in full in this information sheet. I understand that payment is expected in full at each session unless I am billing your insurance company or another arrangement has been made.
(*Note-The following only applies to negotiated cash discounts:* I, ____ , agree to pay $__________ per session.)

____________________________________	________________________
Signature	Date