Agreement of Professional Services and Business Policies

Welcome to my practice. This document, the **Agreement**, contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a **Notice of Privacy Practices**, or **Notice**. The Notice, a separate document, explains HIPAA and its application to your personal health information in greater detail. Please read it carefully and note any questions you might have so that we can discuss them.

About Me: I obtained my Master of Arts in Clinical Art Therapy from the University of Marylhurst. I am licensed to practice as a Mental Health Counselor in the State of Washington (LH 00009595). I specialize in working with children, adolescents, adults, families, couples, military families and LGBTQ. I have over 15 years experience working with these populations both in outpatient and inpatient treatment settings.

For more information about my work and specialties, please visit my web page at www.wendybiondi.com.

Professional Relationships: I have an office sharing relationship agreement between Dr. Laura Asbell, Stephanie Sherve, and Marcia Richard to occupy a joint premises, but our professional practices are separate and independent legal entities. Due to this independence, neither one of us is responsible for the behavior of the other. There is one exceptions - a business agreement contract between myself and Marcia Richard that describe in some instances some insurance companies require a therapist to be supervised for a client to use his or her mental health benefits. You will be informed if this arrangement is required, and you may request to meet with the therapist's supervisor at any time. Other than this specific supervisory relationship, all our work remains independent and not under the control of the other therapist.

Therapeutic Model: My therapeutic model recognizes that each person is an individual with biological, psychological, and sociological aspects of their being. Depending on your needs and preferences, I attempt to integrate these aspects within a developmental, cognitive behavioral and interpersonal approach. You and I will discuss your goals and the proposed course of therapy periodically throughout counseling. If you have any concerns or questions, please bring them to my attention. You have the right at any time to refuse therapy, change therapists, or request a change in therapeutic approach.

Confidentiality: You have privileged communication under the laws of Washington. That means, with some exceptions, anything you disclose in therapy and information I obtain about you from any source, even that you are a client, is confidential and can be disclosed to others only with your written authorization. However, disclosure ***without*** your consent or authorization can be made, or may be required by state or federal law, if the disclosure is:

- To a government agency or federal, state or law enforcement requesting information for health oversight activities or as required by law;
- To proper authorities if there is reason to believe that a child or vulnerable adult has been abused or neglected, or if I feel you are of danger to yourself or others;
- To the courts if under a valid subpoena or court order;
- To licensing boards if I am under disciplinary investigation;
- To the WA Department of Labor and Industries and your employer if the services I am providing are relevant to a worker's compensation claim you have filed;
- To public health care authorities for notifiable health conditions unless the condition notification has already been made;
- To a health care provider or facility for the purpose of coordination of care, unless you instruct us not to do so; or
- To county coroner's and medical examiners for the investigation of death.

Additionally, I may disclose relevant information if you file a complaint or lawsuit against me or if you commit a crime on the premises against me. If disclosure is required without your authorization, I will attempt to discuss the situation

with you to clarify options and look for alternate solutions. In that case, disclosure of information will be limited to what is minimally necessary.

You may ***revoke an existing release of information authorization*** by completing the **Revocation of Release of Information Authorization** form. This form will then be placed in your chart records and the corresponding release of information will be revoked.

Other Limits to Confidentiality: For both clinical and administrative purposes, such as scheduling, billing, and quality assurance, along with billing staff and administrative staff may have information about you. I also may have contracts with professionals such as accountants, billing software vendors, computer technicians, or attorneys who may have information about you. If you request, I can provide you with the names of these individuals. All are legally, contractually, and ethically bound to protect your confidentiality.

In the case of **relationship or family therapy, or when multiple family members** are seen by the same therapist, it is assumed confidentiality to be waived among participants unless other prior arrangements are made.

In some cases, it might be useful for your situation and needs if I can discussed with others such as a teacher or physician; in that case, I will seek your written authorization for this exchange of information. Please be aware that after information is released, with your signed consent, I will no longer have control of how that information is controlled or distributed.

Several mental health care providers share emergency calls through the pager system with me. I will share your name and other clinical information with them only to the extent necessary to provide adequate emergency coverage for you. Additionally, I occasionally find it helpful to consult about a case with other professionals. In this case, I will make every effort to avoid revealing your identity. Those consultants, of course, also are legally bound to keep your information confidential. All consultations will be noted in your clinical records.

Treatment Records: I keep records of the services provided to you. All treatment records are maintained in a secure location, which restricts access and protects confidentiality and is consistent with HIPAA requirements. Dr. Asbell shall have unrestricted access to those clinical records maintained while I was working under Asbell Professional Group (prior to 8/1/2012).

You may ask to see or obtain a copy of your treatment records, and you may ask to amend your records. Your request to amend your records must be in writing, and it must explain why the information should be amended. I may disagree with you; in that case, I will provide you with a written explanation. You then have the right to respond to my explanation with a statement that will be added to the information you want amended. If I agree with amending the records, I will make reasonable efforts to inform others of the correction, including people or entities you name, and to include the changes in any future disclosures of that information. You may be charged an appropriate fee for time and costs involved with any information request. Payment is required at the time of the request. Please see the **Notice** for further rights regarding your records.

A co-mingled clinical record of my work is kept when seeing **couples or families**. However, any release of information you request will apply only to sessions in which you were seen individually. I require a release from both parties for records involving joint sessions.

Therapy with Minors: In the state of Washington, the legal definition of minors includes all persons under the age of 18. In Washington a minor can consent to counseling/therapy at the age of 13 without parental/legal guardian permission. It is ***my*** policy, in the case of children **under the age of 18,** parent(s) or legal guardians holds the communication privilege and must be in agreement of the minor receiving services. This means that the parent is entitled to information about the child and is the person who authorizes any release of information about the child. However, I ask that you waive your right to access to your child's treatment records. I will discuss with the parents the child's general progress and specifics if indicated. I will attempt to act in the child's best interest in deciding to disclose confidential information without the child's consent.

Each parent will be required to agree that you will not involve my work with your children in any legal disagreement between the two of you. In particular, by signing this agreement, you agree that in any such proceedings neither of you will ask me to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or my records or to refer in any court filing to anything I have said or done.

140 S Arthur, Suite 690, Spokane, WA 99202-2260

Phone: (509) 590-6339 Fax: (509) 535-7073 E-Mail: wendy@wendybiondi.com Website: www.wendybiondi.com

Agreement of Professional Services and Business Policies

Client Rights: HIPAA provides you with several new and expanded rights with regard to your Clinical Records and disclosures of protected health information. These include the rights to request restrictions on what information from your Clinical Records is disclosed to others; request an accounting of disclosures of protected health information that you have neither consented to nor authorized; determine the location to which protected information disclosures were sent, have any complaints you make about my policies and procedures recorded in your records; and obtain a paper copy of this Agreement, the Notice, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Telepsychology Electronic Communications: Telepsychology includes the transmission of information in any electronic form, including telephone, email, or text contact. You may contact me by email at **wendy@wendybiondi.com.** Electronic communication is an easy and fast way to communicate and handle routine questions and my office may use electronic communication for administrative purposes. However, any technology can have difficulties, and any ***electronic communication is not secure*** and involves potential risks to confidentiality. Please let me know if you have difficulty with me using this form of communication. Also, please call me if there is any urgency to your communication, if I have not responded within one business day, or if my response is not sufficient for your needs. Following are some guidelines—and cautions—for the use of electronic mail.

Guidelines:

- Please put an identifier such as "Appointment" in the subject line.
- Remember to put your name in the body of the message.
- Limit your communication to arrange and modify appointments or general comments or questions.
- For your protection, do not email your personal health information.

Cautions:

- Your message, as well as my response, will become part of your Clinical Records.
- Your communication is ***not secure***. If you prefer and your system allows, I can help you use encryption to better protect your confidentiality.

SMS (mobile phone text messaging): You may contact me using text messaging but please be aware that engaging with me this way could compromise your confidentiality as it has the potential to be viewed by others. For your protection I will not discuss critical issues or client identifying information other than what is required to send and receive such messages. I prefer that this form of communication be limited to arrange or modify appointments only. If you choose to communicate with me in this format, be aware that any texting I receive from you and any responses that I send become part of your Clinical Records. **Text Messaging: 509-590-6339**

Business Review Sites: You may find my professional practice on sites such as Google, Yahoo, Merchant Circle, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites automatically add listings without the business's knowledge. 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 client. You have a right to express yourself on any site you wish but keep in mind that in doing so you are self-disclosing as a client. I urge you to protect your privacy just as I take precautions to protect your confidentiality.

Fees and Cancellation Policy: Therapy sessions are 45 minutes ("clinical hour") in length. Fees vary based on the service provided. The fee for the initial intake session is $180.00; subsequent sessions are $130.00. These fees may change and are assessed for adjustment annually on July 1 to reflect changes in expenses.

Fees for ***telephone calls***, ***email consults***, attendance at meetings with other professionals you have authorized, preparation of records or summaries, or other services you might request from me are pro-rated based on my normal hourly fees, with a minimum fee of 10 minutes (1/5 hour). You understand that if I am subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. Billing for ***court related work*** will be at two times the hourly rate, for a minimum of four hours. Cancellation for court related work is required 48 hours in advance to avoid a late cancellation fee.

You must *cancel* scheduled appointments 24 hours in advance; otherwise, you will be billed for half the normal session fee, even if the cancellation was unavoidable. *I require payment for services at the time of service* unless you have a health insurance company that requires a different arrangement. Payment for reports and court related work is required at the time of the request.

140 S Arthur, Suite 690, Spokane, WA 99202-2260

Phone: (509) 590-6339 Fax: (509) 535-7073 E-Mail: wendy@wendybiondi.com Website: www.wendybiondi.com

Agreement of Professional Services and Business Policies

A *late payment fee* of 1.5% per month will be added on *any balance after 60 days*. Any balance that goes unpaid after 90 days will be submitted to a *collection service* unless a payment agreement has been made with me. The fee to process a *returned check* is $30.

Billing for Services: I contract with **K Abbott Billing Service**, with whom I have a written agreement that contains terms that will protect your privacy. If you would like your health insurance company to be billed for our sessions, you will need to contact the billing manager, **Kristi at 509-725-0236** before your first appointment. Her office hours are Monday – Thursday 9 – 4. At intake, you will be asked to sign the **Insurance Information and Authorization Form** to complete billing.

Contacting Me: I am often not immediately available by telephone, but I do check my messages frequently throughout the day. I will make every attempt to return your call within the same business day. For true emergencies only, you can access assistance through the ***emergency pager*** at **(509) 623-2720**. The emergency pager coverage is shared among several colleagues, so you may not be able to reach me specifically. However, the therapist on call can help you in an emergency situation. If you feel that you cannot wait for me to return your call, you should contact your family physician, call the Crisis Line at (509) 838-4428, or go to the Sacred Heart Medical Center Emergency Room or the Emergency Room at your nearest hospital.

Concerns and Complaints: If for any reason you should have a concern or complaint about the services I deliver, ***please let me know.*** You also have the right to submit a complaint to the ***Washington*** State Department of Health, Health Professions Quality Assurance, PO Box 47860, Tumwater, WA 98501-7860, (360) 236-4700.

Client Agreement: When you sign this document, it will represent an agreement between us. You may revoke this agreement **in writing** at any time. That revocation will be binding unless we have taken action in reliance on it; there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or you have not satisfied financial obligations you have incurred. I will revoke this agreement if you have not made any contact or arrangements to reschedule after 120 days and you will no longer be consider a client under my care.

I have read and I understand and agree to the above-stated policies. (If you have any questions, please ask before signing).

_____	_____	_____
Print Name	Client or Legally Authorized Signature	Date

I have discussed this disclosure with the client:

_____	_____
Wendy A Biondi, LMHC Therapist's Signature	Date

Notice of Privacy Practices

Acknowledgement

My **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information.

By signing below, I acknowledge having been provided a **Notice of Privacy Practices**.

_____	_____	_____
Print Name	Client or Legally Authorized Signature	Date

140 S Arthur, Suite 690, Spokane, WA 99202-2260

Phone: (509) 590-6339 Fax: (509) 535-7073 E-Mail: wendy@wendybiondi.com Website: www.wendybiondi.com

Biondi; Agreement, 2/2015; 6/2014; 8/2012