Samaritan
Center of Puget Sound

Instructions for Completing Intake Paperwork

Welcome to Samaritan Center of Puget Sound. Please take a few minutes to complete and return the following paperwork in this packet before you meet with your therapist. It is highly recommended that you save a copy of this completed packet for your records.

Client Referral Information
Complete this form, which gives us basic information and helps us know how you heard about Samaritan Center.

Client Information
Complete one of these forms for yourself. Each additional person is to complete his/her own.

Notice of Privacy Practices
Please read prior to starting therapy, and keep for your records. This form does not need to be returned.

Informed Consent for Use of Email
Please complete and sign this form, which discusses the use of email for communication. You will discuss your methods of communication with your therapist. Note: This form is especially important to sign prior to returning any forms by email. If you choose not to return forms this way, talk with your therapist about alternative methods.

Fee Agreement
You may have clarified your fee with your therapist prior to your first session, or it may be set at the first session. Please read and sign at the bottom. Each additional person is to do the same. **Note:** If you do not plan to use insurance, write your initials in the space provided. Each additional person is to do the same. Your therapist will sign and return a completed copy to you.

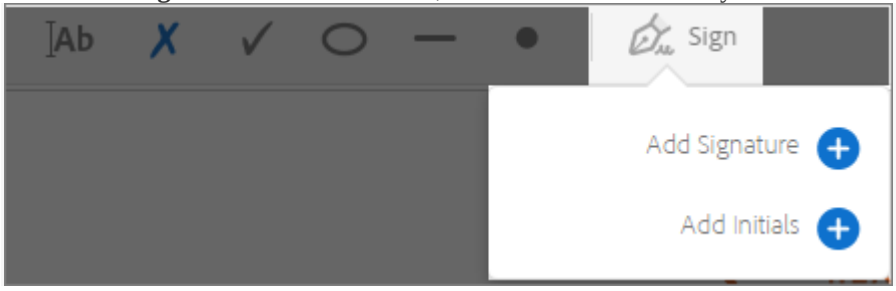
Insurance Information (two sides)
If you have insurance that you hope will help cover the cost of our service, please fill out this form and sign it in the **two** spaces provided. If you are meeting your therapist in our Main Office, ask the support staff to make a photocopy of your insurance card (front and back) to add to this packet. If you are filling the forms out and returning electronically, please include a scanned or photographed copy of the card. Although the information requested on the Insurance form appears redundant to what is on your insurance card, it is important that you complete the form entirely. If you are unsure about how to complete the Insurance form, ask your therapist to assist you.

Disclosure Statement
Please read this, print your name in the space for 'client name,' then sign and date where indicated on the last page. If you are coming with others, have them read and double-sign the last page as well. Your therapist will sign and return a completed copy to you.

Signing Forms Electronically

The enclosed PDF-fillable versions of these forms allow for digital signatures, which can help with easier transmission of files without printing. Below are some guidelines for digitally signing your forms.
Note: In order to sign your forms, it is recommended that you open this packet using Adobe Reader.

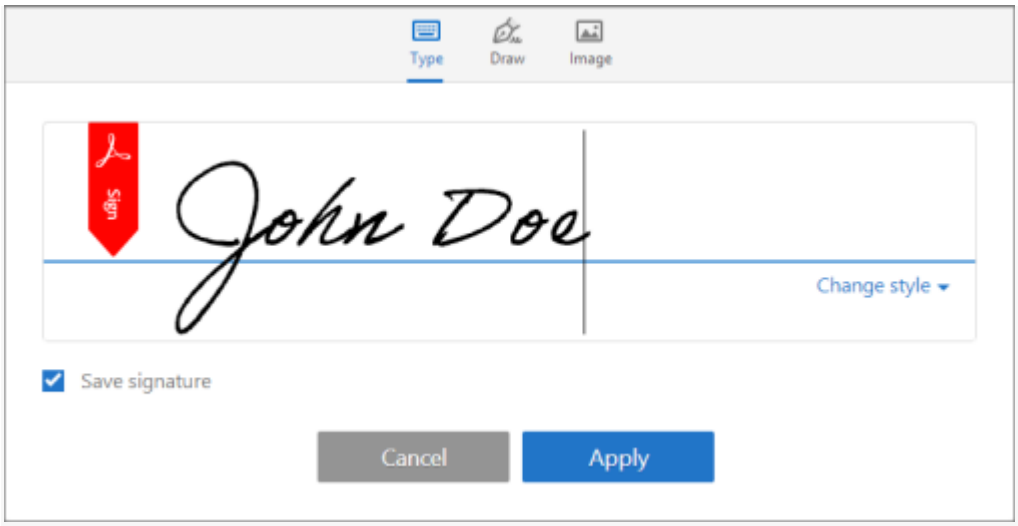
- Click the **Sign** icon in the toolbar, and then choose whether you want to add your signature or just initials.



If you have already added signatures or initials, they are displayed as options to choose from.

- If you've already added your signature or initials, just select it from the Sign options, and then click at the place in the PDF where you want to add your signature. Skip to the next step.

If you are signing for the first time, you see the Signature or Initials panel. Below is an example of the Signature panel.



You can choose to type, draw, or import a signature image. Added signatures and initials are saved for future use.

- **Type:** Type your name in the field. You can choose from a small selection of signature styles; click Change Style to view a different style.
- **Draw:** Draw your signature in the field.
- **Image:** Browse and select an image of your signature.
- **Save Signature:** When this check box is selected, and you're signed in to Acrobat Reader or Acrobat, the added signature is saved securely in Adobe Document Cloud for reuse.

Click **Apply**, and then click at the place in the PDF where you want to place the signature or initial.

Returning Forms

When you are finished completing this packet, please keep it in your possession and hand it to your therapist when s/he meets you (if your first meeting is in person). When meeting initially via teletherapy, you have the following options for returning forms:

1. You may send the completed forms to your therapist by **email** (please ensure you've read and signed the Informed Consent for Use of Email form).
2. You may use a secure, electronic **file-sharing program** to deliver to your therapist if you have access to one (i.e., Drop Box, Google Drive, OneDrive, etc.).
3. You may **hand-deliver** your forms to the Main Office mailbox (564 NE Ravenna Blvd., Seattle, WA 98115). Please use an envelope indicating the therapist's name and "New Client Forms"). The mailbox, which remains locked, has a drop slot on the side of the front door.
4. You may **fax** them to the Main Office at (206) 527-1009. Subj: New Client Forms
5. You may **mail** them to the Main Office (address above). Please send to:

   Samaritan Center of Puget Sound
   Administrative Dept.
   546 NE Ravenna Blvd.
   Seattle, WA 98115

Please note: If you are using methods 3-5, administrative staff will coordinate with your therapist in order for your therapist to sign and return copies of the forms to you. We will work as quickly as possible on this, though delays can occur.

Thank You,

Samaritan Center of Puget Sound

Samaritan
Center of Puget Sound

Thank you for choosing Samaritan Center of Puget Sound.

Name (s) _____ Today's Date _____

Are you a returning client? ☐ Yes ☐ No

Type of counseling you are seeking:

Individual ☐ Relationship (or Couple) ☐ Child ☐ Family ☐

Age of Primary Client (*please check one*)

☐ Under 13 years
☐ 13-18 years
☐ 19-64 years
☐ 65 + years

Gender of client(s) _____

Did you come because you had a specific therapist in mind? ☐ Yes ☐ No Name of therapist_____

If so, is the therapist on your insurance provider list? ☐ Yes ☐ No ☐ Don't Know

How were you referred to the counselor / agency? (*please include name – optional*)

nation

☐ Friend _____
☐ Relative _____
☐ Medical Professional _____
☐ Clergy _____
☐ Web Search _____
☐ Insurance Company _____
☐ Other _____

May we send a Thank You to them? ☐ Yes ☐ No

If yes, their contact address / information:

We appreciate your help to make our services more widely accessible.

Samaritan Center of Puget Sound

Chart # _____

Client: First Name _____ M.I. _____ Last Name _____ Date _____

Address _____
Street Address Apartment #

_____
City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address _____ Birthdate _____ Age _____
☐ *(Check if you authorize communication, including billing statements, to be sent to this address.)*

Occupation _____ Employer/School _____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity _____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

_____

If client is a minor, name/address/phone of custodial parent, if different from name above:

_____

Gross annual family income $_____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*
Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?
_____	____	____	_____	☐ Yes ☐ No
_____	____	____	_____	☐ Yes ☐ No
_____	____	____	_____	☐ Yes ☐ No
_____	____	____	_____	☐ Yes ☐ No
_____	____	____	_____	☐ Yes ☐ No

Religion _____ Place of worship _____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

Emergency Contact Name _____ Phone _____

PLEASE CONTINUE ON PAGE 2 ↳

Chart # _____

Physician's Name _____Phone _____ Date of last exam _____

Physician's Address_____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: ☐ *(Please sign a release of information with your therapist for this purpose.)*

List any surgeries or illnesses you have had the past five years_____

_____

_____

List any medications, including the amount that you currently take or have taken in the past 3 months:

Medication	**Dosage**	**Purpose**	**Start Date**

What is your purpose in coming to Samaritan at this time?

Have you done previous counseling/therapy? ☐ Yes ☐ No If yes, when?_____

Name of Previous Therapist(s) _____ Purpose/issues at that time:

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

FOR THERAPIST'S USE

Therapist:_____ **Office:**_____ **Fee (90791):** _____ **Fee (90834/47):** _____ **Date:** _____

Payment: ☐ Ins***** ☐ Samaritan Fund (requires therapist's application) ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e., church) ☐ Self-pay

***** Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

File: ☐ Individual ☐ Couple ☐ Family (Number of family members _____) ☐ Group ☐ Child/Adolescent

If Couple or Family, check one: ☐ **Primary client** ('patient' for insurance purposes; contact for scheduling) ☐ **Additional client(s)**

Samaritan
Center of Puget Sound

INFORMED CONSENT
FOR THE USE OF EMAIL

Samaritan clients wishing to communicate with their therapist and/or administrative staff using email are welcome to do so. However, there are a number of privacy concerns and potential risk factors which should be considered before transmitting confidential information by email.

General concerns include: email is immediately broadcast worldwide and can be received by unintended recipients; email messages can be forwarded without the sender's or intended recipient's permission or knowledge; email can easily be misaddressed; back-up copies of emails may exist after the sender or the recipient has deleted them; and email is easier to falsify than documents that are signed and sent as regular mail through the postal service.

Privacy concerns related to a one's personal health information also need to be considered, and are detailed below. Please read the following information outlining Samaritan's conditions for the use of email:

- Samaritan Center of Puget Sound cannot guarantee that electronic communications will be private. Samaritan takes reasonable steps to protect confidentiality but is not liable for improper disclosure of confidential information not caused by negligence or misconduct.

- If the client chooses to use email, the client is responsible for informing Samaritan of any limitations to the kind of information that will be sent by email.

- The client is responsible for protection of their own password or other means of access to email sent or received. Samaritan is not liable for breaches of confidentiality caused by the client.

- Because employees do not have a right of privacy in their employer's email system, clients should not use their work/business system to send or receive confidential medical information.

- When an email is received by a Samaritan therapist or administrative staff person, there will be an attempt made to read it promptly and, when appropriate, respond. However, Samaritan cannot assure a specific time frame and suggests sending a follow-up email or phone call if some time has passed.

- Emails concerning diagnosis and/or treatment become part of the client's medical record and is available to certain authorized entities such as health care providers and insurers for the purposes of treatment and reimbursement. While emails may be forwarded within the agency for these purposes, Samaritan will not forward the email outside the agency without the consent of the client or as required by law. (Please see your therapist's disclosure statement for details.)

- **Email should not be used when transmitting sensitive medical information.**

- **Email should not be used in the case of a medical emergency.**

Please continue to the back to sign your agreement to these conditions.

I have read the above privacy concerns and conditions for the use of email and consent to the use of email for communications to and from Samaritan Center of Puget Sound.

_____ _____

Signature of Client Date of Signature

_____

Printed Name of Client

INDIVIDUAL COUNSELING FEE AGREEMENT
PSYCHOLOGIST LEVEL THERAPIST

Appointments:

We are pleased that you have chosen Samaritan Center for your counseling. Counseling sessions include the time used for scheduling and payment. When you need to cancel or reschedule an appointment, please give us at least 24 hours notice. Because your therapist has committed that specific time to your session, our policy is to charge the full fee for late cancellations or missed appointments. Insurance does not reimburse for missed appointments.

Samaritan Fee Policies:

Payment is due at each session. Please make your check payable to Samaritan Center. If your account becomes two sessions past due, our policy is to not schedule additional appointments until payments are current or an installment plan is arranged.

During the course of your counseling, if you need additional services for such things as extended sessions, phone consultations, reports, correspondence or the copying of records, we will prorate charges for these services.

For those with financial need, we try to arrive at an adjusted fee. Our ability to adjust fees depends on the resources available to Samaritan.

By signing this document, you agree to pay all charges for services received. If you use insurance to cover some or all of your counseling at Samaritan Center, you agree to pay any amount that your insurance carrier does not pay. This may include, but is not limited to services and charges determined by your insurance carrier not to be medically necessary, and/or services and charges not covered by your insurance plan.

Samaritan Fees:

The standard fees for an individual counseling session are:

Diagnostic Evaluation Fee:	$230.00
45-minutes	$155.00
60-minutes	$205.00
Other_____	$_____
_____	$_____

My initials here _____ indicate I do not plan to use insurance.

I have read, understand, and agree to the above.

Client(s) Signature _____ Date _____

*Guarantor Signature _____

Therapist Signature _____

**Guarantors do not have access to confidential client information.*

Samaritan
Center of Puget Sound

Chart # _____

INSURANCE INFORMATION

Client: First Name_____M.I.____Last Name_____

Social Security # _____ Birth Date _____ Gender _____
(Medicare, Tricare, and United Healthcare only)

Is there is a specific injury or illness which precipitated coming for counseling: _____

Is patient's Condition Related to: Employment ☐ Auto Accident ☐ Other Accident ☐

State in which occurred _____

Date of current injury or illness _____ Date of same or similar condition _____

Work lost due to current condition from _____ to _____

Hospitalization due to current condition from _____ to _____

Client or Authorized Person's Signature:

I authorize payment of medical benefits to Samaritan Center of Puget Sound.

Signed _____ ***Date*** _____

I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed _____ ***Date*** _____

To be completed by therapist

Therapist:_____ Provider Number:_____

Prior authorization number (if required):_____

Diagnosis: _____ _____ _____

CPT (Procedure) Code _____ _____ _____ _____ _____ _____

In which office will this client be seen?

FOR OFFICE USE ONLY:

Insurance carrier:

Coverage:

$_____Client Co-Pay

_____% Client

_____% Payment

$_____Deductible ☐ Met

$_____Remaining

_____ # of Sessions ____ # Remaining

Policy Effective and End Date:_____

Referral: ☐ None Needed ☐ P.C. Physician

Comments:

Authorization:

☐ None ☐ Regence ☐ +ÁÉÓÅÒ 0ÅÒ Í ÁÎÅÎÔÅ ☐ UBH

Other _____

Authorization #:_____

# of Sessions Auth. _____

Authorization Date From: _____

☐ Fee Schedule Unavailable

Code	Allowed	% Amt	Code	Allowed	% Amt
☐ 90791	$ _____	/ _____	☐ 90832	$ _____	/ _____
☐ 90834	$ _____	/ _____	☐ 90837	$ _____	/ _____
☐ 90847	$ _____	/ _____	☐ 90846	$ _____	/ _____

Comments:

Chart # _____

INSURANCE INFORMATION
(CONTINUED)

Insurance Company Information—Primary Coverage

Policy Holder Information *(complete section below **IF** policy holder is not client—**OR**—copy of card is not present)*:

First Name _____ M. I._____ Last Name _____

Address_____

City_____ State_____ Zip _____

Birth Date _____ Gender_____

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? Y ☐ N ☐ Insured's Social Security # _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip _____

ID number _____ Group number_____
include alpha prefix if present

Insurance Company Information—Secondary Coverage

If there is another health benefit plan complete the following.

Other Insured Information:

First Name _____ M. I._____ Last Name_____

Birth Date _____ Gender_____

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? Y ☐ N ☐ Insured's Social Security # _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip _____

ID number _____ Group number_____
include alpha prefix if present

Samaritan
Center of Puget Sound

TERMS IMPORTANT IN UNDERSTANDING THE HIPAA PRIVACY RULE

Health Information:

Any information, whether oral or recorded in any form, created or used by health care professionals or health care entities.

Individually Identifiable Health Information: A subset of Health Information that either identifies the individual or that can be used to identify the individual.

Protected Health Information (PHI)

Individually Identifiable Health Information becomes Protected Health Information when it is transmitted or maintained in any form or medium. More specifically, PHI is information that relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of health care to individual; and that identifies the individual or could reasonably be used to identify the individual.

Psychotherapy Notes

Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session, and that are separated from the rest of the individual's medical record.

Use and Disclosure

The privacy rule defines "use" as the sharing, employment, application, utilization, examination or analysis of individually identifiable health information within an entity that maintains such information.

The privacy rule defines a "disclosure" as the release, transfer, provision or access to, or divulging in nay other manner of information outside the entity holding the information.

The definition of the privacy rule specifically excludes information pertaining to medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis and process to date.

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 it carefully.

We have a legal responsibility under the laws of the United States and the state of Washington to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on March 26, 2013 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices would affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Samaritan Center of Puget Sound. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no additional charge to you.

Here are some examples of how we use and disclose information about your health information.

Section I: Permissible uses and disclosures without your written authorization.

We may use or disclose your health information without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center’s operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

7. When required or permitted to do so by law. For example, to appropriate authorities if your therapist reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your health information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law
8. We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

Section II

With written permission: We may use or disclose your health information to anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.

Psychotherapy Notes: Notes recorded by your therapist documenting the contents of a counseling session with you ("Psychotherapy Notes") are not part of your health information. They will be used only by your therapist and will not otherwise be used or disclosed without your written authorization.

As a client of Samaritan Center of Puget Sound, **you have these important rights:**

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. You will be charged a fee for making these photocopies, based on the total number of pages. For more information about the current price per page, contact the Samaritan front office.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

HIPAA Security Officer:	**Address:**
Matthew Percy, Psy.D. **Telephone: (206) 527-2266** **Fax: (206) 527-1009** **E-mail: mpercy@samaritanps.org**	**Samaritan Center of Puget Sound** **564 NE Ravenna Blvd.** **Seattle, WA 98115**

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Samaritan
Center of Puget Sound

restoring hope . . . reconciling relationships . . . transforming lives

Welcome to Samaritan Center of Puget Sound.

We are pleased that you have chosen Samaritan for assistance at this time in your life. We hope that you will find this to be a positive and useful experience.

About Samaritan Center

Samaritan Center of Puget Sound is accredited by the Samaritan Institute and affiliated with the Presbytery of Seattle. Our therapists come from a variety of Christian faith perspectives and represent a wide range of ages and life experiences. They are interested in and respectful of the spiritual values, beliefs and cultural heritage of all persons.

In providing therapy, we seek to engage in a process that is attentive to the integration of mind, body and spirit. We believe that healing occurs on multiple levels – mind, body, spirit and soul – and are always willing to consider with our clients the physical and spiritual as well as psychological aspects of healing. We are curious about the part that spirituality plays in wrestling with life's dilemmas and transition points, and we bring our own heartfelt responses to the situations in which our clients find themselves. We endeavor to promote growth and well-being in our clients, engaging with them in a collaborative manner to make the changes that they desire in their lives.

Parking at the Ravenna Office:
Off-street parking is available in the lot adjacent to the Church, as well as along Ravenna Blvd.

Young Children:
Please do not leave young children unattended in the waiting room. We cannot be responsible for their safety.

Crisis Calls:
In the event of a personal crisis, clients may call Samaritan's on-call therapist at 206-527-2266. To leave a message for the on-call therapist during office hours (M-F 9am-6:30pm), clients should press 0 during the recorded message, or, if the call is made outside of office hours, press 6. If the call is not returned by the on-call therapist after a half hour, clients should call the Crisis Clinic at 206-461-3222.

Non-Crisis Calls:
To leave a non-crisis message, to cancel or change an appointment with your therapist, call 206-527-2266 and follow the voice prompt.

On the following pages you will find information that will ensure that your needs as an informed client are met. This includes the training, professional background of your therapist, his or her theoretical orientation and approach to therapy, the rights of clients in therapy, and information about confidentiality.

DISCLOSURE STATEMENT

NEAL TENG

Training and professional background:

Neal Teng, Ph.D., is a licensed clinical psychologist (license #904) and a member of the American Psychological Association. Dr. Teng has been a staff psychologist at Samaritan Center of Puget Sound since 1984.

B.A. with distinction, psychology, Stanford University
Ph.D., clinical psychology, University of Washington
Clinical psychology internship, Neuropsychiatric Institute, UCLA Medical Center
Postdoctoral fellow, clinical/counseling psychology, University of California at Berkeley.

Theoretical orientation and approach to counseling:

The approach to counseling will vary, depending on the issues to be resolved and individual client needs. Counseling may include but is not limited to cognitive-behavioral or psychodynamic approaches, pastoral counseling, family of origin work, etc.

Rights of Clients

It is appropriate for clients to raise questions about the therapist, the therapeutic approach, the progress of therapy, and the cost. As informed consumers, it is the client's responsibility to choose the therapist and therapeutic modality which best suits their needs. Clients have the right to request a change in therapeutic approach, referral to another therapist, or termination at any time. In addition, clients have the right to refuse treatment.

All therapists at Samaritan Center of Puget Sound are bound by the ethical codes of their professional organizations, by the laws of the State of Washington, as well as by agency policy regarding the special nature of the therapist-client relationship. This agency expects all therapists to continually be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her therapist is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the therapist and/or bring it to the attention of the agency's President/CEO. If you suspect that your therapist's conduct has been unprofessional (as defined by RCW 18.130.180), you may contact the Department of Health by phone at 360-236-4700 or mail : Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857.

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. To see your record, or get more information about it, contact your therapist.

Confidentiality

Counseling sessions are held in strict confidence. In general, it is the client or the guardian of a minor child (age 12 and under) guardian, not the therapist, who determines whether protected health information may be released outside Samaritan Center of Puget Sound. However, there are some exceptions to this rule:

1. Washington State Law requires that suspected abuse or neglect of a child (anyone under the age of 18) be reported.

2. Washington State Law requires that suspected abuse, abandonment, neglect, or financial exploitation of vulnerable adults be reported.

3. Washington State Law requires that others be informed if your therapist has reasonable cause to believe that you are gravely disabled or present an imminent likelihood of serious harm to yourself or others. If a threat against others is perceived to be serious, the proper individuals must be contacted; this may include the individual against whom the threat is made.

4. Washington State Law requires that behavior by healthcare professionals which is unprofessional or poses a clear and present danger to patients or clients be reported to the Washington Department of Health.

5. In the event of a medical emergency, emergency personnel may be given necessary information.

6. If you bring a complaint against your therapist with the State of Washington Department of Health, information will be released.

7. In the event of a court order, therapists may be required to disclose information in the presence of a judge.

8. In the event of your death or disability, the information may be released if your personal representative or the beneficiary of an insurance policy on your life signs a release authorizing disclosure.

9. In order to ensure the highest quality of care, your therapist may seek consultation and supervision from other therapists; in these circumstances, identifying information is protected and confidentiality rules bind the consultants.

10. Health information, excluding Psychotherapy Notes, may be disclosed without written authorization from you for the purposes of treatment, payment, and health care operations. Examples of these types of disclosures are listed in Section I of the Notice of Privacy Practices for Samaritan Center of Puget Sound.

11. If you provide written authorization to disclose information to an identified third party for a specified purpose, your therapist will disclose it. You may revoke this authorization in writing at any time. When you revoke an authorization it will only impact shared health information from that point on.

By my signature below, I acknowledge that I have received, read, and understand the Disclosure Statement.

Signature of Client or Personal Representative_____ Date _____

Signature of Client or Personal Representative_____ Date _____

Therapist Signature _____ Date _____
Neal Teng, Ph.D.

By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices for Samaritan Center of Puget Sound.

Signature of Client or Personal Representative_____ Date _____

Signature of Client or Personal Representative_____ Date _____

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

You will receive one copy of this form and one will be kept in your Samaritan record.