Joseph Elias, MA, NCC, LMHC
901 N. Monroe St., Ste. 356
Spokane, WA 99201
(509) 492-5503

Thank you for entrusting me with the opportunity to work with you. I want my office to be a place of encouragement and effective change. I realize the investment of your time, energy and resources is valuable, and I am grateful that you have chosen me to help you in the process of counseling and healing. Please take a moment to read the enclosed paperwork.

Before your appointment, please read the Practice Policies and Treatment Contract (attached). It is important to read this prior to your first appointment. I am happy to discuss the details with you and answer any questions you may have before we begin our initial session.

Upon arrival for your appointment, please stay in the waiting room of suite 356 and I will call you back to the office when it is time for you to be seen. If for any reason you have trouble entering the building (i.e. late/weekend appointments), please call me for assistance.

I look forward to meeting with you.

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PROFESSIONAL DISCLOSURE STATEMENT

Licensed Mental Health Counselor in Washington # LH 60512800

I invite you to read this prior to selecting me as your counselor. This document is part of the standards of practice of the Washington Board Licensed Mental Health Counselor (LMHC). The Disclosure Statement is designed to inform you of my professional credentials, my experience and training, and types of services offered.

Training

Master of Arts in Community Counseling, Gonzaga University, 2012
Circle of Security Parenting, Circle of Security International, 2013
Mindfulness, Institute for Better Health, 2015
Motivational Interviewing, Frontier Behavioral Health, 2016
Cognitive Behavioral Therapy Plus, Harborview Center, 2016

Counseling Experience

Panic Disorder
Attachment
Adult, Child, & Family
Anger management
Anxiety and/or Fears
Self Esteem
Behavioral Issues
Sexual Abuse
Chronic Impulsivity
Coping Skills
Depression
Mood Disorders
Thought Disorders
Family Conflict
Trauma
Phobias
LGBTQ Issues
Mindfulness
Peer Relationships/Social Skills
Self-Harm Behaviors
Sleep or Insomnia
Suicidal Ideation
OCD (Obsessive Compulsive)
Personality Disorders
Rejection Sensitivity
Loss or Grief
Emotion Regulation

Confidentiality Practices

Information you share with me will be regarded with respect and handled in a professional manner. In most situations, I will request a Release of Information to be signed before communicating with others. Limits to confidentiality include any concern that you will harm yourself or others and court orders that request information. I am also mandated to report any suspected abuse or neglect of a vulnerable person (child, disabled, or elderly individual). You

will be given a copy of my Notice to Privacy and you will be asked to sign client consent for use and disclosure of protected health information.

Complaint Procedures
If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or whether referral would be appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, contact:

Washington State Board of Licensed Mental Health Counselors
HSQA Complaint Intake
PO Box 47857
Olympia, WA 98504-7857

I encourage you to voice any questions or concerns about the counseling process and/or the therapeutic relationship as soon as they arise. Please sign your name below if you have read and understand the above information and voluntarily agree to participate in such services.

_____ _____
Signature of Consumer (13 years and older) Date

_____ _____
Signature of Consumer (13 years and older) Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Counselor Date

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Practice Policies and Treatment Contract

Thank you for choosing me as your mental health care provider. Here is some information about our treatment partnership that you will find useful including important information about services and business policies.

Waiting Room and Supervision of Minors

Our waiting room area does not have a receptionist and is not setup to accommodate unattended young children. We cannot take responsibility for providing supervision of children left unattended. Either a parent of a minor or a responsible party (18 years or older) must remain on the premises during the child's appointment.

If a child is attending regular therapy appointments and is brought to the appointment by another adult, means for payment or copayment must be arranged beforehand by means of credit card authorization form.

Missed Appointment Policy

Your appointment time is reserved exclusively for you. To promote efficient access for services, I require that any appointment that is no longer needed or unable to be kept be cancelled **at least 24 hours in advance** so that other patients waiting to be seen are able to access the open timeslot. Monday appointments will need notification before 7 pm the preceding Friday.

If you miss an appointment or cancel with less than 24 hours' notice, there will be a charge of $50 for the appointment time. I may grant exceptions to the missed appointment fee at my discretion. Continued occurrences of late cancellations or missed appointments may result in cancellation of "recurring" appointments or discharge from services. ***Please note that missed appointments are not covered by insurance.***

After Hours and Urgent Care

For any potentially life threatening emergency, call 911 or go to your nearest emergency room. If there is an urgent need and you unable to reach me, please contact the First Call for Help Crisis Line at 509-838-4428. This service is available 24 hours a day, 365 days a year. Please

do not leave emergency messages on my voicemail as I may not receive them in a timely manner.

Insurance and Payment

INTAKES AND THERAPY APPOINTMENTS:		
New Client Intake Assessment Session:	**60-90 minutes**	**$225.00**
Therapy Session (Individual and/or Family):	**46-60 minutes**	**$150.00**
Therapy Session (Individual and/or Family):	**45 minutes or less**	**$112.50**

ALL FEES ARE DUE AT THE TIME OF SERVICE: I am required by insurance companies to collect co-payments at the time of service. For minors, the parent or legal guardian (in the case of divorced parents) that requests the appointment is responsible for the co-payment.

Payment through medical insurance: I will bill your insurance company for covered services rendered and agree to accept the allowed insurance reimbursement rate (whether I am considered a preferred provider or an out-of-network provider). Every insurance plan is different regarding coverage and co-payment. I'm currently in-network with First Choice, Kaiser, Aetna, and Asuris. I am able to accept Premera Blue Cross, Regence Blue Cross, and Lifewise in-network under Sarah Shears, MSW, LICSW, LMHC.

By signing this form, **you acknowledge that you have contacted your insurance company, that you understand the details of your plan's coverage for mental health services, and that you know your financial responsibilities for services rendered.**

Self-Pay and Uninsured Clients

(Please note: If I am an in-network provider with your insurance company, you cannot self-pay.)

I offer a 50 % discount on my regular fees (noted above) when you pay for your session, in full, at the time of service.

Payment for services is an important part of any professional relationship. If you are unable to pay at the time of service, no service will be rendered. You can pay with cash, check, debit or credit card. A charge of $50.00 charge will be added to your account balance if your payment by check is denied by your financial institution for any reason. Please always come prepared to pay your expected co-pay and co-insurance amount. I will then make any adjustment (if needed) after I receive back the Explanation of Benefits from your insurance company for that service.

It works against the therapeutic process to allow clients to carry an outstanding balance for services rendered. Therefore, as long as an account has an outstanding balance, no additional services will be provided or scheduled. In the *rare* event that you have an outstanding balance for longer than 30 days, you will be charged a 10% finance charge. Every month you carry a balance will result in another 10% finance charge. In the *exceptionally rare* event that you have an outstanding balance longer than 90 days, I will refer your account to an attorney or agency for collection. Any additional charges accrued in the process of collections will be added to the outstanding balance owed. PLEASE NOTE: Insurance will not cover finance fees.

Other Fees

Fees are available upon request. Charges will be made for services rendered outside appointment times, such as report and letter writing, form completion and telephone calls lasting longer than 10 minutes.

Confidentiality

Communication between mental health provider and patient are accorded strict confidentiality. The few exceptions are: situations when a person has serious and imminent plans to harm him or herself or someone else; if a person is unable to provide adequate and essential care for him or herself; or in cases in which mental health providers are bound by law to report, such as suspected child or elder abuse. Please bring any questions about limits of confidentiality to my attention and I will provide further clarification.

Patients who are 13 and older have the right to confidentiality for their mental health treatment under Washington State Law.

Termination

You have the right to terminate treatment with me at any time. However, before coming to this final decision, I would encourage you to discuss your concerns with me. Likewise, I may also terminate care if in my opinion I cannot meet your mental health needs in a professionally ethical and appropriate manner.

Consent for Treatment

I am requesting services for me or my child. I have been provided information regarding office policies, including fee agreement, missed appointments and late cancellations, extent of confidentiality, professional information about Joseph Elias, MA, NCC, LMHC. My signature below means that I have read, understand, accept and agree to the terms and conditions of the practice of Joseph Elias, MA, NCC, LMHC. If the patient is under the age of 13 or unable to

consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Print Name: _____

Signature: _____

Date: _____

Joseph Elias, MA, NCC, LMHC
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TODAY'S DATE: _____

PRE AUTH 1 REFERRAL NEEDED Y/N
DIANOSIS _____
REFERRED BY_____
PRIMARY CARE DR. _____
PHONE # _____

Patient Name: _____ Date of Birth: _____ Male/Female____

SS# _____ Marital Status: __Married __Single __Divorced __Widowed __Partner

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Ok to call? Y/N_____

Cell Phone: _____ Ok to call? Y/N _____

Employer/School: _____ Ok to call? Y/N _____

IF PATIENT IS A CHILD

Mother's Name: _____ Date of Birth: _____ SS#: _____
(Enter Responsible Party's Name if not Biological parent)

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Ok to call? Y/N_____

Work Phone: _____ Ok to call? Y/N _____

Cell Phone: _____ Ok to call? Y/N _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Subscriber Name: _____ Subscriber ID #: _____

Group #: _____ Employer: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Subscriber ID #: _____

Group #: _____ Employer: _____

I understand that Joseph Elias and/or his billing personnel will use the above information for billing purposes.

I acknowledge that it is my responsibility to contact my insurance company to verify my outpatient mental health benefits as well as to obtain and maintain an authorization to see Joseph Elias, MA, NCC, LMHC and maintain a required authorization from my insurance company. I understand that I will be financially responsible for the visits denied due to lack of authorization. I further understand that I am fully responsible for all payment of the services provided.

I hereby authorize payment directly to Joseph Elias, MA, NCC, LMHC for his regular charges for the services provided. I understand that I remain financially responsible to Joseph Elias, MA, NCC, LMHC for all charges that I incur.

Signature: _____ Date: _____

Acts of Unprofessional Conduct

RCW 18.130.180

Unprofessional conduct.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by RCW 18.130.345, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon

demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

_____ _____

Signature of Consumer (13 years and older) Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Provider (Name and Credentials) Date

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

***Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**

***Obtain payment from designated third-party payers.**

***Conduct normal healthcare operations such as quality assessments or evaluations, and physician certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name: _____ Date of Birth _____

Signed (Patient or Legal Representative for Patient): _____

Legal Representative's Relationship to Patient: _____

Date: _____

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