Reid Stell Counseling

Client Registration Information

Please PRINT and complete ALL sections below. Thank you!

PERSONAL INFORMATION

Name: ______________________ (last name) ______________________ (first name) ______ (initial)

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Cell Phone: (_____) ____________________ Work Phone: (_____) ____________________ Home Phone: (_____) ____________________

Address: ________________________________ Apt. #: _____ City: ________________ State: ____ Zip: ________

Driver's License No.: ________________________ Issue Date: _____ / _____ / _____

Email Address: ____

INSURANCE INFORMATION

Please present insurance cards to the front desk.

PRIMARY Insurance Name: ____

Name of Policy Holder: ____________________________ Date of Birth: _____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Member ID: ____________________________ Group No: _________________________

SECONDARY Insurance Name (IF APPLICABLE) ____

Name of insured: __________________________________ Date of Birth: _____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Number: ________________________________ Group No.: _____________________________

EMERGENCY INFORMATION

Name: ____ Relationship: ____________________________________

Address: ____ City: ____________________ State: ____ Zip: ____________

Cell Phone: (_____) ____________________ Work Phone: (_____) ____________________ Home Phone: (_____) ____________________

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Reid Stell Counseling for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. If I am the parent of an adolescent client (aged 13 to 18), I acknowledge I am not the client and can only receive information pertinent to scheduling and billing.

Client Signature: ____

Date: ________________

Parent Signature (if client is under 18): ____

Date: ________________

CONFIDENTIAL CLIENT INTAKE INFORMATION

M. Reid Stell, LMHC
Reid Stell Counseling
14535 Bel-Red Rd, B-202
Bellevue, WA 98007

O *(206) 457-3038*
F *(206) 858-9206*
ReidStellCounseling@gmail.com

RELATIONSHIP INFO:

Relationship Status: Single Married Cohabitating Divorced Widowed

Sexual/Gender I.D.: ____

EMPLOYMENT/EDUCATION INFO:

Employment Status: Full-Time Part-time Unemployed Retired Self-Employed

Occupation: ______________________________ Employer: ____

Student Status: Full-Time Part-Time Non-Student Current School: _________________________

Highest Level of Education: ______________________ Degree: _____________________________________

HEALTH INFO:

Health Issues: ____ Date of last Physical: _______________

Medications & Dosages: ____

ADDITIONAL INFO:

For this section, please give concise, honest answers. If you are uncomfortable answering a question, feel free to leave it blank.

What is your opinion about counseling? Have you been before?

____

What are your most pressing issues at the moment?

____

Do you have any prior diagnoses from a doctor or mental health professional?

____

Do you have any physical or learning disabilities I should know about?

____

Have you ever attempted suicide or been hospitalized for hurting yourself? If so, when?

____

Do you currently have any suicidal or homicidal thoughts, plans, or concerns?

____

Are you or have you ever suffered from addiction of any sort?

____

Is there other information that could be helpful for me to know?

____

Reid Stell Counseling
HIPAA and Washington State Notice of Rights and Privacy Practices

NOTICE:

I keep a record of the health care services I provide you. You may ask me to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it at Reid Stell Counseling, 14535 Bel-Red Rd, Suite 202, Bellevue, WA 98007.

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.

Your health record contains personal information about you and your health. State and Federal law protects the confidentiality of this information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health, or condition, and related health care services. If you suspect a violation of these legal protections, you may file a report to the appropriate authorities in accordance with Federal and State regulations.

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 to your PHI. This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control 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 of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by sending you an electronic copy, sending a copy to you in the mail upon your request, or providing one to you in person.

How I am permitted to Use and Disclose Your PHI

For Treatment. I may use medical and clinical information about you to provide you with treatment services.
For Payment. I may use and disclose medical information about you so that I can receive payment for the treatment services provided to you.
For Healthcare Operations. I may use and disclose your protected PHI for certain purposes in connection with the operation of my professional practice, including supervision and consultation.
Without Your Authorization. State and Federal law also permits me to disclose information about you without your authorization in a limited number of situations, such as with a court order.
With Authorization. I must obtain written authorization from you for other uses and disclosures of your PHI. You may revoke such authorizations in writing in accordance with 45 CFR. 164.508(b)(5).
Incidental Use and Disclosure. I am not required to eliminate every risk of an incidental use or disclosure of your PHI. Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to protect your PHI, and the information being shared was limited to the minimum necessary.

Examples of How I May Use and Disclose Your PHI

Listed below are examples of the uses and disclosures that I may make of your PHI. These examples are not meant to be a complete list of all possible disclosures, rather, they are illustrative of the types of uses and disclosures that may be made.
Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation or supervision activities with other health care providers, or referral to another provider for health care services.
Payment. I may use your PHI to obtain payment for your health care services. This may include providing information to a third-party payor, or, in the case of unpaid fees, submitting your name and amount owed to a collection agency.
Healthcare Operations. I may use or disclose your PHI in order to support the business activities of my professional practice including; disclosures to others for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to assist in the delivery of health care, provided I have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments.

Other Uses and Disclosures That Do Not Require Your Authorization

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 of this type of disclosure include healthcare licensure related reports, public health reports, and law enforcement reports. Under the law, I must make certain disclosures of your PHI to you upon your request. In addition, I must make disclosures to the US Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of privacy rules.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If I disclose PHI to a health oversight agency, I will have an agreement in place that requires the agency to safeguard the privacy of your information.

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the required mandated report.

Deceased Clients. I may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Criminal Activity or Threats to Personal Safety. I may disclose your PHI to law enforcement officials if I reasonably believe that the disclosure will avoid or minimize an imminent threat to the health or safety of yourself or any third party.

Compulsory Process. I may be required to disclose your PHI if a court of competent jurisdiction issues an appropriate order, and if the rule of privilege has been determined not to apply. I may be required to disclose your PHI if I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, no protective order has been obtained, and a competent judicial officer has determined that the rule of privilege does not apply.

Essential Government Functions. I may be required to disclose your PHI for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Law Enforcement Purposes. I may be authorized to disclose your PHI to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if I suspect that criminal activity caused the death; (5) when I believes that protected health information is evidence of a crime that occurred on my premises; and (6) in a medical emergency not occurring on my premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Psychotherapy Notes. If kept as separate records, I must obtain your authorization to use or disclose psychotherapy notes with the following exceptions. I may use the notes for your treatment. I may also use or disclose, without your authorization, the psychotherapy notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the Washington Department of Health or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law.

Uses and Disclosures of PHI with Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. I will not make any other uses or disclosures of your psychotherapy notes, I will not use or disclosure your PHI for marketing proposes, and I will not sell your PHI without your authorization. You may revoke your authorization in writing at any time. Such revocation of authorization will not be effective for actions I may have taken in reliance on your authorization of the use or disclosure.

Your Rights Regarding Your PHI

You have the following rights regarding PHI that I maintain about you. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

Right of Access to Inspect and Copy. You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as I maintain the record. A "designated record set" contains medical and billing records and any other records that I use for making decisions about you. Your request must be in writing. I may charge you a reasonable cost-based fee for the copying and transmitting of your PHI. I can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right of recourse to the denial of access. Please contact me if you have questions about access to your medical record.

Right to Amend. You may request, in writing, that I amend your PHI that has been included in a designated record set. In certain cases, I may deny your request for an amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You may request an accounting of disclosures made for treatment purposes or made as a result of your authorization, for a period of up to six years, excluding disclosures made to you. I may charge you a reasonable fee if you request more than one accounting in any 12-month period. Please contact me if you have questions about accounting of disclosures.

Right to Request Restrictions. You have the right to ask me not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for restrictions must be in writing and I am not required to agree to such restrictions. Please contact me if you would like to request restrictions on the disclosure of your PHI.

You also have the right to restrict certain disclosures of your PHI to your health plan if you pay out of pocket in full for the health care I provide to you.

Right to Request Confidential Communication. You have the right to request to receive confidential communications from me by alternative means or at an alternative location. I will accommodate reasonable written requests. I may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. Please contact me if you would like to make this request.

Right to a Copy of this Notice. You have the right to obtain a copy of this notice from me. Any questions you have about the contents of this document should be directed to me.

Right to Opt Out. You have the right to chose not to receive fundraising communications. However, I will not contact you for fundraising purposes.

Right to Notice of Breach. You have the right to be notified of any breach of your unsecured PHI.

Mental Health Advance Directive

You have the right to file a Mental Health Advance Directive (MHAD) with me. A MHAD is a legal written document that describes what you want to happen if your mental health problems become so severe that you need help from others. This might be when your judgment is impaired and/or you are unable to communicate effectively. It can inform others about what treatment you want or don't want, and it can identify a person to whom you have given the authority to make decisions on your behalf. You can download, print, and fill out a MHAD form from my website and I will retain it with your records. Complaints concerning noncompliance with your MHAD should be referred to the DOH.

Contact Information

I act as my own Privacy and Security Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:

Reid Stell Counseling, PLLC
14535 Bel-Red Rd, Suite B-202
Bellevue, WA 98007

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing with me, as my own Privacy Officer, as specified above. You also have the right to file a complaint in writing to the Washington Department of Health or to the US Secretary of Health and Human Services. I will not retaliate against you in any way for filing a complaint.

Effective Date

Effective date of this notice: March 16, 2020

DISCLOSURE STATEMENT

Your Rights and Responsibilities, Under Washington State Law
As a Client of Reid Stell Counseling

M. Reid Stell, LMHC
Reid Stell Counseling
14535 Bel-Red Rd, Suite B-202
Bellevue, WA 98007
(206) 457-3038
ReidStellCounseling@gmail.com

State of Washington Department of Health License Number: LH 60425029

Therapeutic Orientation

Whether you want to solve a particular problem, make a decision, or understand what is happening in your life, my commitment to you is to collaborate with you as a partner. Though this is your journey, you need not face the challenges alone.

I will help you explore what has worked for you in the past as well as patterns that may have proven counterproductive. I use psychodynamic, cognitive-behavioral, and family systems techniques to focus on building solutions based on achievable goals. If you would like clarification about these therapeutic orientations, I will be happy to explain them.

Education and Credential

I hold a Master of Arts degree in Counseling Psychology from City University of Seattle, where I also fulfilled my internship. I have been granted the title of Licensed Mental Health Counselor by the Washington State Department of Health. This license is current as of the date of the signing of this document.

Course of Treatment

How long will treatment take? The answer to this question can vary, depending upon what you want to work on and how hard you want to work. Most counseling sessions take place weekly and last about 50 minutes. Depending on your needs, sessions might be scheduled more or less frequently. The number of sessions you require for your couples or family treatment will be estimated after we get started. Together, we can settle on a target ending date of treatment and then revisit this question subsequently.

Fees and Other Information

The fee for an approximately 50-minute session is $135, payable at the time service and rendered by cash, check, or credit/debit card. In cases of financial hardship, a sliding fee scale may be available. Your per session rate is __________. ***In order to avoid being charged your session fee for missed appointments (barring illness), a 24-hour notice of cancellation is required.*** An “hour” of counseling is traditionally between 45 and 55 minutes long. Occasionally, it may be necessary or desirable to meet for a longer period, such as 90 or 110 minutes. You are entitled to know the fee for a longer session.

Insurance

Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know what your policy covers and what it does not. If your insurance plan requires that you have a referral to see me, it is your responsibility to make sure that you have a referral on file with your insurance company before your appointment. If your insurance covers mental health counseling, I will gladly bill them for you. You are responsible for the copay, deductible, and payment for non-covered services as payment in full. Copayments MUST BE made at the time of service or there will be a $15 charge.

Non-Covered Services

You are welcome to a copy of your records at any time, but if you need a mental status exam report, or a letter written, expressing opinions or other details about your progress, insurance usually does not cover these. I am happy to discuss the fees for these services should they be required.

Payment Policy

Payment is expected at the time of service. This includes any copay, fees not covered by your insurance, etc. Keep in mind that you will receive statements from Reid Stell Counseling to keep your account current. A $5 rebilling fee will be assessed if there is a failure to make a payment or make contact with Reid Stell Counseling. If your account is over 90 days past due, you may receive a letter stating that you have a specified amount of time to make payment arrangements. Failure to make payment arrangements will result in your account being referred to a collection agency and your treatment may be immediately terminated. A $5-$25 fee will be charged to all non-sufficient funds (NSF). Insurance usually does not cover these fees. When a minor is seen at Reid Stell Counseling, payment is expected from whoever accompanies the minor to the visit.

For your convenience, I will send statements by email, instead of mail. Please provide your email address below: Please be sure to check your junk mail folder and adjust your email settings to make sure you receive these emails. For your convenience, I will also communicate with you via text message or email for the purpose of scheduling appointments and other administrative tasks. Please be aware that I cannot guarantee absolute confidentiality of any information exchanged via email or text message. Please let me know if you do not want me to communicate with you via email or text so that we may make alternate arrangements.

Appointments

A missed appointment is a loss to everyone. Please give 24 hours notice if you are unable to keep your appointment, barring illness; otherwise I reserve the right to charge for the time reserved at my full clinical rate. This charge is your responsibility, as insurance companies do not pay for missed appointments.

Social Media

Professional and ethical standards do not allow me communicate with clients via personal social media. For this reason, I ask that you do not communicate with me via social media. If you have feedback about my services, I would welcome you to give that feedback to me directly rather than posting it on online platforms or social media.

Telehealth

Telehealth (also known as telemedicine) is defined as healthcare delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. Telehealth may also involve the communication of mental health information, both orally and visually, to other healthcare practitioners located in Washington State. For synchronous video sessions, Reid Stell Counseling uses a HIPAA secure platform which exceeds HIPAA security standards (256 bit AES [Advanced Encryption Standard]). As a client of Reid Stell Counseling, you may need to download applications and/or software in order to use this platform. The appropriate technological infrastructure and equipment, such as an adequate broadband connection, a smartphone, a computer or tablet device, or similar equipment and services, will also be required.

Confidentiality

Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid court order or subpoena from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;

- If, without prior written agreement, no payment for services has been receive after 90 days, the account name and amount may be submitted to a collection agency;
- If I have any other legal duty, obligation, or right to report.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

Client Rights

According to Washington State Law, you, as my clients, have the right to refuse treatment and the right to choose whether or not to employ me as your practitioner. You also have the right to decide which methods or modalities might best suit your needs.

Emergencies

If you are experiencing an emergency or crisis, please call 911 or the Crisis Line at (206) 461-3222 or (800) 244-5767. In such situations, you may also go to the nearest hospital Emergency Room.

Department of Health Contact Information

If you have a question, comment, or complaint about service provided, you may contact:
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
(360) 236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

By signing this document, you are attesting to your consent to participation in counseling services provided by M. Reid Stell, LMHC, in-person and/or via telehealth.

____
M. Reid Stell, LMHC

____
Date

____
Client Signature Date of Birth (clients under 13)

____
Parent/Guardian Signature

____
Date