

Client Disclosure and Agreement Form

Neusha Hejazinia, MSW, LSWAIC

Neusha Hejazinia Counseling
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Contact Information:

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425-298-7799

Please read the following the following disclosure statement carefully as it provides information regarding provider's policies, procedures, confidentiality, and financial responsibility. Please feel free to discuss questions and concerns with the provider at any time.

Education

University of Washington, Master of Social Work- 2016

University of Washington, Bachelor of Arts in Psychology- 2012

Credentials and Training

I am a Licensed Independent Clinical Social Worker Associate (LSWAIC). I work under a supervisor who oversees my training and ensures quality of care in my practice. I meet with him regularly to continue my training in this field. Your identity will always remain confidential during these sessions.

I have training in working with issues surrounding trauma, depression, anxiety, addiction and relationship issues. I strive to build an honest, open, and non-judgmental relationship with my client as the relationship between the client and provider is the most important aspect of an effective therapeutic process. I also have some training in leading meditation exercises and will incorporate in treatment upon request.

Fees and Services

I provide individual and couples counseling to adults 18 years old and above. I do not provide paper work for disability, unemployment, L&I, crisis management, and court-mandated documents.

I see clients on a sliding scale basis. The rate will be discussed with client and will be decided, at the discretion of the provider, prior to the initial intake session. Payments are due at the beginning of the session and I have the right to cancel or reschedule the appointment if you are not prepared to pay.

Your appointment is scheduled and reserved specifically for you. I require a 48-hour cancellation notice for your appointments. I may charge you a \$60 cancellation fee if you miss or cancel your appointment in less than 48 hours. I may terminate our recurring sessions if you cancel several sessions as it places a barrier in our therapeutic process. Please get in touch with me if you have concerns and questions about your commitment to this process.

Emergency

If you are in crisis, experiencing emergency, or are a threat to yourself or others, please dial 9-1-1 or go to the nearest emergency room. You may also call the Crisis Clinic at 206-461-3222

Confidentiality

I am compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to personal health care information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices. This Notice, which is attached to this agreement, explains HIPAA in detail and its application to your personal health care information.

Notice of Privacy Practices

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have choices in the way I use and share information as I:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

I may use and share your information as I:

- Treat you
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee. Ask me to correct your medical record. You can ask me to correct health information about you that you think is incorrect or incomplete. I may say “no” to your request, but I’ll tell you why in writing within 60 days.

You can request confidential communications. You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address. I will say “yes” to all reasonable requests.

You can ask me to limit what I use or share. You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or our operations with your health insurer. I will say “yes” unless a law requires me to share that information.

You can get a list of those with whom I’ve shared information with. You can ask for a list (accounting) of the times I’ve shared your health information for six years prior to the date you ask, who I shared it with, and why. I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

I’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with

a paper copy promptly. Choose someone to act for you If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. I will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell me your choices about what we share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want us to do, and I will follow your instructions. In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest.

I may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases I never share your information unless you give me written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising: I may contact you for fundraising efforts, but you can tell me not to contact you again.

My Uses and Disclosures:

How do I typically use or share your health information?

I typically use or share your health information in the following ways:

- I can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- I can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- I can use and share your health information to bill and get payment from health plans or other entities. Example: I give information about you to your health insurance plan so it will pay for your services.

How else can I use or share your health information? I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

I can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety
- Do research.

Compliance with the law:

I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I’m complying with federal privacy law.

- I can share health information about you with organ procurement organizations
- I can work with a medical examiner or funeral director
- I can share health information with a coroner, medical examiner, or funeral director when an individual dies
- Address workers’ compensation, law enforcement, and other government requests
- I can use or share health information about you for workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
- I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities:

I am required by law to maintain the privacy and security of your protected health information. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I must follow the duties and privacy practices described in this notice and give you a copy of it. I will not use or share your information other than as described here unless you tell us we can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. We will not market or sell personal information.

Technology Policies

Although I am available by email, I cannot guarantee its security, privacy and confidentiality. By signing the Client Agreement Form you acknowledge and accept these risks.

I can be reached by email at neusha.hejazinia@gmail.com or by phone at 425-298-7799. I will respond to your emails within 48 hours, and your phone calls within 24 hours.

Please contact 9-1-1 or the Crisis Clinic if you are in crisis.

Client Rights and Responsibilities

In Washington State all individuals over the age of thirteen have the right to choose their own therapist, and to make their own decisions regarding the type of mental health treatment they determine is best for them. You have the right to terminate treatment at any time. If you have any concerns with your experience in counseling, please discuss it with me. It is my goal to provide the best treatment I can, and your feedback allows me to better direct our work in a way that is beneficial for you. If you have any concerns or complaints, you can contact the Washington State Department of Health, Health Professions Quality Assurance at P.O. Box 47865, Olympia, WA 98504-7865, or at (360) 236-4700.

Client Statement

By signing the Client Disclosure and Agreement form I acknowledge that I have reviewed and agreed to the terms and conditions of receiving services at this practice. I have been informed of and understand my rights and responsibilities. I am mentally and physically capable of making this decision and voluntarily choose to pursue services offered by Neusha Hejazinia, MSW, LSWAIC.

Client Name (Printed)

Client Signature

Date

Neusha Hejazinia, MSW, LSWAIC

Date

Financial Responsibility (sign if different than the client)

Financially Responsible Party (Name)

Signature

Date