1450 North 16th Ave Suite 102 •Yakima 98902 (509) 574-5000
Email: bethelridge@gmail.org • Website: bethelridge.org

Dear Client,

Counseling is a professional relationship where a client is seeking answers to troublesome problems. Counselors first need to know and understand the nature of the problem. Counselors must take into account other factors affecting the problem. Together the client and counselor develop a new way of thinking, acting, and planning.

You can expect first an assessment interview where your goals for counseling are heard and understood. There is a need for specific testing, the proper test will be provided and evaluated upon completion. A prescribed plan is formulated to achieve the goals we have discussed. This plan includes verbal feedback from the diagnostic phase together with methods and time expectations.

As the Director of Counseling for Bethel Ridge Family Resources, I have been in private practice as a Social Worker (MSW) since 1972. I chose a degree in social work because of its comprehensive study of individuals, families and societal relationships. A Master in Social Work (MSW) and, in particular, the Licensed Clinical Social Worker (LCSW), is more recognized by medical professionals and insurance companies. I received my formal training at Multnomah School of the Bible, and was a pastor for one year. I attended Trinity College/BA Degree, and the University of Missouri/MSW. Some of my Postgraduate studies include The Gottman Institute, Chemical Dependency, Residential Treatment of Adolescence, Behavior and Emotive Theory, Single Parenting, and Psychological Testing. My clinical experience has been working with families and teenagers in crisis at the Flying H Youth Ranch as well as a private counseling practice for over thirty-five years.

As a Licensed Clinical Social Worker (#LW00004987) for the state of Washington, I agree with and adhere to the laws regulating counselors. Please read the materials from our state entitled *Counseling Clients* included in this packet. “Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department of Health does not include a recognition of any practice standards nor necessarily imply the effectiveness of the treatment.” Especially important to me (and you) are the protections this law offers for confidentiality. To release counseling information without your written consent would violate the counseling ethics of this law as well as my own personal ethical and moral code. However, this law requires that in two situations I must report to authorities. First when there is clear indication that someone may be harmed; and second when a child or dependent person is being sexually or physically victimized.

You are beginning what I hope will be a meaningful counseling experience. Therefore, it is the aim of Bethel Ridge Family Resources and your right to select a counselor who best suits your individual needs and purposes. I am committed to your long-term best interest.

With Sincerity of Purpose,
Gregg Hires - Director of Counseling

OFFICE USE
DX ____________________
____

1450 North 16th Ave. #102 Yakima 98902 (509)574-5000

CLIENT INTAKE **TODAY'S DATE** ________				Male ❑ Female ❑
Last Name:			Single ❑ Married ❑ Divorced ❑ Widowed ❑ Date________ Date_________ Date_______	
First Name:			MI:	SS#:
Address:			Date of Birth: Minor ❑	Email:
City:		State:	ZIP:	Home Phone:
Employer:				Work Phone:
Referred to Counseling by:				Cell Phone:

EMERGENCY CONTACT (RELATIONSHIP TO PATIENT)

Last Name:	First Name:	Phone:

INSURANCE INFORMATION: PRIMARY ATTACH COPY OF INSURANCE CARD **FRONT** AND **BACK**

Insured Name:			*Relationship :*		Date of Birth:	SS#:
Insurance Company:			*Mailing Address:*			
Ins Company Address:			*Physical Address:*			
City:	State:	ZIP:	*City:*	*State:*		*Zip:*
Policy No:	Grp No:		*Employer:*		*Empl Phone#*	

INSURANCE INFORMATION: SECONDARY ATTACH COPY OF INSURANCE CARD **FRONT** AND **BACK**

Insured Name:			*Relationship:*		*DOB:*	*SS#:*
Insurance Company:			*Mailing Address:*			
Ins Company Address:			*Physical Address:*			
City:	State:	ZIP:	*City:*	*State:*		*Zip:*
Policy No:	Grp No:		*Employer:*		*Empl Phone#*	

LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

________________________ ____
Date Signature of Guarantor

MEDICARE -- LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for any services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.

________________________ ____
Date Signature of Guarantor Rev 9.1.10 NCP 2 PDF

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Email: bethelridge@gmail.org • Website: bethelridge.org

Insurance Information Disclaimer/ Waiver

The purpose of this information sheet is to inform you of our office insurance billing process and your responsibilities.

Our gift to you

Billing is a courtesy. Our office bills your insurance company as a courtesy to you. The only insurance company we are **required** to bill is Medicare.

Insurance information

We call your insurance company for benefits and eligibility information for internal office use. We are happy to share this information with you as long as you understand your insurance company quotes this information and is not a guarantee of payment. Also, please be aware that coverage and benefits may change without notice.

Your responsibility

The relationship is between you and your insurance company.
Our involvement is on a courtesy basis only.

It is your responsibility to confirm benefits, eligibility requirements, the need for referrals and/or authorizations, deductible amounts, visit limits, plan exclusions, in or out of network benefits, Co-pays as well as Co-insurance amounts with your insurance company. You can accomplish this by calling your insurance company or contact your employer or benefits administrator or check your Plan Benefit Booklet.

____ ____________

Client Signature Date

1450 North 16th Ave Suite 102 • Yakima 98902 (509) 574-5000
Email: bethelridge@gmail.com • Website: bethelridge.org
Gregg Hires, LICSW • Glenna Hires, MA Ed - LIMHC

Counseling Agreement

Thank you for your interest in counseling with Bethel Ridge Family Resources. I look forward to this time to serve you and I am committed to your best interest. In order to be as clear as possible about the counseling you will be receiving, please read through this new client packet and sign and date those pages as indicated.

Description of Counseling

I, as a counselor, will be talking with you about what you think, feel and the choices you make. You will learn how the things you believe and feel are affecting your choices. Change can happen as you view life and choose differently. Counseling may include the recommendation of various materials, evaluation tools and possible exercises/assignments.

Clinical/Office Setting: Usually a 50 minute session unless otherwise scheduled. Sessions are located at the Aspen View Counseling Office or Bethel Ridge Retreat.

Intensive Setting: Located at Bethel Ridge Retreat, 134 Flying H Loop, Naches, WA, 98937. Counseling is provided in extended blocks of time in a private mountain home or bed and breakfast setting. Individuals, married couples and families are able to receive counseling over a scheduled number of days in a quiet secluded setting. Many programming opportunities are offered to reinforce learning and develop new patterns of relating.

Doctrinal Statement

I believe there is a God who created us. We are spiritual beings in need of a relationship with Him. He loves us and has provided a way for us to know and experience a loving relationship with Him. The Bible describes God, Jesus and the Holy Spirit clearly. Creation also helps us know God. God, the Creator knows all about life and reveals this in the Bible. As a counselor, this doctrine is foundational to my thinking and counsel.

Confidentiality

Washington State laws provide client confidentiality in counseling sessions. Without your written consent, I cannot, and will not, release any information regarding you and or your counseling time. Exception: See attached Washington State Department of Health publication, *Counseling Clients,* Confidentiality Statement, pgs. 1 and 2.

Fees

Our typical office fee is $150 for a fifty minute session. New client diagnostic intake fees are $240. However, we will work with your particular financial and insurance situation; and a sliding scale is available where applicable. Non insured clients will be billed at the same rate and will also receive the same provider portion discount that insured clients receive. At times I do extended sessions and the fee is adjusted accordingly. We attempt to work with you and any medical / insurance benefits you may have. If

you are uninsured, you may request an application for a scholarship to help cover the fees. Fees may then be adjusted to the sliding fee based on your IRS 1040 gross income.

Adjusted Fee (if qualified))
I agree to pay the following fee for regular office visits as determined from the sliding fee scale. ________________________

Insurance Payments

You need to be aware that we are not accepted by all insurance companies as *a preferred* or *in network provider*. You will need to check with your insurance company regarding your specific benefits. You may need to get special authorization or a referral from your primary care doctor. ***You are responsible for payment if your insurance does not cover services provided.*** We will bill your insurance directly and notify you about any unpaid balance that is your responsibility. Any insurance questions may be directed to our billing company, Advanced Billing at (509) 574-5000 on Wednesdays from 10:00am to 5:00pm.

Missed Office Appointments

Appointment times are decided upon in mutual consultation. Individual, couple, and family sessions are 50 minutes in length. Longer or shorter sessions may be negotiated according to need and available time. We require at least **twenty-four (24) hours notice if you must cancel your reserved time.** This will allow us to attempt to fill your appointment time for someone with an urgent need. Cancellations with less than 24 hours notice will be charged the **full rate.** Please understand that insurance companies cannot be charged for missed appointments and **you are fully responsible for any charge due to a missed appointment.** We are asking for a credit card number to put in your file for missed appointments and late cancel fees because insurances will not pay for either of these.

Credit Card Number and Expiration Date ____

Counseling Retreat Cancellations – see attached

Phone Call Consultation and E-mail – Teleconference Appointments

It may be necessary for you to call me after hours; and I want to be able to meet your need. Calls and emails will be charged upon the length of the time spent conferencing. This may not be reimbursed by insurance companies. Therefore, you will be personally responsible for non-reimbursed charges. The fee will be computed by the hourly rate. Please know that I would like to be available for you. However, with our Counseling Retreat sessions in the evenings and weekends, it is best for us to work through your issues during scheduled office visits.

I have read and understand the above material and agree to the described conditions.

____ ___________________
Signature Date

____
Please print name

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Client Symptom / Status – *Please, Print Clearly*

CLIENT INFORMATION

Client Name:____

Client Reasons for Counseling / Desired Goals (results)

____

____

____

____

CURRENT SYMPTOMS

Affect/Energy

___ depressed mood
___ diminished energy
___ diminished interest
___ increased irritability
___ feelings of guilt
___ feelings of worthlessness
___ inability to concentrate
___ inability to make decisions
___ other ________________

Anxiety

___ generalized fear
___ shortness of breath
___ depersonalization
___ chest pains
___ hot/cold flashes
___ fears of dying
___ fear of going crazy

____ other______________

Sleep Disturbance

____ difficulty falling asleep
____ early morning awakening
____ restless sleep
____ excessive sleep
____ nightmares
____ night terrors

___ other ______________

Eating

___ increased appetite
___ decreased appetite
___ weight gain
___ weight loss
___ purging
___ other _____________

Avoidance Symptoms

___ fear of specific places
___ fear of social situations
___ constriction of lifestyle
___ other ______________

PTSD Symptoms

____ intrusive memories
____ hypervigilance
____ distress from triggers
____ numbing
___ other _______________

Alcohol/Drug Use

(Write "**R**" for regular; "**O**" for occasional; "**I**" for infrequent; "**N**" for never)

___ alcohol ___cocaine ___ marijuana ___ methamphetamine ___opiates ___other

specify use of other drugs ____

Client Name: ___________________________________

CURRENT MENTAL STATUS: Instructions: Please check *all* that apply

Thought process: ___ intact ___ circumstantial ___ tangential ___flight of ideas ___ loose associations
Hallucinations: __ none ___ auditory ___ visual ___olfactory ___ command
Delusions: ___ none ___ persecutory ___ grandiose
Memory: ___intact ___ impaired: ___ immediate ___ recent ___ remote
Judgement: ___ intact ___ impaired: ___ mild ___ moderate ___ severe
Suicidality**:** ___ not present ___ ideation ___contemplation ___plan ___ activity
Homicidality**:** ___ not present ____ ideation ___contemplation ___ plan ___ activity
Impulse Control**:** ___within normal limits ___ impaired

Other: ____

For Office Use Only:

CURRENT DIAGNOSIS *(include DSM-IV numeric code)*

Axis I ____
Axis II ____
Axis III ____
Axis IV (psychosocial stressors) ____
MEDS / Prescribing Physician ____
____

Total number of sessions completed for current calendar year
___ individual ___couples ___ family ___group ___ med. management

CURRENT TREATMENT PLAN

Instructions: Please document treatment goals, interventions, & time frames to address current diagnosis and symptoms.

	Treatment Goal	Intervention	Time Frame
1.	______________________________	__________________________	__________
2.	______________________________	__________________________	__________
3.	______________________________	__________________________	__________

Number/types of sessions being requested of complete treatment (subject to contractual limits)
____

Are you communicating with patient's PCP regarding their treatment? ___ Yes ___ No
If yes, how? ___copy of intake ___phone ___progress notes ___treatment summary

Signature of Mental Health Provider _____________________________ Date: _________

Gregg Hires, LCSW
Administrative Office: 130 Flying H Loop, Naches, WA 98937

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Client History

Today's Date ______________

Name____ Date of Birth ____________

Phone _________________________ Email __________________________________

Spouse ____Date of Birth_____________

Employer ______________________________Occupation _______________

Phone __________________________

Personal History

Marital History*/Significant Relationships (client)*

____

____

____

____

Spouse(current) marital history

____

____

____

Children/Dependents   #Boys _____   #Girls ______

Name ____Age____________

Name ____Age____________

Name ______________________________ ____________________Age____________

Additional Children: _________________________________

Client's Family History

Father's Name ______________________ Age (if living)_____ Occupation_____________ Marital Status __________

Mother's Name _____________________ Age (if living)_____ Occupation_____________ Marital Status __________

Guardian's Name (if applicable)____ Relationship _________________

Reason for guardianship ____ Date of guardianship __________

Siblings ***# Brothers _______*** ***# Sisters _______***

Name ______________________________ Age _______ Relationship __________________ Marital Status __________

Name ______________________________ Age _______ Relationship __________________ Marital Status __________

Name ______________________________ Age _______ Relationship __________________ Marital Status __________

Name ______________________________ Age _______ Relationship __________________ Marital Status __________

More than four siblings? Yes _________ No ___________

Names: ____

Has anyone in your immediate family been hospitalized or received some form of professional help for psychological problems? If so, please specify who, when they received help, and the nature of the problem.

____

____

____

____

<u>Occupational History</u>

What positions have you held in the past?

____

Does you present work satisfy you, it not, please explain.

____

____

____

Briefly list any additional information that you think would be helpful for your counselor to know.

____

____

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NOTICE OF PRIVACY PRACTICES

(MEDICAL NON-PROFIT VERSION)

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable counseling information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your counseling information is used. “HIPPA” provides penalties for covered entities that misuse personal counseling information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your counseling information and how we may use and disclose your counseling information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- ♦ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- ♦ **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- ♦ **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified counseling information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected counseling information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected counseling information, including those related to disclosures to family members, other relatives, close personal friends, or

any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected counseling information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected counseling information.
- The right to amend your protected counseling information.
- The right to receive an accounting of disclosures of protected counseling information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected counseling information and to provide you with notice of our legal duties and privacy practices with respect to protected counseling information.

This notice is effective as of April 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected counseling information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to the written complaint with our office or with the Department of Health and Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA
Or to file a complaint:

Please contact Bethel Ridge Family Resources
1450 N 16th Ave Suite 102
Yakima, WA 98902
509-574-5000

or

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Email: bethelridge@gmail.com • Website: bethelridge.org

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my counseling information. 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 above to obtain a current copy of the *Notice of Privacy Practices.*

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

Client Name:____

Relationship to Client:____

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date	Initials:

Reason:

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Email: bethelridge@gmail.com • Website: bethelridge.org

CLIENT CONSENT FORM

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments 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 counseling 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 above to obtain a current copy of the *Notice of Privacy Practices.*

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

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

Client Name: ____

Signature: ____

Relationship to Client: ____

Date: __________________________________

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Statement of Understanding

At the start of our work together, I wish to provide you with the following important information. It is important that you understand these issues. Please review this material carefully, so we may discuss any questions or concerns you may have. Bethel Ridge Family Resources (BRFR) is a group of highly trained mental health professionals whose goal is to help individuals, couples, and families develop resources to eliminate or cope with problems and enjoy a more fulfilling life. The following information is provided to answer any procedural questions that may arise while using BRFR services.

1. **Office Hours:** Appointments are available Monday through Friday, 9:00am to 4:00pm, and by special arrangements on some weekends at another location.
2. **Appointments:** Services are available by appointment only and may be scheduled with individual therapists. Sessions are usually 45 to 50 minutes long. Between session, time is needed by the therapist to make notes, prepare for the next session, and perhaps return phone calls, etc. Please be respectful of the need to complete sessions during the allotted time.
3. **Cancellations/Missed Appointments:** Your appointment is reserved for you. It represents a commitment of time and resources for which payment is expected. If you need to cancel an appointment, please contact BRFR as soon as possible. No charge will be made for cancelled appointments if 24 hours notice is given; <u>otherwise you will be charged the full $150 for the session.</u> Please note that insurance companies do not reimburse for missed appointments or late cancel sessions.
4. **Telephone:** When the receptionist is not answering the phone, you may leave a voicemail message at **509-574-5000.** She will be checking messages throughout the day and will return your call. In case of an emergency assistance, please contact **911**.
5. **Emergencies:** BRFR is not set up to handle emergencies. If you have an immediate or emergent need, assistance can be reached by calling **911**.
6. **Fees and Insurance:** You have the option of paying BRFR directly or using insurance benefits; in either case, you are financially responsible for the services for which you are arranging, even if your insurance refuses to pay for them. Fees are discussed during your first telephone contact. Please remember that **you will be billed for missed appointments not cancelled 24 hours ahead of time.**
7. **Confidentiality:** A key aspect of psychotherapy is the development of a trusting relationship between client and therapist. To achieve this goal, all information disclosed to your therapist is kept in strictest confidence according to professional ethical guidelines.

   Exceptions are made if the therapist believes that:

   - A client is contemplating a dangerous act against him/herself
   - A client is contemplating a dangerous act against another person

- There is evidence of child abuse, abuse of a physically or mentally impaired person or abuse of an elderly person
- Full confidentially might not be possible if a court subpoenas information
- If you have a “Managed Care” type of insurance, your insurance company may require initial and periodic reports and information from your therapist in order to authorize treatment for you
- If you are under 18 years of age, you should be aware that your parents have the right to receive some information concerning your treatment. While we are working together, we will give your parents general information on how the treatment is proceeding, but only after discussing it with you

I, the undersigned, have read and agree to the above guidelines.

______________________________________ ______________________________________

Signature of the Patient Signature of Parent, Guardian, or Conservator

____

Date

*******************Please Sign One Copy and Keep One for Your Records******************

Counseling Clients

Client and Counselor Responsibilities and Rights

Counselors must provide disclosure information to each client in accordance with chapter 18.19 RCW prior to implementation of a treatment plan. The disclosure information must be specific to the type of counseling service offered; in language that can be easily understood by the client; and contain sufficient detail to enable the client to make an informed decision whether or not to accept treatment from the disclosing counselor.

If you have concerns about being dependent upon your counselor, talk to him or her about it. Remember, you are going to that person to seek assistance that helps you learn how to control your own life. You can and should ask questions if you don't fully understand what your counselor is doing or plans to do.

Requirement for Registration of Licensure

Your counselor must be either registered under chapter 18.19 RCW or certified under chapter 18.224 RCW through the Washington State Department of Health unless otherwise exempt. To be registered, a person fills out an application and pays a fee. To become licensed, a person fills out an application form and pays a fee, but he/she must also show proof of appropriate education and training. There are some people who do not need to be either registered or certified because they are exempt from the law. You should ask your counselor if he/she is registered or licensed and discuss his/her qualifications to be your counselor.

Definitions

Counseling means using therapeutic techniques to help another person deal with mental, emotional and behavioral problems or to develop human awareness and potential. A registered or certified counselor is a person who gets paid for providing counseling services.

Confidentiality

Your counselor cannot disclose any information you've told them during a counseling session except as authorized by RCW 18.19.180:

1) With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;
2) That a person registered or certified under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;
3) If the person is a minor, and the information acquired by the person registered or certified under this chapter indicates that the minor was the victim or subject of a crime, the person registered or certified may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
4) If the person waives the privilege by bringing charges against the person registered or certified under this chapter;
5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or
6) As required under chapter 26.44 RCW

Assurance of Professional Conduct

Thousands of people in the counseling professions practice their skills with competence and treat their clients in a professional manner. If you and the counselor agree to the course of treatment and the counselor deviates from the agreed treatment, you have the right to question the change and to end the counseling if that seems appropriate to you.

We want you to know that there are acts that would be considered unprofessional conduct. If any of the following situations occur during your course of treatment, you are encouraged to contact the Department of Health at the address or phone number in this article to find out how to file a complaint against the offending counselor or hypnotherapist. The following situations are not identified to alarm you, but are identified so you can be an informed consumer of counseling or services. The conduct, acts or conditions listed below give you a general idea of the kinds of behavior that could be considered a violation of law as defined in RCW 18.130.180.

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 or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For 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 proceeding 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) 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 or documents; (b) Not furnishing in writing of all 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 proceedings; 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 9.96 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;

(a) 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/her from providing evidence in a disciplinary proceeding; (a) Current misuse of: Alcohol; (b) Controlled substances; (c) or Legend drugs

22) Abuse of a client or patient or sexual contact with a client or patient;

23) 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.

This article should not be considered as the final source of information. If you want more information about the law regulating counselors and hypnotherapists or want to file a complaint, please write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington 98504-7869.
If you want to contact someone by phone to discuss the law or talk about a possible complaint, call (360) 236-4700 Monday through Friday, 8:00a.m. to 5:00p.m.

1450 North 16th Ave. Suite 102 • Yakima 98902 (509) 574-5000
Email: bethelridge@gmail.com • Website: bethelridge.org

Record of Disclosure

Bethel Ridge Family Resources has provided me with a New Client Packet which includes:

Letter of Welcome (NCP1)
Client Intake Information (NCP2)
Insurance Disclaimer (NCP2a)
Counseling Agreement (NCP3a/b)
Client Symptom Status (NCP4)
Client History (NCP5)
Notice of Privacy Practices (NCP 6, HIPPA)
Notice of Privacy Statement and Acknowledgement (NCP7, HIPPA)
Client Consent Form (NCP 8, HIPPA)
Counseling or Hypnotherapy Clients (by Washington State) (NCP9)
Record of Disclosure (NCP10)

Client is to keep:
Letter of Welcome
Counseling Agreement (client copy)
Notice of Privacy Practices
Counseling or Hypnotherapy Clients

BRFR to received signed copies of
Counseling Agreement (brfr copy)
Client Intake Information
Insurance Disclaimer
Client Symptom Status
Client History
Privacy Statement and Acknowledgement
Client Consent Form
Statement of Understanding
Record of Disclosure

I have read and understand the information provided

Signed ______________________________________

Date ______________________________________

Witnessed by counselor _____________________

Date _______________________________________