Lindsay Beard

LMHC CMHS

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THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

This document also contains information related to the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice will be provided to you in the form of a handout and will explain HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information during our initial meeting/ session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us and serves to verify that you have received the HIPAA information handout. If you do not continue therapy or sessions you may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy or, if you have not satisfied any financial obligations you have incurred

Qualifications

Lindsay Beard is a licensed mental health counselor in the State of Washington. Licensure insures that a counselor has: 1) a Masters degree from an accredited university; 2) a clinical internship; 3) has passed the national written examination and 4) had 2 years post degree working in a clinical setting. As a Child Mental Health Specialist she has over 100 hours in training working with children and adolescents in addition to 2 years primarily counseling children and families.

Lindsay has been supporting families and individuals through various capacities since 2004, beginning as direct staff in residential settings. She obtained her BS degree from Western Washington University, and then her MA in Clinical Psychology from Argosy University of Seattle. During her graduate schooling she was the program manager of residential homes set up specifically for children on the Autism Spectrum with high intensity needs. She received 2 years

of training under an ABA therapist and learned how to develop and tailor behavior support plan for each child in the program. From there she developed a passion to advocate for these children and their families. In efforts to obtain counselor licensure she began case management and counseling for community mental health agencies from 2008-present. In this setting she obtained her specialization working with children as young as 2 years of age. She continues to work in Community Mental Health and also in private practice where she offers social skills groups for varying age sets of children as young as pre-school.

Treatment Philosophy

My goal is for therapy to be a positive and fulfilling experience. It requires time, an open mind, and willingness to change. My approach is experiential and tailored to each individual's interests and strengths. This may include journaling, role playing, play therapy, take home assignments, art projects, etc. I am always open to feedback about what is helpful, what is difficult.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by state law and/or HIPAA. With your signature on a proper Authorization Form, I may disclose information in the following situations:

- I may occasionally find it helpful to consult other health and mental health professionals about your case. If I consult with a professional who is not involved in your treatment, I make every effort to avoid revealing your identity. These professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called Personal Health Information (PHI) in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that at times I may assign administrative work to a contract administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and quality assurance. Contract office workers receive training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.

MINORS & PARENTS

Children clients under 13 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine treatment records. Since privacy in psychotherapy is often crucial to successful progress, I will normally request an agreement from the parents that they not request access to their child's records or detailed information about what is disclosed in therapy if I am meeting just with the child (I normally meet with parents and children if under the age of 13, during parts of most sessions). If agreed upon I will provide parents with general information about the progress of the child's treatment if the parent is not participating in therapy routinely. I will also provide parents with a summary of their child's treatment or assessment when it is complete and go over it in detail if requested and scheduled. I

will also inform the custodial parent(s) if I feel that the child is in danger or is a danger to someone else.

TREATMENT AGREEMENT:

I will make a copy of your insurance card at our first meeting, and will verify your benefits. If you would prefer to do the verification, that is fine as well. If you choose not to bill your insurance, or if I am not paneled with your insurance—we will provide you with a statement of services at each session. If I am given ample notice of illness, other circumstances—you will not be charged for a re-scheduled session. However, **NO-SHOWS will be charged the regular rate.**

PLEASE INITIAL THAT YOU HAVE READ EACH ITEM**:**
CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. _____
I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO LINDSAY BEARD. WHILE HER OFFICE MAY BILL MY INSURANCE COMPANY, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED IF MY INSURANCE COMPANY DOES NOT PAY. _____

IF MY PORTION OF THE BILL IS NOT PAID WITHIN 60 DAYS FROM THE LAST DATE IT WAS INCURRED A LETTER WILL SENT GIVING ME 10 DAYS TO PAY MY ACCOUNT OR TO ARRANGE FOR A PAYMENT PLAN. IF I DO NOT RESPOND WITHIN 30 DAYS THEREAFTER, I WILL BE ADVISED BY LETTER THAT MY ACCOUNT MAY BE SENT TO COLLECTIONS_____.

PLEASE BE AWARE THAT FAX OR E-MAIL TRANSMISSIONS RELATED TO YOUR TREATMENT MAY AT TIMES BE PROCESSED BY BILLING OR OTHER OFFICE PERSONNEL CONTRACTED FOR THIS PURPOSE. CONFIDENTIAL RECORD TRAINING IS PROVIDED TO ANY SUCH OFFICE PERSONNEL AS PART OF THEIR WORK. CONFIDENTIALITY IS MAINTAINED WITH SUCH HANDLED RECORDS, AS WITH ALL RECORDS IN MY OFFICE.

Your signature below indicates that you have received the information in this document and agree to abide by its terms during our professional relationship.

Patient Signature_____Date_____

Guardian Signature_____Date_____

Therapist Signature_____Date_____