Megan Fisher, MA, LMHC
Megan Fisher Counseling, LLC

Notice of Privacy Practices and Patient Rights as required by the Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Federal and state law requires licensed health professionals to maintain the privacy of your health information. That law also requires us to inform you of our privacy practices, our legal duties, and your rights concerning your health information.

Protected Health Information (PHI) includes any information that describes the health problems or symptoms for which you are being treated, in conjunction with any personal identifying information about you. Information pertaining to your treatment and the condition for which you are seeking treatment will not be disclosed to any entity or individual without your written authorization, with the following exceptions:

- Healthcare professionals have a duty to protect. In the event your practitioner or identified representative determines that you are at risk of severe harm to yourself or another individual, that practitioner or identified representative is obligated to contact any appropriate individual, including law enforcement, to protect you or other identified individuals from harm.
- Healthcare professionals have a duty to warn. In the event your practitioner or identified representative determines that you are at risk for causing severe harm to another individual, that practitioner or identified representative is obligated to contact any appropriate individual, including the potential victim(s) as well as law enforcement, to warn that individual(s) of their potential of harm.
- Healthcare professionals have a duty to inform the proper authorities regarding any disclosure of information pertaining to the harm of a child or individual who is not legally, mentally, or physically able to act on their own behalf to protect themselves from this harm.
- Your health information may be disclosed in order to coordinate your treatment with other healthcare providers who are participating in your healthcare treatment.
- Your health information may be disclosed as necessary to obtain payment for services that are provided to you.
- Your health information may be disclosed to provide you with appointment reminders (such as email or voicemail messages).
- In the event of an emergency, information about you may be disclosed to a family member or other appropriate person involved in your care.
- As required by law via court order.

Your healthcare provider will take all reasonable precautions to protect the confidentiality of your health information.

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Patient Rights

You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to this information. Your provider reserves the right to charge a reasonable fee for this service to cover postage, copying, or other related expense.

You have a right to receive a list of instances in which your healthcare information was disclosed. This list will not include disclosures pertaining to treatment, appointment reminders, payment, and healthcare operations as authorized by you. Your provider reserves the right to charge a reasonable fee for this service to cover postage, copying, or other related expense.

You have the right to request that your provider communicate with you by alternative means or locations. You must make this request in writing and specify the alternate means and location, including how you will pay for this alternate communication if your provider incurs additional costs.

You have the right to request that your provider amend your health information. Your request must be in writing and must explain why s/he should amend the information. S/He may deny your request under certain circumstances.

You have a right to file a complaint with the U.S. Department of Health and Human Services, without retaliation, if you believe your provider has violated the privacy of your PHI.

Questions and Complaints

You may contact your provider using the information contained below if:

- You want more information regarding your privacy rights.
- You believe your rights have been violated.
- You believe your provider has made an incorrect decision about access to your health information.
- You believe your provider's response to a request pertaining to your health information was incorrect.
- You want your provider to communicate with you by alternate means or location.
- You have any questions or complaints pertaining to your care or the privacy of your health information.

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Disclosure Statement

General Information

My mission is to provide a safe and supportive environment in which you can grow, come to know yourself more deeply, and find ways to relieve your suffering. My counseling style is educational, experiential and therapeutic. I believe that at our core, each person is fundamentally unique, healthy and good, and that by finding out more about yourself, you can find healthy ways to get your needs met and live your life more fully.

My Approach

While my work is heavily influenced by the Internal Family Systems (IFS) model of psychotherapy, I bring other approaches, skills, and experience to my work as well. My work is also influenced by my educational background, experience in the field of counseling, spirituality and the connection between the mind, body and spirit. Often, therapy involves working through layers of thoughts and feelings to get down to other core issues and beliefs. I believe that our symptoms are ways that the marginalized parts of ourselves are attempting to communicate with us and by listening to these messages we can find a path to health and wholeness.

Education, Training and Affiliations

I am a licensed Mental Health Counselor in Washington State (LH60718775). I received a Master of Arts degree in Mental Health Counseling from Gordon Conwell Theological Seminary in Boston, MA and a Bachelor of Science degree in Business – Finance from Montana State University. I am a Level One Certified Practitioner of Internal Family Systems therapy through The Center for Self Leadership. I am a member of the American Counseling Association (member ID 6368629).

Consultation

I seek on-going consultation from other experienced therapists as part of my desire to bring you the best possible care. Thus, at times, I may share pieces of your story with a consultation group. As much as possible, when sharing such information, I will protect your privacy and limit the information I share to the minimum necessary.

Therapeutic Work and Termination

You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. I believe doing so is part of the healing process in therapy.

When or if you would like to end therapy, I do ask that we first discuss this in person. This is due to the fact that sometimes when old wounds are reopened a natural human tendency can be to flee. Part of our therapeutic relationship is safely and comfortably looking at these wounds to find ways to heal them. The very notion that you might want to leave abruptly might be an indication that we are making great progress.

Ethics and Professional Standards

Washington State Law: I honor all regulations in the 18.225 RCW. The purpose of the law is: (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Client Rights: As a client receiving counseling services in the State of Washington, you have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality which best suits your needs. You also have the right to terminate your treatment at any time for any reason.

Confidentiality: As a counseling client you have privileged communications under state law. With the exceptions of situations listed in my Notice of Privacy Practices, you have the right to have information shared in therapy sessions to be held in the strictest confidentiality, including the fact that you are seeing me for counseling. The privilege is yours, not mine, and cannot be waived without your written consent. I will always act to maximize your privacy even when you waive your confidentiality.

Complaints: If you have any concerns about your experience, please discuss it with me. If you feel I have been unethical or unprofessional, you can contact the Washington State Department of Health, HSQA Complaint Intake, PO Box 47857, Olympia, WA 98504-7857. You may also call them directly at (360) 236-4700 or access online forms and information at www.doh.wa.gov/hsqa.

Fee Information, Cancellation Policy and Legal Matters

Fees: Unless agreed upon otherwise, the fee for a private 50-minute session is $135 and is payable at your session, in the form of check, cash, or credit card (a fee may be applied to credit card transactions). Payment is due at the time of your session. Returned checks will incur an additional $25 fee as well as collection fees if your balance is not paid with-in 2 weeks. Accounts with an outstanding balance will not be scheduled for further appointments until the balance is paid in full. If, without prior written agreement, no payment for services has been received after 90 days, minimal identifying PHI and amount due may be submitted to a collection agency, per the Notice of Privacy Practices.

Court time will be billed at an adjusted rate of $300 per hour that will be required for any preparation and attendance should I be drawn into legal proceedings and additional fees may apply.

Reports or letters may be needed or requested from time to time. If they exceed 10 minutes of preparation then they will be treated as additional services and will incur fees in 30 minute increments.

Due to the needs of clinical care and my desire to keep basic fees as reasonable as possible, client telephone calls in excess of 10 minutes will be treated as additional services with a fee of $1 per minute. This applies to client or parent contact in excess of 10 minutes outside of therapeutic sessions.

Cancellation: If you must cancel your appointment please contact me **at least 24 hours in advance.** This ensures I can see other clients in the opening and can plan accordingly. **You will be responsible for the fee when cancellations are received less than 24 hours in advance, or if you do not show up for your appointment**

In the event that you are less than 20 minutes late for a scheduled appointment, you will be seen for the remainder of the time reserved for you. If you are more than 20 minutes late, it will be treated as a missed appointment and fees will apply.

Please note that insurance companies do not provide reimbursement for cancelled or missed sessions, so clients using such benefits will be responsible for the full cost of the appointment.

Insurance: I accept insurance for several plans. Also, some insurance plans will cover my work as an out-of-network provider. Please contact your insurance company for coverage information, or talk to me with questions. Insurances will be billed via a third party medical billing company and any co-pay or co-insurance fees are your responsibility.

It is important to understand that health insurance companies will only pay for services considered medically necessary. This means that your therapist is required to diagnose you with a "mental illness" according to the Diagnostic and Statistical Manual of Mental Disorders, which then becomes part of your permanent medical record; this could impair your ability to obtain certain jobs, life insurance, independent health insurance, or other opportunities. Please discuss any questions or concerns you may have about medical necessity or exemptions with your therapist.

Emergencies: I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate, or consult. If for any reason you are unable to contact me by telephone and you are having a true emergency, please call the Crisis Clinic (206-461-3222) or 911 or check yourself into the nearest hospital emergency room immediately if your personal safety or mental health is at stake.

Professional Boundaries: It is my intention to maintain a relatively comfortable, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1. I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship. This is a professional boundary, not one of not caring. In this same vein, I will not accept social network "friend" requests.
2. Because my business does have an internet presence (listings on Yelp, Facebook, etc.), it is possible for you to place unsolicited reviews on those sites of me and my business if you wish. It is very important to your treatment that you communicate your intent to do so prior to actually doing it. This is to keep communication flowing between us. In other words, if you have feedback for me (positive, negative, or ambivalent) it is best for us to discuss them in person as they are likely very important for your treatment. I always appreciate word of mouth referrals to your friends and associates.
3. I will not, at any time, have physical or sexual contact with you. This excludes handshakes and the like, but only when or if you initiate. None of these are expected from you, though.
4. I will not, at any time, accept any gifts from you.
5. If I were to see you in public at any time, I will not initiate any contact with you, out of respect for your confidentiality. If you initiate I will respond in kind, but no further than you offer.
6. I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services.

CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

I understand that if I have any questions or would like additional information, I am free to ask during the initial session and any time during psychotherapy process.

I understand that confidentiality cannot be assured for electronic communication like cell phone and e-mails. I do not hold Megan Fisher responsible or liable for breach of confidentiality if I choose to communicate with my psychotherapist by these electronic means. I also give permission for such electronic communications to take place in consultation by my psychotherapist, who shall make efforts to exclude personally-identifiable information in such communications.

I understand that sometimes in psychotherapy things get worse (because of repressed issues and systematic dynamics) before things get better. I understand this may be a natural part of the psychotherapeutic process. I understand that Megan encourages her clients to discuss these issues in session.

I have received and reviewed this Disclosure Statement. I have had the opportunity to ask any questions regarding this material and understand the information provided. I am of sound mind and body, participate voluntarily, and understand that I am personally responsible for my experience. I have also received a copy of the HIPAA and Washington State Notice of Rights and Privacy Practices.

I understand that Megan Fisher desires to maintain strict confidentiality. This includes not discussing with any person that may have referred me that I have entered into a professional relationship with her. However, I may grant Megan permission to express her gratitude to the person who referred me, which would involve mentioning of my name (no other information would be revealed). I give Megan Fisher permission to express her thanks to _____, by initialing here _____.

_____

Client Name (printed) Date

_____

Client Signature Date

_____

Counselor Signature Date

_____

Parent of Guardian Signature Date