psychiatric solutions
Behavioral Health Services

COUNSELOR DISCLOSURE STATEMENT

The State of Washington requires us to disclose the following information to you about Psychiatric Solutions:

SPOKANE ADDRESS:

Psychiatric Solutions
1620 North Mamer Rd. Building B
Spokane Valley, WA 99216

Division of Behavioral Health and Recovery (DBHR) License Number: 200528

AGENCY PHILOSOPHY:

At Psychiatric Solutions, we believe that a multi-disciplinary approach is the most effective method to providing quality care. We are proud of our high patient satisfaction. Our staff is knowledgeable, compassionate, and skilled in the most effective psychotherapeutic techniques.

Our Spokane behavioral health facility has a psychiatrist, psychologists, marriage and family therapists, social workers and a psychiatric health nurse practitioner available to help our patients. Together, we work under the direction of board-certified psychiatrists with a long history of service to patients in Eastern Washington. Our psychiatrists assess patients, prescribe and manage medications, and provide individualized treatment as needed.

COUNSELOR EDUCATION & CREDENTIALS:

1. **Clinician Name:** Kayla Hicks, MSW, LSWAIC, MHP
   Credential Type: Licensed Independent Clinical Social Worker-Associate
   Credential Number: SC60743530

2. **Clinician Name:** Angela Mello, MSW, LICSW, CDP, MHP
   Credential Type: Licensed Clinical Social Worker; Chemical Dependency Professional
   Credential Number: LW60260475; CP00006373

3. **Clinician Name:** Joseph Judd, LMFT, MHP
   Credential Type: Marriage and Family Therapist License
   Credential Number: LF00002458

METHODS OR TECHNIQUES AND TYPE OF COUNSELING USED BY PSYCHIATRIC SOLUTIONS CLINICIANS:

Psychiatric Solutions provides comprehensive, personalized treatment programs for behavioral health disorders. We combine our evidence-based treatment with personalized integrative interventions. We

utilize person centered, strengths based and solution focused therapies during the course of the treatment program.

FEE INFORMATION/BILLING PRACTICES: Please refer to the Financial Responsibility Agreement and Attendance Policy Acknowledgement.

CONFIDENTIALITY: Please refer to the Informed Consent for Therapeutic Services.

COMPLAINTS/GRIEVANCES: Please refer to the Grievance Procedure.

Contact information to make a complaint about a healthcare provider to the Department of Health (DOH) is available upon request.

SIGNATURES:

My signature indicates that I have provided the client listed below with a copy of Psychiatric Solutions Counselor Disclosure Statement for my location (where applicable). I have reviewed the education, training, experience, methods and/or techniques and type of counseling used by Psychiatric Solutions clinicians with the client listed below.

Counselor Signature: _____ Date: _____

Counselor Name (printed w/ credential): _____

My signature indicates that I have been provided with a copy of Psychiatric Solutions Counselor Disclosure Statement and that I have read and understand the information. I understand that during the course of my treatment at Psychiatric Solutions, my treatment team may consist of any or all of the therapists listed on this disclosure in addition to any or all of the disciplines listed above.

Client Signature: _____ Date: _____

Client Name (printed): _____

Parent/Guardian Signature*: _____ Date: _____

Parent/Guardian Name (printed)*: _____

*Required if client is a minor and under the state-mandated age of consent.

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W: psychsolutions.com

INDIVIDUAL RIGHTS

You Have the Right To:

1. Receive services without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.
2. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service.
3. Be reasonably accommodated in the event of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
4. Be treated with respect, dignity, and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
5. Be free of any sexual harassment.
6. Be free of exploitation, including physical and financial.
7. Have all clinical and personal information treated in accord with state and federal confidentiality regulations.
8. Review your clinical records in the presence of the Administrator or designee and be given an opportunity to request amendments or corrections.
9. Receive a copy of patient grievance procedures upon request and to lodge a complaint or grievance with the agency, if you believe that your rights have been violated.
10. File a complaint with the Department of Health when you feel the agency has violated a requirement that regulates behavioral health agencies.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

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STATEMENT OF UNPROFESSIONAL CONDUCT

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:

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 the 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 proceedings 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 result 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, violation of any drug law, or prescribing controlled substances for oneself;
7. Violation of any state of 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, documents, records, or other items;
   b. Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority.

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c. Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; 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. Violation 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 purpose 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 on the disciplining authority;
20. The willful betrayal of a practitioner- patient privilege as recognized by law;
21. Violation of chapter 19.68 RCW.
22. 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

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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 or her from providing evidence in a disciplinary proceeding;

23. Current misuse of:
    a. Alcohol;
    b. controlled substance; or
    c. Legend drugs;
24. Abuse of a client or patient or sexual contact with a client or patient;
25. Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vender of medical or health-related products or services intended for patients, in contemplation of a sale of 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.

Anyone having questions or wishing to file a complaint should write or call:

Washington State Department of Health
Health Systems Quality Assurance Complaint Intake
P.O. box 47857
Olympia, WA 98504-7857
Local: 360-236-4700
Email: HSQAComplaintIntake@doh.wa.gov

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

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CONSENT FOR SERVICES

The Right to Consent

Washington law provides that all patients, including those who receive behavioral health services, have the right to give or refuse consent of treatment. All mental health patients have the right to:

An explanation of their diagnosis;

Information about their recommended treatment, including the possible risks and expected benefits;

Any alternatives to the recommended treatment, along with the risks and benefits of such alternatives; and

Give or refuse to give consent for treatment

By signing below, I am voluntarily agreeing to receive mental health services from Psychiatric Solutions. These services may include psychiatric evaluation, psychotherapy and medication management. I understand that I may decide to stop such treatment or services at any time. I understand that my medical information is protected by federal and state confidentiality laws and that my treatment information will be kept confidential to the extent possible by law.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE

Notice of Privacy Practices: Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C. Our 'Notice of Privacy Practices' provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our 'Notice of Privacy Practices' is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 509-863-9608.

If you have any questions about our 'Notice of Privacy Practices', please contact P.C.

I acknowledge receipt of the 'Notice of Privacy Practices' of Psychiatric Solutions, P.C.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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SUBSTANCE USE CONTRACT

Patient (Name):_____

Agrees to avoid the use of any non-prescribed substances for recreational or self-medication purposes while participating in this program at Psychiatric Solutions. I understand that failing to do so will jeopardize my eligibility to participate further in the program through Psychiatric Solutions. This agreement is based on my understanding of the fact that using illicit drugs will interfere with my ability to achieve therapeutic gains. I also agree to the following:

1. I agree to be assessed for Agonist therapy and agree to consider this treatment if the treatment team believes it would be beneficial for my progress.
2. I agree to consider residential substance abuse treatment, if I experience multiple failures in compliance.
3. It is the policy of Psychiatric Solutions that when you enter the program we have the right to require you to submit to a urinalysis. The testing will be at random and may or may not be required during your program attendance.
4. I understand that the purpose of this agreement is to ensure my successes in treating my mental health issues without the interference of substances. I also understand that this agreement will be utilized as a treatment tool to help me comply with my treatment goals. I also understand that failing to comply with the above terms repeatedly will jeopardize my ability to participate in the program.

Consent for Drug Test

Hereby gives his/her permission for testing his/her urine at a lab designated for such for the duration of his/her treatment attendance.

The results of the urine analysis will be kept confidential to the extent possible by law. If the lab report returns positive, this does not necessarily mean that you will be unable to continue treatment with Psychiatric Solutions. The purpose of this test is to help measure and formulate your needs and treatment strategy. Thank you for your cooperation.

Psychiatric Solutions would also like to notify you that there will be a collection charge from our office and the urine analysis will be sent to an outside source for processing. Billing for this service will be in accordance with standard Psychiatric Solutions, P.C. policies.

Patient Signature: _____ Date:_____

Parent/Guardian Signature:_____ Date:_____

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CONFIDENTIALITY STATEMENT

GENERAL

All information concerning patients, their presence in this program and their medical condition is confidential. This privacy is protected by both federal and state laws. In signing below, I acknowledge that I have been informed of the requirement for confidentiality with respect to patients, and that I agree to abide by the same.

CONFIDENTIALITY OF SUBSTANCE ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Psychiatric Solutions is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, unless:

- The patient consents in writing
- The disclosure is allowed by a court order, or
- To report suspected abuse of a child or vulnerable adult
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations (Federal Regulations 45 CFR Parts 160 & 164 and 42CFR, Part 2) by this program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations

Federal law and regulations do not protect any information about a crime committed by a patient either at this program or against any person who works for this program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

PARTICIPATION IN GROUPS

I understand that all issues discussed in groups in which I participate are highly confidential. Such information shall not be discussed outside the group sessions with anyone other than my therapist or physician.

My signature below indicates my agreement to comply with the confidentiality policy.

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Parent/Guardian Signature: _____ Date: _____

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INSURANCE BENEFITS

I hereby authorize payment of the insurance benefits otherwise payable to me to be paid directly to my physician. I hereby authorize release of information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Authorization to Release Information

I hereby authorize Psychiatric Solutions and/or the undersigned Psychiatrist, Radiologist, Pathologist, Cardiologist, Neurologist, Attending Physician, Consulting Physician and/or Anesthesiologist to release information acquired in the course of my examination or treatment, for the purpose of payment and processing of claims

I hereby assign my insurance and benefits to be paid directly to Psychiatric Solutions and authorize payment directly to Psychiatric Solutions and/or physician(s) insurance benefits otherwise payable to me, but not to exceed the balance due to the specified program and physician's regular charges for this period of treatment. I understand I may be financially responsible to Psychiatric Solutions and physician(s) for charges not covered by this authorization.

PLEASE NOTE

It is your responsibility to check with your insurance company regarding requirements for pre-authorization or pre-certification before admission to the specified program. Your benefits may be reduced by as much as 50% if these authorizations are required and not obtained prior to admission.

Insured Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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PSYCHIATRIC SOLUTIONS
PATIENT FINANCIAL RESPONSIBILITIES

The fundamental ingredient in the psychotherapeutic relationship is clear communication between the doctor and the patient. This philosophy extends to our policies on fees and services. Please feel free to discuss these with us at any time.

INSURANCE: If you have insurance that covers this service, we will be happy to bill your insurance company. **Your co-payment is due and payable at the time of each session**.

****We will need a copy of your current insurance card at the time of your appointment. If you do not have your insurance card with you at the time of your appointment you must present one within 30 days of your appointment or all charges will be billed to you.**

Please note that the Mental Health portion of insurance coverage often differs from other medical coverage. Pre-authorization is often required. Some mental health services may not be covered by your health insurance plan or may only be partially covered. We strongly suggest you contact your insurance company before treatment begins to be certain that you thoroughly understand both your obligation and that of the insurance company regarding mental health coverage. If we provide services to you that are not covered by your health insurance plan, you will be responsible for payment in full for those services. If we provide services to you that are only partially covered by your health insurance plan, you may be responsible for the remainder of payment for those services. Your signature below constitutes agreement to pay for such services.

As a courtesy, our office will contact your insurance company on your behalf to check your benefits and work to obtain authorization for services rendered. If we are not contracted with your insurance company, and if no out of network benefits are available, we will work with your insurance company to try and obtain 'Single Case Agreement'. Please understand an authorization of a Single Case Agreement is not a guarantee of payment and we will be unaware of how your benefits will be applied until your claim is processed by your insurance company. We highly recommend and encourage you to call your insurance company to verify your benefits and understand them prior to any service rendered. Any questions regarding how your insurance company processed your claim needs to be directed to your insurance company. All co-pays are required at the time of service. If you are in one of our programs it is required that your care, be followed by a physician. Your co-pay is required at each of those office visits.

I understand that I am financially responsible for any balance not covered by my insurance carrier, including but not limited to deductibles, co-pays, co-ins, or any out-of-pocket percentages. A copy of this signature is as valid as the original.

LATE CANCELLATIONS AND MISSED APPOINTMENTS: Your appointment time has been reserved for you. If you must cancel an appointment, contact us within 24 hours at (509)863-9779 so that we may schedule another patient on the waiting list. If our office is not notified of a cancellation 24 hours in

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advance of your scheduled appointment, **you will be charged $125 fee for a no-show for appointments. As a courtesy to our office and other patients, we ask that you please cancel your appointments within the 24-hour period to avoid the no-show charge, and to allow us to schedule another patient during that time. The PHP and IOP programs are excluded from this policy but we strongly encourage all patients to provide as much notice as possible prior to missing a session. Please be informed that three consecutive no-shows could lead to termination of care.**

CONSULTATIVE REPORTS AND FORMS: As a courtesy, we will send a report to the professional who referred you at no additional charge. You may need to request completion of other reports or forms. Fees for this service are determined on an individual basis; **typically, the charge is $15** depending on the length and complexity of the report. Insurance does not cover this service and payment is due upon completion of the report.

I have read and understand these policies. You may have a copy of this for your records upon request.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

This is the continuation. Be careful when typing because the first and second pages aren't "continuous." When you reach the bottom of the first place, please manually start a paragraph on page 2.

Please note that while the background looks washed out in the screen, it will print at full saturation.

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