ASBELL
HEALTH STRATEGIES

Agreement

Welcome to my practice. This document, the **Agreement**, contains important information about my professional services and business policies. It also contains references to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purposes of treatment, payment, and health care operations. A Notice of Privacy Practices, a separate document, addresses HIPAA and its application to your personal health information.

When you sign this document, it will represent an agreement between us. 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.

I have a PhD in Clinical Psychology from Washington State University and interned through the University of Washington School of Medicine. I am licensed to practice as a Psychologist in the states of Washington (PY00001310) and Idaho (PSY-279). I specialize in individual and relationship issues and health psychology.

For more information about my practice, please visit my web page at www.asbellhealth.com.

Professional Relationships: In Spokane, I lease office space from Fernwell Office Suites which professionally manages services and office space for many independent businesses. My practice has no professional relationship with any of these entities.

Therapeutic Model: My therapeutic model recognizes that each person is an individual with biological, psychological, and sociological aspects of their being. Depending on your needs and preferences, I attempt to integrate these aspects within a developmental, cognitive behavioral, and interpersonal approach. Periodically throughout therapy we will discuss therapy goals and the proposed course of therapy. If you have any concerns or questions, please bring them to my attention. You have the right at any time to refuse therapy, change therapists, or request a change in therapeutic approach.

Fees: Therapy sessions generally are 40 to 45 minutes ("clinical hour") in length. Fees vary based on the service. Fees for the initial visit are $250.00 and $175.00 for subsequent sessions. The fee for a brief session (20 to 25 minutes) is $100.00; the fee for an extended session (50 to 60 minutes) is $210.00. Longer sessions are prorated based on the clinical hour fee. Crisis sessions are $5.00 per minute. There is a 5% discount for individuals not using their insurance

who pay at the time of service by cash or check. These fees may change—fees are adjusted annually on July 1 to reflect changes in expenses.

> ***Please Note:*** **You must *cancel* scheduled appointments one business day/24 hours in advance; otherwise, you will be billed for half the normal session fee, even if the cancellation was unavoidable.** If you do not use your full appointment, you will be billed half fee for the portion you did not attend. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Please initial here _____to indicate your understanding and acceptance of the fee policy.

Fees for ***telephone calls***, ***email consults***, services not considered medically necessary, attendance at meetings with other professionals you have authorized, preparation of records or summaries, letter writing, or other services you might request are prorated based on my clinical hour fee, with a minimum fee of 10 minutes (1/5 hour). These services normally are not covered by health insurance. Also, if I am subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony, even if I am called to testify by another party. Billing fees for ***court related work*** will be one-and-one-half times the hourly rate, for a minimum of four hours. Cancellation for court related work is required two business days in advance to avoid a late cancellation fee.

I require payment for services at the time of service unless we agree otherwise or you have a health insurance company that requires a different arrangement. Payment for services such as reports and court related work is required at the time of the request. A late payment fee of 1.5% per month will be added on any balance after 60 days. The fee to process a returned check is $30.

If you would like me to bill your health insurance company, you will need to give me a copy of your insurance card and agree to and sign an Insurance Information and Authorization Form.

Confidentiality: You have privileged communication under the laws of Washington and Idaho. That means, with some exceptions, anything you disclose in therapy and information I obtain about you from any source, even that you are a client, is confidential and can be disclosed to others only with your written authorization. However, disclosure ***without*** your consent or authorization can be made, or may be required by state or federal law, if the disclosure is:

- to a federal or state law enforcement agency requesting information for health oversight activities or as required by law;
- to proper authorities if I should have reason to believe that a child or vulnerable adult has been abused, exploited, or neglected, if we feel you are of danger to yourself or others, or if you make an actual threat against a reasonably identifiable person;
- to the courts or other party if I am under a valid subpoena or court order;
- to licensing boards if I am under disciplinary investigation;
- to the WA Department of Labor and Industries or ID State Insurance Fund and your employer if the services I am providing are relevant to a worker's compensation claim you have filed;

- to public health care authorities for notifiable health conditions unless the condition notification has already been made;
- to county coroners and medical examiners for the investigations of death;
- to a health care provider or facility for the purpose of coordination of care, unless you instruct me not to do so; or
- to immediate family members unless you instruct me not to do so.

Additionally, I may disclose relevant information if you file a lawsuit against me or if you commit a crime against me. If disclosure is required without your authorization, I will attempt to discuss the situation with you to clarify options and look for alternate solutions. In that case, I will limit my disclosures to that minimally necessary.

Other Limits to Confidentiality: For both clinical and administrative purposes, such as scheduling, billing, and quality assurance, administrative staff may have information about you. I also may have contracts with professionals such as accountants, billing software vendors, computer technicians, or attorneys who may have information about you. If you request, we can provide you with the names of these individuals. All are legally, contractually, and ethically bound to protect your confidentiality.

In the case of relationship or family therapy, or when **multiple family members** are seen, confidentiality is waived among participants unless other prior arrangements are made.

In some cases, it might be useful to your therapy for me to discuss your situation with others such as a teacher; in that case, I will seek your written authorization for this exchange of information. Please be aware that after we release information, with your signed consent, I will no longer have control of how that information is controlled or distributed.

I occasionally may find it helpful to consult with another professional about our work. In this case, I make every effort to avoid revealing your identity. Those consultants, of course, also are legally bound to keep your information confidential. I will note any consultations in your clinical record.

Therapy with Children: In the case of children **under the age of 18**, the parent(s) or legal guardian holds the communication privilege. This means that the parent is entitled to information about the child and is the person who authorizes any release of information about the child. However, I ask that you waive your right to access to your child's treatment record. I will discuss with the parents the child's general progress and specifics if indicated. I will attempt to act in the child's best interests in deciding to disclose confidential information without the child's consent.

I require that each parent agree that you will not involve our work with your children in any legal disagreement between the two of you. In particular, by signing this agreement, you agree that in any such proceedings neither of you will ask me to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or my records or to refer in any court filing to anything I have said or done.

Treatment Records: I keep records of the services I provide you. You may ask to see or obtain a copy of those records, and you may ask to amend those records. You may be charged an appropriate fee for time and costs involved with any information request. Payment is required at the time of the request. Please see the Notice for further rights regarding your records.

I keep a commingled clinical record of our work when I see **couples or families**. However, any release of information you request will apply only to sessions in which you were seen individually. I require a release from both parties for records involving conjoint sessions.

Client Rights: HIPAA provides you with several new and expanded rights with regard to your Clinical Records and disclosures of protected health information. These include the rights to request restrictions on what information from your Clinical Records I disclose to others; request an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determine the location to which protected information disclosures were sent, have any complaints you make about our policies and procedures recorded in your records; and obtain a paper copy of this Agreement, the Notice, and our privacy policies and procedures. I are happy to discuss any of these rights with you.

Telepsychology: Telepsychology includes the transmission of information in any electronic form, including telephone contact and email. You need to be aware that both telephone and especially email contact is ***not secure*** and involves potential risks to confidentiality. If you prefer and your system allows, I can help you use email encryption with me to better protect your confidentiality.

Email: Email is becoming an easy and fast way to communicate and handle routine questions such as those regarding scheduling or billing, and my office may use electronic communication for administrative purposes. If you contact me by email, please put an identifier such as "Appointment" in the subject line. Also, please remember to put your name in the body of the message.

Because it is not secure, email is ***not*** a good medium for sending personal or clinical information. Please call me if there is personal information you need to tell me; if there is any urgency to your communication; if I have not responded within three working days; or if my response is not sufficient for your needs. If you send personal information to me in an email, I cannot respond except to offer alternative means of contact.

A copy of any email I send to you or receive from you will become a part of your clinical record.

Telephone: Although I have experience with therapy using this media and have had training related to its use, if we conduct therapy sessions by telephone, you must be aware that this is considered an innovative treatment because of limited research on therapy using this modality. Further, because we lack visual feedback, we could miss important cues or information that we could normally use in our work. There also may be risks if our communication becomes disrupted. If there is a disruption that cannot be restored, I will attempt to restore contact with you in an alternate manner. I request you do the same.

Contacting Me: I am often not immediately available. If you cannot reach me, or you feel that you cannot wait for me to return your call, you should contact your family physician, call First Call for Help at (509) 838-4428, call 911, or go to the Emergency Room at your nearest hospital.

Concerns and Complaints: If for any reason you should have a concern or complaint about the services I deliver, ***please let me know.*** You also have the right to submit a complaint to the ***Washington*** State Department of Health, Health Professions Quality Assurance, PO Box 47860, Tumwater, WA 98501-7860, (360) 236-4700 or the ***Idaho*** State Board of Psychologist Examiners, Bureau of Occupational Licenses, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642, (208) 334-3233.

Client Agreement: Your signature below indicates that you have read and understand the information in this Agreement and agree to abide by its terms during our professional relationship. (If you have any questions, please ask before signing.)

_____	_____	_____
Printed Name	Client or Legally Authorized Signature	Date
_____	_____	_____
Printed Name	Client or Legally Authorized Signature	Date

I have discussed this Agreement with the client:

_____	_____
Laura Asbell, PhD	Date

Notice of Privacy Practices

Acknowledgement

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information.

By signing below, I acknowledge having been provided a **Notice of Privacy Practices**.

_____	_____
Client or Legally Authorized Signature	Date
_____	_____
Client or Legally Authorized Signature	Date