Rain City Therapy Associates, PLLC
CLIENT REGISTRATION

Thank you for choosing our office. In order to serve you, we will need the following information.

PLEASE PRINT:

Name: _____ Date: _____

(Parents/caregivers): _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ _____ _____
(home) (work) (cell)

Email: _____ Gender ID: ___ Date of Birth: _____ Age:__

Emergency Contact: _____ Phone: _____

Who referred you: _____ PCP: _____

Address: _____ Phone: _____

Primary Insurance Company: _____

ID#: _____ *(a copy of both sides of card must be attached)*

Effective date: _____ Employer: _____ Co-pay: _____

If patient is NOT policy holder, fill in below: Policy Holder Information:

Name: _____ D.O.B: _____ SS#: _____

Relationship: __Parent __Spouse __Child __Other Employer: _____

Secondary Insurance Company: _____

ID#: _____ (a copy of both sides of card must be attached)

Effective Date: _____ Employer: _____ Co-pay: _____

If patient is NOT policy holder, fill in below: Policy Holder Information:

Name: _____ D.O.B: _____ SS#: _____

Relationship:__ Parent __Spouse __Child __Other Employer:

Federal regulations allow me to use or disclose Protected Health Information from your record to provide treatment, obtain payment for the services I provide and operate my practice. Nevertheless, I ask your consent in order to make your permission explicit. My Notice of Privacy Practices describes these disclosures in greater detail which you have the right to review before signing this consent.

I hereby authorize the provider of service to furnish information requested by my Insurance Carrier and I hereby assign to the provider all payments rendered to myself or my dependents. I understand it is my responsibility to pay for any deductible amount, co-payment or other allowable balance not paid for by my insurance.

Date_____ **Signature** _____

For office use: Therapist_____ DX_____ DX2_____

The full fee will be charged for any session missed or canceled without 36-hour notice.

Late Cancellation & Missed Appointment Policy

At Rain City Therapy Associates, PLLC each clinician sees a fixed number of clients each week. Once you schedule an appointment with a Rain City therapist, that time is reserved exclusively for you. In order to successfully operate our clinical practice, we need to be able to rely on these therapy appointments. Therefore, we have established the following policy for missed and late canceled appointments.

For any appointment that is missed or canceled with less than the required 36-hour notice, no matter what the reason, clients will be charged the fee that Rain City Therapy Associates, PLLC would have billed for that session, as shown below. Also, keep in mind that missed or late canceled appointments are not covered by your health plan and cannot be billed to your insurance company.

These rates below are for 60-minute appointments. 90-minute appointments are billed $225.

Initial Evaluation $200	**Family $150**	**Group $60**
Individual $150	**Couples $150**	**Legal Reports $150/hr.**

We realize that on infrequent or rare occasions an event may occur in your life that requires the canceling of your scheduled appointment with less than the required 36-hours. Such cancellations may be the result of a sudden illness in yourself or family member, the untimely breakdown of your automobile or an employer requiring you to stay late at the office. We will do our best to offer you a timely rescheduling of your appointment. Nevertheless, keep in mind that regardless of the understandable reason for cancellation, you will still be charged for the time we have reserved for you.

The only exception to this policy is for cancellation in severe weather. If the driving conditions are such that you do not feel safe driving to our office, please call us as soon as possible. If you call us and we confirm your cancellation due to inclement weather, the cancellation fee will be waived.

Should you have any additional questions, please discuss them with your individual therapist.

I have been informed of the policies and procedures at Rain City Therapy Associates, PLLC.

Signature:_____ Date_____

BILLING AND PAYMENT FEES

Payment is expected at the time of your appointment unless other arrangements have been discussed and agreed upon in advance. Your health insurance company may reimburse for your appointments. However, you are responsible for any deductible, co-payment or balance applicable to your individual policy. Rain City Therapy Associates, PLLC asks all clients to submit a credit card authorization sheet. In the unlikely event that you have a balance owed for more than 60 days, Rain City Therapy Associates will charge the overdue amount to your account and notify you of this charge.

CREDIT CARD AUTHORIZATION FORM

To be used only for bills <u>60 days</u> overdue unless you specify otherwise below.

NAME: _____ (Please Print)

CLIENT NAME: _____ (Please Print)
(If different from credit card name)

TYPE OF CARD: Visa____ Master Card_____ Discover Card_____ Debit Card_____

CREDIT CARD#: _____

EXPIRATION DATE: _____ 3-DIGIT CODE: _____
(last 3 digits on the back of card)

ZIP CODE: _____ (where credit card bill is mailed)

SIGNATURE: _____

If you want Rain City Therapy Associates, PLLC to bill your credit card monthly, please sign below:

_____

If your credit card changes or expires, please let us know. Thank you.

CLINICIAN SIGNATURE: _____

Rain City Therapy Associates, PLLC, 21905 64th Ave W, Ste 301A, Mountlake Terrace, WA 98043

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize Rain City Therapy Associates, PLLC to use and disclose the health and clinical information of_____ (***Your name here)*** for the purposes of Treatment*, Payment** and Health Care Operations***.

***Treatment** (includes activities performed by Rain City Therapy Associates, PLLC) providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional).

****Payment** (includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre-certification and preauthorization). Rain City Therapy Associates uses TapRoot Billing Services to directly bill your insurance for you. YOU WILL RECEIVE MONTHLY STATEMENTS TO REFLECT YOUR BALANCES. For questions or concerns, please call either Lacey of TapRoot Billing. Lacey can be reached by phone at (425) 681-1190 or by email at lacey@taprootbilling.com.

*****Health Care Operations** (includes the administrative and business functions of this practice).

You should review Rain City Therapy Associates, PLLC ***Notice of Privacy Practices*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because we reserve the right to change our privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted in clinician offices indicating the effective date of our current ***Notice of Privacy Practices*** in the upper right hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to us after the effective date of the current ***Notice of Privacy Practices***. *Y*ou will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices,*** you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request.* If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you.

Other practitioners who provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices***.

Please verify that you have received a copy of our ***Notice of Privacy Practices*** by signing your initials here_____.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Rain City Therapy Associates, PLLC has already used or disclosed the information in reliance on this CONSENT.

Signature of Client _____Date_____

Signature of Legal Guardian or Representative_____Date_____

Please indicate the nature of your relationship to the client

_____

Rain City Therapy Associates, PLLC
21905 64th Ave W, Ste 301-A
Mountlake Terrace, WA 98043

HIPAA NOTICE OF PRIVACY PRACTICES

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.

Rain City Therapy Associates, PLLC respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. **Your health information rights.**
   The health and billing records we create and store are the property of Rain City Therapy Associates, PLLC. The protected health information in it, however, generally belongs to you. You have a right to:
   - Receive, read and ask questions about this Notice.
   - Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
   - Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
   - Request that you be allowed to see and get a copy of your protected health information. You can make this request in writing.
   - Have us review a denial of access to your health information – except in certain circumstances.
   - Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
   - When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months.
   - Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
   - Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

   For support with these rights during normal business hours, please contact: 425-610-7584 or you may discuss your concerns/questions with your clinician.

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it or by specifically asking your clinician for a copy of the Notice.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: 425-610-7584 or speak to your clinician directly.

If you believe your privacy rights have been violated, you may discuss your concerns with your clinician. You may also deliver a written complaint to your clinician at Rain City Therapy Associates, PLLC. You may also file a complaint with the department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For Treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan.
    - Accounting, legal, risk management, and insurance services; and
    - Audit functions, including fraud and abuse detection and compliance programs.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- **Required by law**: We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
    - To prevent or reduce a serious a serious, immediate threat to the health or safety of a person or the public.
    - To public health or legal authorities:
        - To protect public health and safety.
        - To prevent or control disease, injury, or disability.
        - To report vital statistics such as births or deaths.
        - To report suspected abuse or neglect to public authorities.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.

- **Correctional Institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster Relief:** We may share protected health information with disaster relief agencies to assist in notification of you condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require use to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **National Security**: We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. **Uses and disclosures that require your authorization.**
   Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:
   - **Psychotherapy Notes**: If we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures for psychotherapy notes.
   - **Marketing communications**: We must obtain your authorization to sue or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
   - **Sale of Health Information**: Disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations from these sues and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Effective date
This Notice is effective as of September 23, 2013