

Robert Odell, MSW, LICSW

www.seattle-counseling.com

Welcome to my office. My goal is to provide you with professional service.

Before your first appointment, these forms must be completed:

1. Client Information
2. Professional Service Contract and Financial Policies
3. Personal Guarantee of Payment (if included)
4. Acknowledgment of Receipt of Privacy Practices (unless payment for services is privately made, i.e., no insurance or EAP benefit used)
5. You can review and sign the Disclosure Statement prior to your first appointment, if you wish. However, you can also take it home, sign and return it prior to your second appointment. Feel free to ask me any questions about it before you sign. On signature, I will provide you with an identical copy to keep.

When you come in for your first (or any) appointment, please come to the 3rd floor. I will meet you in the waiting room to the right from the elevator. For future appointments, I will also meet you there. If you have any questions about these forms, please ask them at the beginning of your appointment.

Please turn off your cell phone before each appointment.

Thank you,

Robert Odell

Clinical Office
3214 W. McGraw St.
Seattle, WA 98199

Correspondence
PMB 256, 3213 W. Wheeler St.
Seattle, WA 98199

Contact
Tel: (206) 282-3137

CLIENT INFORMATION

Robert Odell, MSW, LICSW PMB 256, 3213 W. Wheeler St. Seattle, WA 98199

Name: _____ Date of birth: _____

Health insurance ID# (if using insurance): _____ Group # _____

Family members or partners who will or may be involved in treatment:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Home address: _____
Street City State Zip

Work address: _____
Street City State Zip

Home phone(s): _____ Work phone(s): _____

Cell phone: _____ E-Mail: _____

Emergency contact: _____
Name Relation Phone #

If insurance is being used, and you are not the policyholder, please enter policyholder information:

Name Birth Date Health insurance ID# Group #

Address City /State Zip Phone

Robert Odell, MSW, LICSW
Professional Service Contract & Financial Policies

This contract must be signed by you below so that I may provide service, including employee assistance (EAP). If you are not using health insurance or employee assistance benefits, please refer to the attached "Disclosure Statement and Statement of Office Policies" to review my fees. *If you are using health insurance or employee assistance benefits, fees are determined by contract or fees set by the carrier. Please indicate whether any of the following steps has been taken:*

_____ I/We intend to pay fees privately and will not use a health insurance or EAP benefit to pay for these services

_____ I/We intend to use health insurance or EAP benefit to reimburse all or part of the fees for these services.

1. The "Person(s) Responsible for Payment" is personally responsible for the payment of my service fees. This includes payment for appointments which are made but not kept or re-scheduled by you, or, if a health insurance carrier or EAP does not reimburse claims due to ineligibility for coverage. [NOTE: *I do not mail bills for missed appointments. Please complete the attached Personal Guarantee of Payment.*]
2. If an insurance claim is denied for reasons beyond my/our control, the Person(s) Responsible for Payment is responsible for payment of fees. If claims are ultimately paid, you will receive a refund within sixty days of receipt.
3. This office only submits claims to one ("primary") insurance plan. Payment of benefits is assigned to my office. A duly authorized agent may be retained to submit claims to your carrier. Amounts due for over 60 days are subject to collection via account debit, or by third party agencies if necessary.
4. Insurance claims require a diagnosis submitted to the carrier. It must be a diagnosis for which your policy has determined treatment to be medically necessary¹. Re-authorization for more treatment sessions requires that I disclose information about you to your insurance company. You may view this information in advance.
5. When you accept an appointment slip at the end of each session indicating the date and time of your next appointment, this is your agreement to keep this appointment. Rescheduling by you must be done over the phone with me within no less than 48 hours of the original appointment. This policy is further described in the attached Disclosure Statement.

¹ Your carrier should define this term in your benefit plan's description.

Professional Service Contract & Financial Policies
Robert Odell, MSW, LICSW

AGREEMENT

Subject to my review of the attached Disclosure Statement, I freely choose to give consent to receive, or discontinue with proper notice, diagnostic and treatment services from Robert Odell, MSW, LICSW. I have been given information regarding my rights and responsibilities as a client. I may address any concerns or grievances with Robert Odell, or the Washington Department of Health.

My signature below confirms my understanding and agreement to the terms above, and to receive services from Robert Odell, MSW, LICSW.

Person Responsible for Payment

Date

Person Responsible for Payment

Date

Personal Guarantee of Payment

Credit or debit card account information (including pre-tax medical flex accounts) are held by Robert Odell as a personal guarantee of payment for services. All account data is immediately transferred to a securely encrypted format. Then, identifying account information on this page will be blacked out.

Here are the only circumstances under which account information is used:

1. Guarantee of payment: If a reimbursement is due for services rendered on a private (not insured) basis, the amount due will be deducted at the end of the week in which the amount came due.

In the event that you make an appointment but do not keep it or provide sufficient notice, my cancellation policies apply (see page 11, Disclosure Statement.) I do not mail out an invoice in this case, but instead deduct the amount due at the end of the week in which the missed appointment or late notice occurred.

2. Insurance-related payment: When an insurance statement is received, it may indicate a deductible amount, co-insurance or co-payment due. I will deduct that amount from the account provided. If it indicates that no insurance payment is due because of a lack of eligibility, you may be charged fees specified in Section II A. of the Disclosure Statement below

3. Account change: If your account information changes, or if charges cannot be made to this account, you agree to provide new, valid account information upon request. Any other use by Robert Odell of this account information is prohibited by law.

4. You are entitled to receive a written receipt for any charges made in this way.

I have read and understood the above terms, the attached Contract for Services, and the Office Policies section of the Disclosure Statement.

Cardholder name [print]

VISA__ MasterCard__ Discover__ American Exp. ____

Account number

Expiration date

Cardholder signature

Date

Robert Odell, MSW, LICSW

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.

I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or "PHI".) I must follow the privacy practices described in this Notice (which may be amended from time to time.)

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information in Section II.G. of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal, and State of Washington law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. Health Care Operations: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing or credentialing activities. I will notify you in advance of any such disclosure

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others. Other disclosure permitted or required by law include the following: disclosure for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI; disclosure to judicial and law enforcement officials in response to court order or to other lawful process; disclosures for research when approved by an institutional review board, and disclosures to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy notes: Notes recorded by me documenting the contents of a counseling session with you (Psychotherapy notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: I will not use your health information for marketing communications without your written authorization.

3. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.

4. Other Uses and Disclosures: Uses and disclosures other than those described in Section I. A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy:** You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of paying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you (such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older).)

B. **Right to Alternative Communications:** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions:** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer", as indicated below. I am not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures:** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment:** You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement", based upon your proposed amendment, must be added to your record.

F. **Right to Obtain Notice:** You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. **Questions and Complaints:** If you desire further information about your privacy rights, or are concerned that I have violated your privacy right, you may contact me, Robert Odell, MSW, LICSW, by telephone at (206)282-3137, or, in writing, at PMB 256, 3213 W. Wheeler Street, Seattle, WA 98199. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. **Effective Date:** This Notice is effective on April 14, 2003

B. **Changes to this Notice:** I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised Notice in the waiting area of my office. You may also obtain any revised notice by contacting me.

Robert Odell, MSW, LICSW

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Robert Odell, MSW, LICSW

Signature of Client (or personal representative)

Date

If this Acknowledgment is signed by a personal representative on behalf of the Client, complete the following:

Personal Representative name: _____

Relationship to Client: _____ (if not self)

FOR OFFICE USE ONLY

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented me from obtaining Acknowledgment
- Other (specified below)

This form will be retained in the medical record.

Robert Odell, MSW, LICSW [Licensed Independent Clinical Social Worker]

Business address: PMB 256, 3213 W. Wheeler St., Seattle, WA 98199

Tel: (206) 282-3137

License # LW 5045

Client Disclosure Statement and Office Policies

It is your right as a client to select the mental health professional who best suits your needs. Before you sign this statement, your consent to treatment requires that you know about my services, and the terms under which I provide them.

I practice according to the Code of Ethics of the Clinical Social Work Association. A copy of this Code is available on request. Please refer to the attached summary of the ethical practices I observe.

I. DISCLOSURE TO CLIENT

A. Credentials

I am a Licensed Independent Clinical Social Worker, and not affiliated with any other practitioner(s). At your request, I can describe the requirements for State of Washington licensure for Clinical Social Work.

B. Confidentiality

The confidentiality of our work is of utmost importance. State of Washington law holds that our communication is privileged information, identical to that between doctors and patients, or lawyers and clients.

If your mental health insurance benefit requires a review of treatment to authorize additional sessions, then certain information about you, your treatment plans and progress may have to be shared with an insurance or managed care company. I will always review these disclosures with you in advance. Please review the information about my patient Privacy Practices mandated by the 1996 Federal law known as Health Insurance Portability and Accountability Act.

C. Education, training & experience

I received my Master's degree from the University of Southern California School of Social Work. In this program, I completed two one-year clinical internships. The first was in a Los Angeles County community mental health clinic serving a wide range of clients and treatment needs. The other was in a corporate Employee Assistance Program (EAP), providing assessment, counseling and referral for personal, work-related and chemical dependency problems.

My post-graduate clinical experience includes individual & family therapy in a Los

Angeles psychiatric hospital. I then practiced in a Los Angeles residential treatment center (court ordered) for adolescent boys, including sex offenders, referred by the state's Dept. of Probation, providing individual, group, couples and family psychotherapy.

I have provided individual and family therapy, case management and emergency room psychiatric assessments throughout Seattle, for Fairfax Hospital. In 1998, I began private office practice in an East Side group practice with psychiatrists, psychologists, nurses, Clinical Social Workers and counselors. In 1999, I opened my solo private practice in Seattle and Bellevue. In 2003, I chose to practice in Seattle only.

My continuing education has included training in marital therapy, human sexuality, ethics, clinical supervision, workplace trauma debriefing, therapy for children and adolescents, EMDR, conflict resolution, child abuse prevention and reporting, and non-violent crisis intervention. I have always exceeded State of Washington Department of Health requirements for continuing education hours.

D. Types of psychotherapeutic counseling provided

Couples, both marital and partnership, with an approach that integrates sexuality as a primary expression of each partner's sense of self;

Adults, specializing in the treatment of depression, anxiety disorders (Panic, PTSD), grieving, problems related to work and career, and relationships;

E. Counseling methods

No treatment method is more important to me than your belief that we are collaborating in finding new possibilities for your health and well-being. My methods are guided by understandings of how people develop over time. I am interested in individual growth, and how it is effected by important relationships. I try to get as close as I can to the meanings that you find within these relationships, in your personal and family histories, life events, and the successes and problems of living.

F. Course of Therapy

If you wish, we can agree in advance to the number of sessions in your treatment plan. You have the right to cancel treatment at any time, subject to the 48 hour notice requirement described below in the Statement of Office Policies, Section B. below.

G. Professional associations

I am the current President of the Board of Directors of the Washington State Society for Clinical Social Work. I maintain membership in the International Critical Incident Stress Foundation.

H. Complaints

If you have a complaint or inquiry about my professional services, you may contact the State of Washington Department of Health. I maintain forms and instructions so that you can submit your complaint or inquiry.

II. STATEMENT OF OFFICE POLICIES

A. Fees & Payment Policies

Please refer to your signed copy of my Financial Policies statement. Here is a schedule of my fees, as submitted for private payment or for insurance reimbursement:

<u>Session Type & Duration</u>	<u>Fee</u>
Assessment or psychotherapy (50 mins)	\$140
Diagnostic evaluation (75-80 mins)	\$175
Couples therapy (80 min) {preferred minimum time}	\$180
Couples therapy (110 mins)	\$230
Couples therapy (170 mins)	\$335

Written reports to third parties are preferable to the submission of progress notes. Reports can be written at a cost of \$85/hr. The number of hours will be agreed to in advance. Insurance does not reimburse for this service.

Couples therapy assumes the participation of both partners. Therefore, if only one partner appears for the appointment, the appointment would be recorded as a late cancellation (see II B. below for fee policies.) Individual counseling appointments can be set up during a couples counseling appointment.

B. Appointment cancellation, rescheduling and changes

Your receipt of the appointment slip is an agreement to meet on that date and time. If you do not appear, your credit or debit account will be charged via the pre-authorization in the Personal Responsibility for Payment form.

Use telephone/voice mail, not e-mail, for making, changing or canceling appointments. If you must change or cancel, **call** - not e-mail - at least **48** hours beforehand [*for Monday appointments, call no later than Thursday 12P; for Tuesday, no later than Friday 12P.*] If you are late, and do not notify me by phone, I will remain in the office for a maximum of 30 minutes past the appointment time.

For a late cancellation (less than 48 hours notice): *If you reschedule within 4 business days, I charge a fee equal to 50% of what I normally receive from you and/or your insurance carrier. After four business days, the full cancellation fee will be charged. If I fail*

to appear, without notice, for your appointment, either your insurance co-payment, or your private fee for the next appointment will be waived. (See below, ¶ 2 of Special Office Policies, for Emergency Service notice)

C. Insurance coverage

Most insurance policies cover treatment by Licensed Independent Clinical Social Workers. I bill your insurance company, and they will issue statements to both you and me of benefits paid or denied. Health insurance carriers need a diagnosis for which they consider psychotherapy treatment to be "medically necessary." I must evaluate on an ongoing basis whether your symptoms meet these 'medical' criteria. If they do not, I cannot submit claims. I can help you evaluate whether this requirement fits with your therapeutic goals.

D. Urgent or emergency contact

I make reasonable efforts to be reachable by phone or pager if you urgently need to speak to me. I cannot return your call while in session with another client. You may call me at any time to leave a message. I will return your call at your request. If your situation is life-threatening or psychiatrically disabling, please dial 911. If you are in a crisis before we are able to speak, call the King County United Way Crisis Line at (206) 461-3222. They can refer you to a community resource, which may include emergency assistance

AGREEMENT

Prior to signing below I understand that I have the opportunity to ask Robert Odell for further explanation, or have received same, for any of above disclosure information and office policies. I will receive an exact copy of this disclosure statement following my signature.

Client

Date

Client

Date

Robert Odell, MSW, LICSW

Date

Robert Odell, MSW, LICSW
Professional Practice Ethics & Special Office Policies

My primary goal is to develop the closest possible treatment relationship with you in the most ethical environment I can create. Disclosure of these professional and personal ethics to you seeks to prevent relationship practices that I believe can hurt or destroy treatment. If you have questions or concerns about any of these policies, please discuss them with me as soon as possible.

1. Your rights as a client do not end when the treatment relationship ends, including the right to confidentiality. I only disclose information about you with your informed consent or written permission. Neither your death nor mine terminates these rights. Exceptions are specified under Federal laws, and the State of Washington (RCW). Written records are destroyed 5 years after the last date of service.
2. I will not develop a social relationship with you outside the office, regardless of the length of time that my services have terminated. I will not accept social or family event invitations from you, and do not offer same. This is not an expression of a lack of interest in you, nor any evaluation of these events.
3. At no time will I engage in any physical contact with you in our relationship, other than the shaking of hands as a greeting or parting.
4. I will not accept any gifts, including food or invitations to meals. This is not a refusal to acknowledge nor a withholding of goodwill, in seasonal or holiday greetings or well wishes to you. It is instead the recognition that professional service, offered and received, is sufficient and complete, needing no other validation.
5. I neither accept nor provide any other services other than the practice of psychotherapy and counseling. I will not enter into any business or financial relationships with clients, other than the receipt of professional fees for service rendered.
6. To help ensure the confidentiality of your status as a client, if I see you in a public setting, I will not initiate any recognition or familiarity with you. If you choose to initiate visible or audible greeting or recognition with me, I will reciprocate, but will initiate no further exchange unless requested.
7. I will only initiate appropriate referrals to other health professionals with a client's consent. I make reasonable efforts to identify at least two professionals for each type of referral. I never accept or solicit any compensation of any kind in return for making or accepting a referral. I do not refer clients to specific attorneys, nor to accountants, financial planners or credit counselors.

Robert Odell, MSW, LICSW
Professional Practice Ethics & Special Office Policies

1. Fragrance Policy

Please refrain from the use of any cologne, after-shave or perfume prior to future appointments. This is a courtesy to all other clients. Some clients may have allergic sensitivity to ingredients in these products.

2. Emergency Service for Critical Incidents

I am contracted with several emergency service networks that help victims of incidents that can cause emotional and psychological trauma. These incidents include but are not limited to robberies, industrial accidents and sudden deaths. I may be called to the scene of an emergency on the same day it occurs, or a day or two after the incident.

I agree to provide these services on a particular date, I make every effort to maintain my scheduled office appointments. However, if schedule changes are unavoidable, I will immediately call all affected clients to reschedule appointments.

If I am called to the scene on the same day an incident occurs, it is possible that I would be unable to reach you in time to prevent your coming to your scheduled appointment. Based on my past experience, the likelihood of this happening is quite small. If it does occur, your rescheduled appointment will receive a 50% fee discount.

Please also be aware that I may receive pager messages from these service networks at any time. This is the only interruption in our appointment that I will allow. When I receive a message during an office appointment, I will notify you of this and then respond as briefly as possible to the call. Typically, the interruption lasts less than two minutes, and I will attempt to make up this time to you during the appointment.