

## **Client Service Agreement and Disclosure Statement**

This agreement is to provide information and disclosure regarding services provided to assist us in working together. Please feel free to ask me if you have any questions regarding the information outlined below. I look forward to working with you!

### **About My Services**

Since 2012, I have provided mental health services with focus on creating an environment of healing and collaborative relationship with my clients with focus on their needs and goals. I provide therapy services to adults who have experienced trauma, anxiety, mood disorders, concerns with life transitions, codependency and relationship concerns, grief and loss, and various life challenges. My practice involves using an eclectic approach based on your needs, including Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution-Focused Treatment, EMDR, Trauma-Focused Interventions, and Mindfulness. By engaging regularly in the therapeutic process, benefits can include, and are not limited to, improvement in mood, increased ability to engage in daily activities, and improved relationships. However, this process can be difficult and may lead to periods of discomfort during healing and personal growth. Please feel free to be open about your experiences in treatment and ask questions as your treatment continues. We will work together through these moments to promote your healing process. Course of treatment varies on an individual basis based on the needs of the client, and we will discuss this throughout treatment.

### **Standards and Ethics**

I am a Licensed Independent Clinical Social Worker (Credential LW60621424). I completed my Clinical Associate's training with Fresh Start Family Services in Las Vegas and Sound Mental Health in Seattle, resulting in independent licensure as of January 2016. My degree (Master of Social Work) was completed in 2010 at University of Nevada, Las Vegas. As a social worker, I am accountable to the NASW Code of Ethics. I do not engage in dual relationships with clients. I am neither authorized nor trained to prescribe medication. We will discuss referral to a prescribing provider if this service is desired.

### **Client Rights**

- You have the right to be treated with dignity and respect at all times.
- You have the right to be informed of my credentials, training, and treatment modalities intended for your care.
- You have the right to discuss with me your progress in treatment and treatment goals.
- You have the right to refuse treatment.
- You have the right to choose the practitioner and treatment modalities which best fit your needs.
- You have the right to confidentiality, with exceptions as required by law and to provide for treatment, which is further outlined in the agreement below.
- You have the right to access your personal healthcare information
- You have a right to a copy of this Client Service Agreement and Disclosure Statement, which is highly recommended so you may reference this throughout the course of your treatment.

## **Client Service Agreement and Disclosure (cont.)**

### **Scheduling and Cancellations**

To obtain the optimal benefits of participation in therapy, it is very important that appointments are attended regularly as scheduled. However, there may be times you are unable to attend your appointment, and with appropriate notice we may be able to seek alternative scheduling. Thus, the cancellation policy is as follows.

- Minimum **24 hours notice** prior to scheduled appointment to avoid **late cancellation fee (\$90)**.
- Late cancellation fee will be applied, regardless of situation, unless the appointment is made up within **5 business days** (usually up to the day before a recurring scheduled appointment), which will void the fee.
- Arriving for an appointment later than **fifteen minutes** is considered a missed appointment and is subject to the late cancellation fee as outlined above. Please allow yourself extra time to arrive for your appointment as well as find parking, as the lot can be busy at certain days and times.
- All cancellations are able to be rescheduled to open spots and requesting placement on the on-call list for cancellation is encouraged.
- Multiple missed recurring appointments may result in the loss of a recurring appointment slot, which will be discussed if the situation arises. Two missed appointments without discussion with myself will automatically result in two late cancellation fees (\$180) and loss of appointment slot.

Please keep in mind these policies are not intended to punish for unavoidable life situations, but to encourage regular participation in sessions, allow for other clients needing services to be able to participate by filling an open spot with as much notice provided as possible, and allow me to financially maintain my practice, as I am unable to bill your insurance if services are not provided. I encourage open discussion regarding missed appointments, as unavoidable life disruptions do occur and we can also discuss payment arrangements for late cancellation fees to help minimize financial hardship. Also, I will make every effort to notify you as soon as possible in the event of my absence, as I also respect your time, effort, and participation in services.

### **Fees, Financial Responsibility, and Insurance Billing**

My standard fee for private pay services for an approximately 50 minute session is \$180, \$200 for intake assessment. Please review the attached financial policy for further details.

Fees such as copays, coinsurance, and deductibles are determined by your insurance provider. Please contact your insurance provider if you have any questions regarding these fees, as these fees are not determined in the practice. Payment in full is due at the time of each session including private pay amounts, copays, coinsurance and deductibles. You will be responsible for any remaining balance. Advanced payment can be discussed with myself and the administrative team, as well as any requests for refund.

Medical records are available at no charge for the first 30 pages. For requests consisting of 31 pages or more, the fee is \$0.50 per page as well as a \$26 clerical fee consistent with **WAC 246-08-400**. Please be aware that a note for each session tends to consist of approximately 3-4 pages. Provider will notify client of anticipated pages and fees prior to printing. Due to the nature of client records, it is recommended requests consist of what is minimally required for the requested task at the client's approval. I am willing to provide a letter of participation and progress at no charge, which can often suffice in lieu of client records and assist in providing the minimal amount of information required.

## **Client Service Agreement and Disclosure (cont.)**

### **Fees, Financial Responsibility, and Insurance Billing (cont.)**

We reserve the right to bill our standard fees for case coordination, clinical and legal write-ups, and phone consultations exceeding 5 minutes per week. Our time is valuable and is best served providing high quality professional services to you while you are here in session. There is no charge for routine telephone calls to our administrative staff regarding scheduling, appointments, or billing. In the event of an unpaid balance, you may be contacted and in extended circumstances this may result in referral to collections and disruption in services. We will attempt to contact you and discuss with you known unpaid balances.

### **My Business Relationship with Mindful Therapy Group**

I am an independent provider with a separate business from Mindful Therapy Group. My relationship with Mindful Therapy Group is to receive their support primarily in provision of office space, billing, electronic medical record programming and related IT services, and the assistance of provider support specialists who provide a very valuable services to both you and I in terms of administrative support in regard to check-ins for appointments, scheduling, and answering questions in regard to insurance verification and billing. Often times, provider support specialists are messengers, providing you information regarding insurance benefits, fees, and reminders of my personal established policies, such as late cancellation fees. Therefore, please be mindful of being respectful to the team when addressing any concerns. **Abusive behavior toward Mindful Therapy Group staff and myself is not tolerated and can result in immediate termination of services.**

### **Contact Outside of Session/In Event of Emergency or Crisis**

As a client participating in services at Mindful Therapy Group, you will likely receive a faster response through the provider support specialists with Mindful Therapy Group when I am unavailable, and I have a separate voicemail specifically for use with Mindful Therapy Group. However, you may also contact me through my direct number and will attempt to return your call within one business day.

The most effective time to address concerns is during session, as this is time which is dedicated to your care. However, there are circumstances in which you may need assistance outside of session:

- **Emergency Assistance Required** - In the event of suicidal/homicidal ideation or medical emergency, please call 911 and go to the nearest emergency room. In event of emergency during session, we will respond and request a release be completed allowing for notifying your emergency contact.
- **Urgent Assistance Required** - In the event of increased symptoms and concerns which cannot wait to be addressed until your appointment, please contact our administrative team and notify of the need for urgent assistance during business hours. However, if I am out of the office, please use the following crisis options which are available 24 hours a day:
  - **Washington Recovery Help Line - (866) 789-1511** – Intervention phone line with professionally trained volunteers/staff. More information available at <https://www.warecoveryhelpline.org/>.
  - **Crisis Text Line – 741741 or Facebook.com/TextCrisisLine** – Provides ability to contact trained crisis counselors via text and Facebook messaging. There is no charge for using this with exception to standard text messaging rates. More information available at <https://www.crisistextline.org>.

### **Client Service Agreement and Disclosure (cont.)**

- **Case management-** Case management needs are best addressed during session, and if contact outside of session becomes excessive, these services may be billed. Please note, due to time spent in sessions, it is likely I will not be able to respond to your attempted contact immediately and will respond when I am in the office and able. Other needs, such as appointment rescheduling and billing, are best addressed by the provider support specialists during business hours.
- **Use of Spruce Health App** – Due to the nature of our current social methods of communication, I am participating with Spruce Health for HIPAA-Compliant phone, text, and e-mail usage. This platform allows for clients to communicate with me through the app or their own personal e-mail/telephone numbers. Please review the “Use of Electronic Information” policy below for further information.

### **Use of Electronic Communication**

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with me.

*Email and Text Message Communications* - I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like requesting communication between sessions and notifying me of a cancelled appointment in conjunction with the Mindful Therapy Group team. While I use Spruce, a HIPAA-Compliant platform, I discourage email or texts about clinical matters to provide additional protection of your personal health information unless otherwise discussed. If you need to discuss a clinical matter with me, please feel free to request a return call, with best times to reach you provided, or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. Email and text messaging should not be used to communicate with me in an emergency situation. I make every effort to respond to emails, texts, and phone calls within one business day (Weekends, holidays, and other times where I may not be in the office are excluded). In case of an emergency, please call 911, contact local crisis services or go to the nearest emergency room.

*Social Media* - I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant privacy risks for you. I participate on various social networks in both personal and professional capacities. If you have an online presence, there is a possibility that you may encounter me in these spaces and not responding to communication via comments, direct messages, etc. is with the intent to protect your right to privacy. If you have concerns regarding encountering these social media accounts, please discuss this

### **Client Service Agreement and Disclosure (cont.)**

with me in session. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

*Websites* - I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

*Web Searches* - I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become common for clients to review their health care provider on various websites. However, mental health professionals cannot respond to such comments because of confidentiality restrictions. It is also generally preferable for clients to discuss their concerns directly with their health care provider. If you have concerns or questions about any aspect of our work together or about any previously posted online reviews of my practice, please let me know so that we can discuss them. I recommend that you do not rate my work with you on any website for several reasons. If you rate my work on a website while you are in treatment with me, it has the potential to affect our therapeutic relationship. If you choose to post an online review about me or another health care provider either while you are in treatment or afterwards, please keep in mind that you may be revealing confidential information about your treatment.

Thank you for keeping this policy in mind and for letting me know of any concerns

### **Termination of Services**

There are various circumstances in which termination of services may occur, such as when the healing process has been completed to the extent it can be accomplished by the services provided, by your choosing, or if the therapeutic relationship is compromised. Length of treatment is on a case-by-case basis and is assessed throughout treatment based on your needs.

Ultimately, you have the right to refuse treatment and choose a practitioner and treatment modality which best suits your needs. There may be other circumstances in which it is determined we are no longer a good fit to work together, and in this case we will discuss the circumstance and make a determination if the therapeutic relationship should continue. We will also discuss the best plan moving forward, including referral to another provider if appropriate based on the circumstance. Specific examples in which early termination may occur include:

Illuminate Transformation, PLLC

Alisa Huffman MSW, LICSW

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**Client Service Agreement and Disclosure (cont.)**

- Unaddressed outstanding balances, or loss of insurance coverage resulting in financial hardship in an attempt to reduce additional stress outside of your individual treatment needs. To prevent additional distress due to financial hardship, sessions will be terminated when balances reach \$500 or more unless a payment plan is in place, and being honored, or we have discussed otherwise. Communication with myself directly is extremely important and valuable to help address financial matters and maintain regular sessions.
- Several appointment cancellations, or two missed appointments in a row with no response to attempted check-in contact.
- If I choose to leave the practice, which will include attempts to provide you with notice as soon as possible based on the circumstances.
- Abusive behavior toward Mindful Therapy Group staff and/or myself, at which point I will consult with the person involved and the Mindful Therapy Group team to determine if continued provision of services at Mindful Therapy Group is able to continue with another provider, often at the discretion of Mindful Therapy Group.

**Contact Information**

**Business Contact Information:**

Illuminate Transformation, PLLC  
1700 Westlake Ave N Suite 200  
Seattle, WA 98109  
(425) 549-4793  
<http://www.IlluminateTransformation.com>

**Practice Location Contact Information:**

Mindful Therapy Group – Elliott Bay  
101 Elliott Ave. W. Ste. 500  
Seattle, WA 98119  
(425) 640-7009  
<http://www.MindfulTherapyGroup.com>

## **Client Service Agreement and Disclosure (cont.)**

### **Confidentiality/Personal Health Information**

You have the right to confidentiality and to access your health information under provisions outlined below and by the Notice of Privacy Practices attached.

- Communication and records are held in strict confidence. However, there are situations in which client information, may need to be released, such as when required by law:
- Client has signed written release indicating consent to release information or, in the case of death or disability, the client's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition
- Expression of serious intent to harm self or others, or communication that reveals the contemplation or commission of a crime or harmful act
- Reasonable suspicion of abuse or neglect toward a minor, older adult, or dependent adult
- For billing purposes with the intent to acquire payment for services
- Disclosure resulting from court order or subpoena. If this occurs, you have the right to assert "privileged communication", with exceptions, including charges being brought against this provider, and it is recommended the desire to assert privilege be discussed with your attorney.
- Clinical consult for integrity of care, in which identifying information is not shared, preserving privacy, with exception to professionals who are also involved in your care for coordination of care.

Please note in any of the above instances I provide only what is absolutely required to assist in further protecting your privacy, and we can discuss your preferences (within requirements of the law) in this at any time. Please refer to the additional Notice of Privacy Practices provided for further details regarding HIPAA compliance and circumstances in which your health information may be shared by law.

If you believe I have provided services in an unprofessional manner and/or violated your rights, I would like to discuss this with you to assist in resolving your concerns. You may also contact Mindful Therapy Group through the number listed above. You do have the right to contact the Washington State Department of Health :

Washington State Department of Health  
Health Systems Quality Assurance  
Complaint Intake  
P.O. Box 47857  
Olympia, WA 98504-7857  
360-236-4700

## Financial Policies

To be able to provide you with continued care, it is important for the following financial policies to be read thoroughly, understood, and followed. Inability to follow these policies may result in disruption of services.

- Fees
  - \$180 – Approximate 50 Individual Therapy Session (Private Pay)
  - \$200- Intake Assessment (Private Pay)
  - \$90- Missed/Late Cancellation (Private Pay and Insurance, See Client Agreement)
  - Copays, Co-insurance, and Deductibles are determined by your insurance provider. Please contact your insurance provider with any questions regarding these fees.
  - Medical Records Requests- Free for First 30 Pages, \$0.50/page and \$26 clerical fee for requests 31 pages or larger.
  - Potential Additional: We reserve the right to bill for case coordination, clinical and legal write-ups, as well as phone consultations exceeding 5 minutes per week. Most of these concerns are best addressed in session. This does not apply to the call for appointment scheduling, billing, etc.
- Payments
  - All payments are due to the administrative team at time of session.
  - Any advanced payment/requests for refund should be addressed with myself and the administrative team to discuss resolution
- Billing
  - You will be billed for any remaining balance not covered by your insurance. If you believe this has occurred in error, please contact your insurance and the billing department if you believe you have been billed in error. If you have a balance which has not been paid, you will be notified.
  - As per the policy of Mindful Therapy Group, an outstanding balance after 60 days will result in contact from our administrative team to discuss payment planning, and after 120 days will result in contact with phone collections, which will require release of personal information and will negatively affect your credit.
  - Outstanding balances may also result in disruption in my ability to provide you services. You will be notified if I am no longer able to provide you services. Specifically, balances of \$500 or more without payment plans which are being honored will result in termination of sessions until the balance in process of being resolved, unless discussed with me otherwise.
  - Please remember: You are responsible for your financial balance. Any abusive behavior, including verbal, toward administrative staff attempting to discuss your balance with you will result in termination of services, which will be discussed with you. **As I contract with Mindful Therapy**



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**Group for their billing services, I also respect and uphold their financial policies, and this agreement does not interfere with nor supersede their financial agreement.**

### 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.**

#### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

#### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

## Illuminate Transformation, PLLC

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- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

### **Our Uses and Disclosures**

#### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

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### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

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We can use or share health information about you:

- For workers' compensation claims
  1. We are required by Washington State law to disclose personal health information to L&I or a self-insured employer when you are treated under a workers' compensation claim. We can disclose personal health information to an employer without an authorization from your patient if that information is about a workplace injury or illness, light duty work, workplace medical surveillance, or a return-to-work examination. We are required by Washington State law to disclose personal health information to L&I if you are treated under a crime victims' compensation claim. We cannot be compelled to restrict disclosures of your personal health information to L&I or self-insurer because it is required by law (45 CFR § 164.512, 164.522(a)(1)(v)).
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

### Privacy Officer:

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Illuminate Transformation, PLLC  
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Seattle, WA 98109  
(425) 549-4793

Alisa@illuminate-transformation.sprucecare.com  
[www.illuminate-transformation.com](http://www.illuminate-transformation.com)

**Initial Effective Date of This Notice: August 1, 2016**

**Telehealth Disclosure**

The following Telehealth disclosure is to assist in facilitating participation in sessions in the event of inability to physically engage in a regularly scheduled appointment due to illness, vacation, inability to travel due to unsafe weather conditions, etc. It is not intended to replace regular participation in recurring sessions.

I \_\_\_\_\_ (patient’s name) hereby consent to engage in Telehealth. I understand that “Telehealth” includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using Doxy and/or AdvancedMD, which are systems that are encrypted to the federal standard and HIPAA compatible. It is my responsibility to disclose to my provider my location, with specific address provided, to ensure services are being completed in Washington state and to allow my provider to reach out to emergency services, if necessary, during my session. It is my responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the technology that you are interacting with. Additionally, I agree not to record any TeleMental Health sessions. During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone, in which my provider will use Spruce, another HIPAA compatible platform. I will ensure that I have a phone with me, and I have provided that phone number. I understand that all fees for Telehealth and non-Telehealth services are the same. I am financially responsible for all services rendered, late cancellations, and missed appointments.

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Client or Representative\* Signature Date

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Provider Signature Date

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Representative Name and Relationship (Only if client is unable to sign)

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**Client Name (Print)**

**Date of Birth**

**Client Service Agreement and Disclosure Statement Acknowledgement Signature**

**Consent for Treatment**

By signing below, you, the client, and myself, the provider, acknowledge this document to represent the agreement between us, and that you have read, understood and received a copy of this disclosure. You agree to receive therapy services from this provider with the understanding you may terminate services at any time and have the right to choose a practitioner and treatment modality of your preference.

---

Client or Representative\* Signature

Date

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Provider Signature

Date

**Financial Policy Acknowledgement Signature**

I have read and agree to the financial policies outlined above. I also understand that this agreement does not interfere with nor supersede the financial agreement of Mindful Therapy Group.

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Client or Representative\* Signature

Date

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Provider Signature

Date

**Notice of Privacy Practices Acknowledgement Signature**

By signing this, you acknowledge reading and receiving a copy of the Illuminate Transformation, LLC Notice of Privacy Practices. I understand if I have any questions regarding the provided Notice of Privacy Practices, I can contact Alisa Huffman MSW, LICSW.

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Client or Representative\* Signature

Date

Illuminate Transformation, PLLC

Alisa Huffman MSW, LICSW

www.IlluminateTransformation.com, 1700 Westlake Ave N Suite 200, Seattle, WA 98109, (425) 549-4793 Alisa@illuminate-transformation.sprucecare.com

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Provider Signature

Date

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\*Representative Name (Print) and Relationship.

(Continued on Back/2<sup>nd</sup> Page)

**Consent for Use of Electronic Communication**

I hereby consent and state my preference to have my clinician, Alisa Huffman MSW, LICSW, and other staff at Mindful Therapy Group communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

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Client or Representative\* Signature

Date

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Provider Signature

Date