**DISCLOSURE STATEMENT**

**Background and Training**

I am a nurse practitioner, licensed in Washington state. I have been licensed in Washington state since 1994 as a family nurse practitioner. Prior to that, I was a hospital and outpatient clinic pediatric nurse. As a family nurse practitioner, my practice focused on the concerns of women, children, and those with chronic disease and mental health concerns. Between 2005 and 2008 I was an assistant professor of family nurse practitioner students at Seattle University and a temporary professor of Seattle Pacific University. In 2005, I obtained my doctorate as a nurse practitioner, and in 2020 I completed a certificate as a psychiatric mental health nurse practitioner. I am board certified as both a FNP and a PMHNP (psychiatric mental health nurse practitioner).

**Professional Associations**

I am a member of the American Academy of Nurse Practitioners, ARNPs United, and the Association of Advanced Practice Psychiatric Nurses. I attend ongoing professional training, workshops and seminars to further my skills in working with children, adolescents, and adults. I am also involved routinely in a consultation group to enhance my work with my clients. If I consult with a professional who is not involved in your treatment, I will protect your identity. These professionals are legally bound to keep all information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Typically, sessions occur every week to every other week initially, then monthly, and finally, once your treatment plan is stabilized, follow ups may occur as infrequently as every three months. You are free to end your treatment with me at any time, for any reason. If you do not have an appointment scheduled, and I do not hear from you for 90 days to make an appointment, and you do not respond to a follow up request phone call, I will interpret this to mean you are ending your treatment with me.

**Social Networking Policies**

Charis Clinic has a webpage that coordinates with a Facebook page and Twitter account. If you choose to interact on Facebook, or Twitter, or another social networking site, and your name is easily identifiable, please be aware that the information you post there will be public, and could compromise your confidentiality. It may also create the possibility that these exchanges will become part of your legal medical record nad need to be documented and archived in your chart.

I do not accept friend or contact requests from current or former clients on Facebook, LinkedIn, or any other social media. If there are things from your online life (including emails) that you wish to share with me, please bring them into our sessions where we can view and explore them together.

Please do not use SMS (mobile phone text messaging) or messaging on social networking sites to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use wall posting or other means of engaging me in a public online medium if

you have already established a therapeutic relationship. I do not interact with clients in this manner.

Please do not email me personal health information, as email is not encrypted, and therefore, not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. If you contact me via email, I will assume that you approve of my replying to you and accept these privacy and other risks.

**Regular Hours and Availability**
I am available during published office hours (currently Monday 9-4, Tuesday 9-12, Wednesday 9-4, Thursday 9-12, and Friday 9-4; these will change in 2022). Our office is open on Mondays, Wednesdays, and Fridays except for holidays. If you need to reach me between those times, you can call 206-714-4476 and leave a voicemail. I will return the call as soon as possible according to urgency. If in CRISIS, please call my number, but also call the Suicide Prevention Lifeline at 1-800-273-TALK (8255). I will make every effort to return your call within 48 hours.

**FINANCIAL, PAYMENT AND OTHER POLICIES**
Thank you for choosing The Charis Clinic PLLC as your psychiatric care provider. We are committed to providing you with high quality health care. Please understand that payment for services is necessary for us to continue to provide care to all. The following are our standard Financial, Payment, and Other Policies. Please read them, ask us any questions you may have, and sign in the space provided. We will provide a copy to you upon request.

**1. Insurance.** We participate in most insurance plans, with the exception of Aetna, Multicare, United Healthcare state plans, and Medicare. If you are not insured by a plan we do business with, you must pay in full at each visit. Please note that **we cannot bill your insurance company unless you give us complete, accurate, and current insurance information**. If you are insured by a plan we do business with, but you don't have an up-to-date insurance card, you must pay in full for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** You must pay all co-payments **at the time of service**. This arrangement is part of your contract with your insurance company. **Additionally, if you have a high-deductible plan (greater than $500 per individual or family), you will be required to pay an estimate of the portion you are responsible for at the time of service**.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full.

**4. Proof of insurance.** All patients must complete our patient information form before seeing their health care provider. We also require identification with your driver's license and a current valid insurance card. If you fail to provide us with the current insurance information, we may not able to see you, and if we discover the information is not current or correct, you will be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that

the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Please note that we bill separately for preventative and problem issues. If you bring up a problem, or if in the course of discussion it is apparent that you have a problem that needs evaluated, you will be billed separately for these issues. Please do not ask us to re-bill the insurance company differently, as we are careful to avoid fraud.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we do not participate in the new plan, you will need to pay cash fees up front. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you.

**7. Payments and Nonpayment.** Payments will occur automatically via the credit card agreement below. If for some reason a check is provided, note that a $25 fee will be assessed for returned checks, plus any additional fees the bank has charged us. Payment for the fee and unpaid balance must be made by cash or credit card before additional sessions are scheduled. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in FULL. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative care. If legal action is necessary to collect payment, its costs will be included in the claim. During that 30-day period, The Charis Clinic PLLC will be able to treat you on an emergency/urgent basis only.

**8. Missed appointments and No Shows.** Once an appointment is scheduled, it is reserved especially for you and you are responsible for the fee for that hour. **Unless you provide 48 hours advance** notice of cancellation, you will be expected to pay for it. Please note, insurance companies do not provide reimbursement for missed or cancelled sessions. You will, therefore, be held responsible for the **$100** late cancellation or no show fee.

**9. Email or phone consultations. Our policy is to charge your insurance for phone conversations that last longer than 3 minutes.** If you are paying cash, you will be charged $25 for phone lasting 5 to 15 minutes. Phone calls lasting longer than 15 minutes will be charged according to usual visit fees below. We prefer that you do not use email for consultations, as email is not HIPAA secure and does not allow the conversation necessary to address medical concerns. However, if email consultations require more than 3 minutes of our professional time they also will be charged at the above rates.

**10. Medical forms or Letters.** Our policy is to charge $40 for each form completed, and $10 per additional 10 minute increments of time required to complete forms.

11. **Limits of confidentiality.** The notice of privacy practices details how I use and disclose your protected health information. I want to highlight that in most situations, I can only release information about your treatment to others if you sign a written authorization that meets certain legal requirements imposed by state law and/or HIPPA. I may disclose information in the following situations when required by health insurers or to collect overdue fees as discussed elsewhere in this agreement. If you are involved in a court proceeding and a

request is made for information concerning the professional services I provided you, I must comply with a court order requiring disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.

Situations where I am permitted to disclose information **without** either your consent or authorization include if a government agency is requesting the information for health oversight activities. Other situations include if a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself, and if a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer and the Department of Labor and Industries.

Other situations in which I am **legally required to take action to protect individuals from harm** include if I have reasonable cause to believe that a child has suffered abuse or neglect. The law requires that I file a report with the appropriate government agency, usually the Department of Social and Health services. Once a report is filed, I may be required to provide additional information.
If I have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services.
If I reasonably believe that there is an imminent danger to the health or safety of a patient of any other individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can help provide protection.

12. **Professional Records.** The protected health information I keep about you constitutes your clinical record. Except in the unusual circumstance that I conclude disclosure could reasonably be expected to cause danger to the life or safety of the patient or any other individual or the person who provided information to me in confidence, you may examine or request a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In most situations, I charge the $1/page for the first 20 pages, and $0.50 for every page thereafter, along with a $25 administrative fee. I may withhold your record until the fees are paid.

**11. Usual & customary rates.** Our practice is committed to providing the best treatment to our patients. Our prices are at or below usual and customary charges for our area. For uninsured clients, we offer a discount**. These fees must be paid in advance. You will place your card on file for your convenience.**

**Note that there will be additional charges for EKG, phone calls, in-house labs, vaccines, and medication injections.***

**12. We require that you place a credit card on file for balances that your insurance does not cover. Please see our Credit Card on File agreement attached below.**

**13. Scheduled Medications.** ***We do not prescribe scheduled medications (such as opioids/narcotics, benzodiazepines, and stimulants) until a complete evaluation has been done, typically at least 3 one hour assessments.*** We also do not prescribe scheduled medications until we receive **all** necessary prior medical documentation for us to determine if this is an appropriate treatment for you. All patients on routine scheduled medications must agree to the terms of a written Medication Contract.

**I have read and understand Charis Clinic's Financial, Payment, and Other Policies and agree to abide by them.**

_____ _____

**Signature of patient or responsible party** **Date**

Printed Name: _____

## CREDIT CARD ON FILE POLICY

Charis Clinic is dedicated to providing excellent and affordable care to our clients. Since the 2014 healthcare act and institution of higher deductible insurance plans, all clients are now required to present a credit card at the time of their appointment. This is consistent with many practices in our area.

Keeping your credit or debit card on file is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your card will be put directly into a secure encrypted service and stored by the bank, just as when you check into a hotel. Only the last 4 digits of your card and expiration will be viewable by us.

Note that all of your rights with respect to the use of your card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment. We will bill your claim to your insurance company who is required to send us and you an Explanation of Benefits (EOB), which will indicate your patient responsibility. After we have received the Explanation of Benefits your credit card will be charged as payment in full for the remaining Patient Responsibility. We will email you your receipt. Please ensure your card account is active and properly funded, as Charis Clinic will not be responsible for overdraft fees. This agreement will remain in effect for future credit cards you have provided to the clinic as well.

This authorization is required as a client of Charis Clinic.

__I request a call prior to my card being charged. Please note that if we do not hear from you, we will charge your credit card in 3 days. Please note that if you refuse to pay your charges from your EOB, additional charges of $10 per statement mailed, late payment charges, and collection action after 120 days will occur.

I authorize The Charis Clinic to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Last 4 digits:

I (we), the undersigned, authorize and request The Charis Clinic PLLC to charge my credit card, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance

company for services provided to me by The Charis Clinic PLLC. I have read Charis Clinic's credit card authorization policy and agree to the terms of this policy.

Patient, Patient 's Parent or Guardian Name: _____

Cardholder Name: _____

Cardholder Signature: _____

Date: _____