DISCLOSURE STATEMENT

WAC246-809-710 requires the disclosure of the following information in written form by counselors to their clients.

Please take the time to carefully read this disclosure statement. As my client, you have the right to know my qualifications, methods, and mutual expectations of our professional relationship. The information presented here is provided to help you decide if my services are suitable for your needs. Please discuss any questions or concerns you may have either now or during the course of your treatment.

My qualification and license
I am a licensed mental health counselor-associate in Washington State (license# MC61151671). I received my Master's Degree in 2002 from Eastern Washington University.

My professional background involves working with individuals who have experienced trauma and understanding the effects and how it can affect your life. My experience as a Behavioral Health Specialist has equipped me to work with a wide range of issues that experiencing trauma can affect including: Anxiety, chronic pain, and depression, to name a few.

The Therapeutic Process
I believe that therapy is about finding your authentic self and learning to embrace suffering that is part of life. It is my passion to develop a genuine relationship with my clients where we can safely have difficult conversations, have and resolve conflicts, and experience your authentic self, including your pain. I will work with you to tune into your true self, recognize your unfavorable coping mechanisms, and discover self-compassionate ways of living. My therapeutic modality is a blend of Mindfulness and Cognitive Behavioral Therapy.

Therapy has both benefits and risks. During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Therapy typically produces benefits over time, but sometimes as you get to the root of tender issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your vulnerable issues and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

I work with all my clients on a weekly basis. If you cancel several sessions, which I perceive as a barrier to a positive therapeutic process, I will ask that you be removed from your recurring appointment slot and be placed on my on-call list. The on-call list creates sessions based on cancellations. I will reach out to you by phone as those times become available. If you do not show up to your appointment without notifying me, all your future appointments will be cancelled until I hear from you.

GENERAL POLICIES

Confidentiality
My practice is compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy and security protections and patient rights with regards to protected health information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices. This Notice, which

is attached to this agreement as Exhibit B, explains my privacy practices and your rights in detail. An electronic copy of this notice can be found on my website at www.mvgcounseling.com/faqs.

Communications
I may use your contact information to send you newsletters, marketing or promotional materials, and other information that may be of interest to you. You may opt out of receiving any, or all, of these communications from me by following the unsubscribe link or instructions provided in any email I send.

Distinguishing between an emergency, urgent, and non-urgent request. In the event of an emergency (you feel suicidal, homicidal, or have a medical emergency), you should call 911 or go to the closest emergency room. If you have an urgent need for consultation (medication side-effects, increase in symptoms, etc.), please follow your provider's crisis policy located in their disclosure statement. Monica V Guillen Counseling is not a medical clinic, but a private practitioner. Therefore, I do not offer clinical staff on-site to assist you with your emergent or urgent needs. If you have an urgent request after hours and on weekends, you should call the crisis clinic at 1-866-4-CRISIS (1-866-427-4747).

FEE AGREEMENT

Fees for Services
Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from (Monica V. Guillen Counseling, PLLC) your account will need to be paid in full.

FEE SCHEDULE:
Per 50 Minute Telehealth Visit
Initial Visit/Assessment: $140.00

Session Fees:
Individual (50 min): $100.00
Couples (50 in): $120.00
*Late Cancellation/No Show: $100.00

Late Cancellation and Missed Appointment Fees
Late cancellation (less than 24 hours before) appointments are billed to the client in the amount of $100.00

Initial: _____

Financial Responsibility
Payment in full is due at the time of each session

Initial: _____

Credit Cards on File
You are required to have a credit card on file that can be charged my full fee each session

Credit cards are stored using a payment processor, Stripe, and are encrypted for security. Once a card is saved on file it can only be charged through my billing software, Kareo. Whenever your credit card is charged, you will receive an email notification that same day with details of the transaction.

Initial: _____

Collections Efforts
If you do not have a credit card on file, or your card is declined, I will reach out via email and/or phone to collect payment for any balance that is owed. I will also require that you place a credit card on file at that time. I may discontinue treatment if there are unpaid balances.
Unpaid balances without a payment plan initiated after 120 days will be turned over to an outside collections agency. This may result in negative marks on your credit.

Initial: _____

Financial Responsibility

I acknowledge that I am responsible for all charges including missed and late cancellation fees assessed by my provider.

I authorize Monica V Guillen Counseling to charge my credit card on file for charges applicable, cancellation fees, and/or private pay.

Print name: [Patient Name]

_____

Signing on behalf of:
(If patient is not financially responsible party)

_____
Relationship:

_____

Signature:

_____

Date: [Current Date]

_____

.

EXHIBIT B
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 health record contains personal information about you and your health and is protected by the Health Insurance Portability and Accountability Act (HIPAA) as well as state laws. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and relates to your past, present, or future conditions and related health care services.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities. You have the right to:
• Get an electronic or paper copy of your medical record – You may request a copy of your medical record and other health information I have about you. I will provide you a copy or a summary of your health information, usually within 30 days of your request.
• Correct your medical record - You can ask your provider to correct health information that you think is

incorrect or incomplete. Your provider may not accept your request at their clinical discretion.
• Request confidential communication - You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address. I will say “yes” to all reasonable requests.
• Ask me to limit the information I share - You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I 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 me not to share that information for the purpose of payment or our operations with your health insurer. I will say “yes” unless a law requires us to share that information.
• Get a list of those with whom I have shared your information - You can ask for a list (accounting) of the times I have shared your health information for six years prior to the date you ask, who we shared it with, and why. I 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). I will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
• Receive 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. I will provide you with a paper copy promptly.
• Choose someone to act for you - 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. I will make sure the person has this authority and can act for you before we take any action.
• Receive notification if affected by a breach of unsecured PHI - You have the right to be notified of any breach of your unsecured PHI.
• File a complaint if you believe your privacy rights have been violated
Your Choices
For certain health information, you can make choices about what I share. If you have a clear preference for how I share your information in the situations described below, tell me what you want me to do, and I will follow your instructions. In these cases, you have both the right and choice to tell me to:

• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation

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

In the following cases, I never share your information unless you give me written permission:

• Marketing or fundraising purposes
• Most sharing of psychotherapy notes

My Uses and Disclosures
How do I typically use or share your health information? I typically use or share your health information in the following ways:
• Treat You - I can use your health information and share it with other professionals who are treating you.
• Run my practice - I can use and share your health information to run my practice, improve your care, and contact you when necessary. Example: I use health information about you to manage your treatment and services.

How else can I use or share your health information?
I am 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. I must meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. I can share health information about you for certain situations, such as:

• 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

Compliance with the law

I 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 I am complying with federal privacy law. For example:

• I can work with a medical examiner or funeral director
• I can share health information with a coroner, medical examiner, or funeral director when an individual dies
• To address workers' compensation, law enforcement, and other government requests • I can use or share health information about you for workers' compensation claims • 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
• To respond to lawsuits and legal actions
• I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities

I am required by law to maintain the privacy and security of your protected health information. I must follow the practices described in this notice and give you a copy of it. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I will not market or sell your personal information.

Your protected health information will not be used or disclosed without your written permission except as described in this Notice of Privacy Practices. You may change your mind regarding authorizations you have provided at any time by submitting an updated written notice. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

I reserve the right to change the terms of this notice at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by sending you an electronic copy, sending a copy to you in the mail upon your request, or providing one to you in person. This Notice of Privacy Practices is effective as of January 1, 2021 and applies to all persons who procure service from Monica V Guillen Counseling PLLC.

If you believe that your rights have been violated, you have the right to file a complaint with the Department of Health and Human Services. The contact information for the Department of Health and Human Services is included below. All complaints must be in writing, describe the violation, and be filed within 180 days of when you learned of the violation. The Department of Health and Human Services requires that complaints be filed by mail, e-mail, or via the OCR Complaint Portal (https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf). I will not retaliate against you for filing a complaint.

U.S. Department of Health and Human Services
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email: OCRComplaint@hhs.gov
Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

You are entering this agreement with
Monica V Guillen Counseling PLLC

Please acknowledge that you:
1. Received a Notice of Privacy Practices explaining HIPAA regulations.
2. Have carefully reviewed all information in this document.
3. Received a printed copy of this document if so requested.

Print name: [Patient Name]

_____

Signing on behalf of:
(If patient is not financially responsible party)

_____
Relationship:

_____
Signature:

_____
Date: [Current Date]

_____

EXHIBIT C
TELEHEALTH AGREEMENT

Introduction of Telehealth

Monica V Guillen Counseling provide sessions virtually via an online telehealth platform. “Telehealth” includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, you will be connecting with your provider using an online encrypted platform, that is HIPAA compliant.

Technology Requirements

You will need access to and familiarity with the appropriate technology in order to participate in the telehealth sessions.

Exchange of Information

The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During your Telehealth session, details of your medical history and personal health information may be discussed with you or other health professionals using interactive video or audio.

Payments

I require a credit card on file prior to any telehealth sessions. I will charge your credit card based on an estimate of the cost of services provided. I reserve the right to update the amount being charged as I receive updated information.

Risks of Technology

These services rely on the use of technology. There are risks in transmitting information that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan

You and I will regularly reassess the appropriateness of continuing to deliver services to you using these technologies and modify treatment plans as needed.

Emergency Protocol and Disruption of Service

During a Telehealth session, if you encounter a technological failure the most reliable backup plan is to contact me directly. In case of Internet or platform failure, please call me at (509) 830-4300. I will request that this contact information is only used during your scheduled visit for the purpose of working through technical difficulties.

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means.
It is your responsibility to maintain privacy on the client end of communication. If you elect to participate in virtual sessions, it is your 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 your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Telehealth sessions.

The Laws & Professional Standards

The laws and professional standards that apply to your provider's in-person mental health services also apply to Telehealth services. This document does not replace other agreements, contracts or documentation of informed consent.

Final Telehealth Agreement

Initial:
_____
I agree to participate in technology-based sessions and other healthcare-related information exchanges with my mental health care provider. This means that I authorize information related to my health to be electronically transmitted in the form of images and data through an interactive video connection to and from MVG Counseling and other persons involved in my health care.

Initial:
_____

I represent that I am using my own equipment to communicate and not equipment owned by another and am specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.
Initial:
_____

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in Telehealth sessions, including, but not limited to, care, treatment, and services deemed necessary and advisable, under the terms described herein.

Initial: _____

RELEASE OF LIABILITY

I acknowledge that I have read this paragraph and specifically acknowledge that I understand its importance. I unconditionally release, hold harmless, indemnify and discharge Monica V Guillen Counseling dba MVG Counseling, its affiliates and employees, from any and all liability having its source

in, arising from, or in connection with my participation in Telehealth. This includes, but is not limited to, any data breach caused by my or my provider's failure to either secure the technology devices or to ensure that the session environments were secured. It is also my responsibility and the responsibility of my provider to ensure that the communications cannot be overheard.

Print name: [Patient Name]

_____

Signing on behalf of:
(If patient is not financially responsible party)

_____
Relationship:

_____
Signature:

_____

Date: [Current Date]

_____