Gavriele Greenwald, MA, LMHC
License #LH61199499
360-328-7040

Terms of Service-Disclosure Statement
Effective January 10, 2022

Washington State law requires that anyone conducting counseling services provide clients with written information about their training and qualifications, counseling methods and therapeutic orientation, confidentiality, and other policies. As the client, it is your right to choose the type of treatment and the counselor to best meet your needs and to refuse services at any time. The information in this document tells you about me and serves as the agreement for our professional relationship. Please read it carefully and discuss with me any questions you have. After all of your questions have been answered and before we begin our first session, you will be asked to sign this document.

General information
My mission is to provide a safe place for you in which you can understand yourself more deeply, grow, and become the best version of yourself. The therapeutic relationship is of utmost importance to me. Our relationship will be based on trust. Once trust and confidence in our relationship have been established, expect me to challenge you with the intention of helping you reach your goals. I do not consider myself the expert nor your healer. Our work together will involve working in collaboration to find a path towards health and healing.

Background
I have worked with families, teens, women, elderly and individual adults in various capacities including outpatient, crisis, and private practice settings. I have enjoyed my time working with clients, and find that it is my favorite part of this field, being able to connect and be a witness to healing in people's lives.

Areas of Interest and Focus
My areas of interest include:
- Depression
- General Anxiety
- Grief and Loss
- Life Transitions/Adjustment Issues
- PTSD
- Trauma

Theoretical Orientation
In my theoretical orientation, I identify with a Person-Centered Approach because it has a philosophy where clients are met with unconditional positive regard and empathy. Cognitive Behavioral Therapy (CBT) is also one of my preferred theories, for its practicality and evidence-based nature. CBT helps clients to identify their thought process that helps to shift behavior, it gives practical and accessible steps for change. I also offer a trauma informed approach utilizing other tools such as Lifespan Integration.

Education, Training & Affiliations
I acquired my Masters of Arts in Counseling through CCU and my Bachelors of Arts in Counseling through TCF. I continually seek further education. I have specialized training in Lifespan Integration and plan to continue with more training around trauma-oriented therapies. I have interned at the Lighthouse Mission (a local homeless shelter) and also doing private practice.

Consultation
I receive consultation from colleagues as well as group consultation to provide you the best possible care. Additionally, if I deem your circumstances to be above the level of care that I am best able to provide, we will determine together the best options available for continuing your therapy or referral options.

Availability & Emergencies
I provide non-emergency counseling services by scheduled appointment. If you experience a personal safety or mental health crisis, please call the 24 hour crisis hotline at 1.800.584.3578, call 911, or go to your nearest hospital emergency room.

Fees & Cancellations
The counseling fee is due at the beginning of every session. Should payment not be provided, it is my policy to reschedule and possibly charge cancellation fees, which is the same amount as a full session.
My fees are as follows:
Initial Intake (includes time to complete intake notes): $175
Individual 60-minute session (includes time to complete intake notes): $160
Individual 45-minute session (includes time to complete intake notes): $120
Couples Intake (includes time to complete intake notes): $175
Couples Ongoing Sessions 60-minute (includes time to complete intake notes): $160
Couples Ongoing Sessions 45-minute (includes time to complete intake notes): $120
Cancellations within less than 24 hours of the session and no shows will be charged the full fee. In unforeseen emergencies a cancellation less than 24 hours before the appointment will be charged half price (no shows are still full price), this will be left to the therapist's discretion. Cancellations prior to 24 hours will incur no charge.

I also offer a sliding scale fee, I have a separate form you will need to request and fill out. The information needed will include household size and proof of income.

The poverty guidelines I follow are from: https://aspe.hhs.gov/poverty-guidelines

I accept cash, check, and credit card. If you should choose to utilize a credit card, Square and/or Simple Practice does collect some of your personal information like email, name, and phone number. If that concerns you, please only use cash or check. It is important to note that Square is not HIPAA compliant and is only an option for your convenience.

I do bill some insurance companies and offer superbills upon request. I utilize a biller, whom I have a BAA contract with, indicating that they will follow HIPAA in using your information for billing purposes.

While you have an open episode, fees will not be subject to change to the most current fees, and you will continue with the agreed upon rate from your first signed disclosure statement. Should you close your episode and then return to services, you will be subject to the newest fees as outlined above.

Washington State Law- Complaints
I honor all regulations in the 18.225 RCW. The purpose of the law is to: (A) Provide protection of public health and safety; and (B) Empower the citizens of the State of Washington a complaint process against those counselors who would commit acts of unprofessional conduct.

If you have any questions or concerns about your treatment or these policies, please discuss them with me. I will work with you to address your concerns if possible. If you feel I have been unethical or unprofessional, complaints

may be directed to Washington State Department of Health, HSQA Complaint Intake, PO Box 47857, Olympia, WA 98504-7857. You may also call them directly at 360.236.4700 or access online forms and information at www.doh.wa.gov/hsqa .

Confidentiality
See privacy practice form for more information.

Your Rights
As a client receiving therapeutic services, you have the right to refuse any treatment you do not want, and the responsibility to choose a mental health provider and treatment modality that best suits your needs. You also have the right to terminate your treatment at any time for any reason. If you think it is in your best interest I encourage you to share your reasons for termination, as I might be able to assist you with your transition. If you feel it is in your best interest, please consider that transitions can be difficult and it is best practice to process the termination of services with the current counselor to honor the story that you have shared, and to support your transition to ending therapy or moving on to a new therapist.

Communication
It is my policy to not discuss therapeutic matters over the phone, email or text messages and ask that these means of communication be limited to logistical matters such as scheduling appointments. I cannot make any guarantees related to your privacy if you choose communication with me by these means. Standard messaging has security vulnerabilities as does email. I offer a secure communication option through Spruce, that you may choose to utilize which is HIPAA compliant if you use the secure messaging option (which is different from standard messages and email).

Telehealth/Video
Video services are utilized to meet for telehealth sessions. There are security vulnerabilities when using video. I have a BAA Contract with Spruce Health and Doxy. I ask that you be mindful of your location, especially for privacy.

Electronic Medical Record
I utilize an Electronic Medical Record (EMR) system to take notes/assessment. It's a secure HIPAA compliant platform and I have a BAA contract with them. If you have any questions or requests to not use the EMR please inform me in writing. By signing this consent, you consent to my use of the EMR. It can be used for scheduling as well.

Professional Boundaries
I will maintain appropriate professional boundaries to model integrity and a safe relationship with you. I follow an ethical code for counselors and it is of utmost importance to do no harm.

Legal Issues
Finally, it is my policy not to become involved in clients' legal matters (e.g. divorce, custody, immigration, etc.). For several important ethical and professional reasons I do not speak with clients' attorneys, provide reports, etc. that serve as an objective evaluation. In short, I am not a forensic psychologist, do not have skill or expertise in dealing with the court and do not feel it would be to your benefit to use me in that way. Should a legal scenario occur that involves a subpoena, charges may occur in regard to seeking legal counsel, preparation of paperwork, etc...

Counseling Informed Consent

I have read this document, had my questions about the information in this document answered, and understand what I have read. I have been provided with a copy of this Terms of Service / Counselor Disclosure Statement to keep.

____
Client Printed Name

____
Client Signature Date

____
Gavriele Greenwald, MA, LMHC Signature Date

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.

We collect and create personal information about you and your health. State and federal law protects your privacy by limiting how we may use and disclose such information. Protected health information ("PHI") is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Rights Regarding Your PHI. The following are rights you have regarding PHI that we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in certain limited circumstances, to inspect and receive a copy of the PHI that we maintain. We may charge a reasonable, cost-based fee for the copying process. As to your PHI that we maintain in electronic form and format, you may request a copy to which you are otherwise entitled in that electronic form and format if it is readily producible, but if not, then in any readable form and format as we may agree upon (e.g., PDF). Your copy request may also include transmittal directions to a third party.

- **Right to Amend.** If you feel the PHI we have about you is incorrect or incomplete, you may ask us in writing to amend the information, although we are not required to agree to the amendment. You may write a statement of disagreement if your request is denied. The statement will be maintained as part of your PHI and will be included with any disclosure.

- **Right to an Accounting of Disclosures.** We are required to create and maintain a prescribed accounting of certain disclosures we may have made of your PHI. You have the right to request a copy of such an accounting.

- **Right to Request Restrictions.** You have the right to request in writing a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are generally not required to agree to such a request. If we have been paid in full for all of the services covered by such a request, then we will honor a request to restrict disclosure to your insurance.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.

- **Right to a Copy of this Notice.** You have the right to obtain a paper copy of this notice upon request.

- **Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. ***We will not retaliate against you for filing a complaint.***

<u>Our Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations</u>

Treatment. We may use your PHI for the purpose of providing you with health care treatment, including management, coordination and continuity of your care with other of your current providers.

Payment. We may use your PHI in connection with billing statements we send you. We may use your PHI for the purpose of tracking charges and credits to your account. Unless you have requested and we have specifically agreed to restrict disclosure of your PHI to your health plan, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability as well as to submit claims for payment.

Health Care Operations. We may use and disclose your PHI for the health care operations of our professional practice in support of the functions of treatment and payment. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist us in our delivery of your health care.

<u>Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object</u>

Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. We also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Health Oversight. We may disclose your PHI to a health oversight agency for activities authorized by law, such as our professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to us, such as third-party payers.

Threat to Health or Safety. We may disclose your PHI when necessary to minimize an imminent danger to the health or safety of you or any other individual.

Business Associates. We may disclose your PHI to the extent minimally necessary to Business Associates that are contracted by us to perform health care operations or payment activities on our behalf, which may involve their collection, use, or disclosure of your PHI. To safeguard the privacy of your PHI, such contracts are regulated by the Department of Health and Human Services and must contain provisions designed to limit the use and re-disclosure of your PHI, to require compliance by the Business Associate with your individual rights, to subject the Business Associate to specified security obligations, and to require the Business Associate to require such obligations of a subcontractor.

Compulsory Process. We will disclose your PHI if a court issues an appropriate order. We will also disclose your PHI if (1) you and we have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) we have received satisfactory assurances that you received notice of your right to seek a protective order, and (4) the time for your doing so has elapsed.

Uses and Disclosures Requiring Your Opportunity to Agree or Object

Prior Providers. We may disclose your PHI to your prior health care providers, unless we have given you the opportunity to agree or object, and you have objected in writing.

Close Personal Relationships. In accordance with good professional practice, we may disclose your PHI to person(s) who are close to you that are involved with your care, unless we have given you the opportunity to agree or object, and you have objected. When you are not present or in situations of your incapacity or in an emergency, and where disclosure, in our clinical judgment would be in your best interests, we will disclose your PHI as minimally necessary.

Disaster Relief Purposes. In situations of your absence, incapacity or emergency and in accordance with good professional practice, we may disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, which are directly relevant to your identification and care.

Uses and Disclosures of PHI with Your Written Authorization

We will make other uses and disclosures of your PHI only with your written authorization. One example is our psychotherapy notes from our sessions (unless we are otherwise required by law). Unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment, you may revoke an authorization in writing at anytime.

Certain Uses and Disclosures of PHI I do not make

We do not engage in academic or commercial research involving patient PHI. We do not engage in marketing activities using patient PHI. We do not engage in the sale of patient PHI. We do no fundraising using patient PHI. We do not maintain directory information for public disclosure. We do not receive compensation for recommending any health care product or service.

This Notice

This Notice of Privacy Practices informs you how we may use and disclose your PHI and your rights regarding your PHI. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI related to you. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at anytime. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by providing you a copy upon your request or by providing you a copy at your next appointment.

Complaints

Our Privacy/Security Official is ____.
If you have any questions about this Notice of Privacy Practices or complaints about how your PHI has been utilized, please contact our Privacy/Security Official. The contact information for help is: ____.

We will not retaliate against you for filing a complaint.

You may also file a complaint with the Secretary of the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services

701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

The effective date of this Notice is September 23, 2013

ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES AND HEALTH CARE PROVIDER DISCLOSURE

I, ____ [patient name], or the parents or legal guardian of the patient, have reviewed the following documents:

[Initial documents received]

_______ Notice of Privacy Practices

_______ Health Care Provider's Disclosure Form.

____ ____________________

Signature of Patient (or Parent or Legal Guardian) Date

Gavriele Greenwald, MA, LMHC
License #LH61199499
Phone: 360-328-7040
Fax: (360) 282-1088

Release of Information

Consent to the Release of Information Date________________

Client Name:____DOB________________

I authorize Gavriele Greenwald, and

____Phone____________________

to exchange written records and verbal summaries of my records to one another as

relevant to ____

____

____

The information may include:

Psychological/Mental Health Records (specify)_________________________________

Medical Records (specify)____

Court/Legal Information (specify)____

Other (specify)____

Information released pursuant to this consent is confidential.

I understand that I may revoke this consent to release information at any time through written communication to Gavriele Greenwald, 1440 10th St #101B, Bellingham, WA 98225

This consent will expire 90 days after termination of treatment with Gavriele Greenwald.
I further acknowledge that the information to be released and the purpose for this consent were explained to me and that this consent is given of my own free will.

____ ____________________

Client Signature Date