NOTICE OF PRIVACY PRACTICES

Julie Holt, MA, LMHC
Julie Holt, LLC EIN 45-3194482
2366 Eastlake Avenue East, Suite 417
Seattle WA 98102
206-979-6764

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

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

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

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

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in supervision and consultation so that I may provide high quality services for your benefit.

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

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.

e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.

f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization:

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

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

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

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

II. YOUR INDIVIDUAL RIGHTS

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

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

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

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

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

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

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Julie Holt, MA LMHC, by telephone at (206) 979-6764, or in writing at 2366 Eastlake Avenue East, Suite 417, Seattle, WA 98102. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360) 236-4900, P.O. Box 47869, Olympia, WA 98504. I will not retaliate against you if you file a complaint with me or the Department of Health.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on June 1, 2011 and was most recently updated March 1, 2018.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will inform you, and you may obtain any revised notice by contacting me. The most up to date form will be available on my website at all times.

THERAPIST DISCLOSURE STATEMENT & CLIENT INFORMED CONSENT

Julie Holt, MA, LMHC
Julie Holt LLC – EIN 45-3194482
2366 Eastlake Avenue East, Suite 417
Seattle, WA 98102
206-979-6764
julieholtcounseling.com

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully and initial each page.

I. THERAPIST DISCLOSURE TO CLIENT

- **Credentials**: I am a Licensed Mental Health Counselor in Washington State (#LH60406542)
- **Education, Training, and Experience:** I received a Bachelor of Arts in Psychology from the University of Washington. I completed my Master of Arts in Psychology with a Specialization in Systems Counseling from the Leadership Institute of Seattle (LIOS), a graduate college at Saybrook University in California. I completed my internship hours at Compass Health where I counseled children, adolescents, adults, and their families. I have also worked with the King County Crisis Clinic as a volunteer crisis phone worker and with Seattle Shanti (a division of Rosehedge/Multifaith Works) as a one-on-one emotional support volunteer. I began my training in the mental health field nearly 20 years ago.
- **Professional Memberships:** I am a member of the American Mental Health Counselor Association (AMHCA) and the former President of the Seattle Counselors Association (SCA).
- **Services Provided:** I provide psychotherapy for individuals (adults aged 18 and older), couples, and families. I provide consultation to other mental health professionals on topics relating to anxiety, depression, and relationship/social issues.

II. WORKING RELATIONSHIP

- Confidentiality: The privacy of your personal information is of utmost importance. I am fully compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.

- Health Care Coordination: It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, it is advised that you get a physical examination from a physician as soon as possible. It would be best to tell your medical provider that you will be working with me so we might begin to coordinate your health care. With your written authorization, I may obtain your medical records so I have a better understanding of your overall health.

- Risks and Benefits: 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. This is absolutely normal. Counseling is intended to alleviate problems, but sometimes as you get to the root of some 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 areas of difficulty and build upon your strengths, it is very likely you will see improvements throughout our work and in the future.

■ First Session: Please complete the following paperwork before your first in-person session: New Client Form, Disclosure Statement, and Notice of Privacy Practices (these last two are in one file). During the first session, we can review your paperwork, discuss the reasons why you are seeking counseling, and talk about your goals. Additionally, I can answer any questions you might have about therapy. We will schedule our next appointment at the end of each session, though generally we will establish an ongoing time reserved for you weekly.

■ Appointments: Please notify me via phone, at (206) 979-6764, or by email Julie@julieholtcounseling.com *at least 24 hours in advance* (48 hours is requested) if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Please note that text messages cannot be used for cancellation notices. Likewise, I will notify you via phone if I should need to cancel our appointment. Please pay attention to any illness symptoms you may have that may interfere with your ability to make our appointment.

When you arrive for an appointment, please make yourself comfortable in the suite's waiting room. Our sessions will be about 45-50 minutes long (standard for therapy appointments), and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

Please note that you are responsible for the full session fee if you miss an appointment without 24 hours notice of any cancellations. You will not be charged if I cancel our appointment or in the case of extreme emergencies. Waking up sick on the day of our appointment when no other symptoms were there the day before would qualify for this type of emergency. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 48 hours) when you attend your next scheduled appointment. Also, please note that most insurance companies will not reimburse in any case for a late cancelled or missed session.

■ Fee for Services: My standard fee is $130.00 per 45-50 minute session. This is the same fee charged for any missed or late canceled appointments. Additional fees might include: preparation of requested documents, or copying and sending records. I will discuss any fees with you at the time of a request. Please inform me of any change in your financial situation that impacts your ability to pay for services. I do sometimes raise my fee. I will give you notice of this usually a month in advance. At this point, I tend to raise my fee at the beginning of the calendar year, but I do not raise it every year.

■ Payment for Services: I accept cash or personal check payments made payable to **Julie Holt**. Payments are due directly to me at the time of service (please have checks complete at the beginning of each session) unless we make arrangements otherwise. If paying by cash or check is a barrier, I can arrange to have you pay by debit/credit card using Paypal Merchant (though they charge roughly a 3% fee on top of this). If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I reserve the right to charge a $30 fee for any returned checks.

■ Insurance: I do not bill insurance, but I can provide you with a receipt, called a "superbill", that you can submit to your insurance company for reimbursement. This is a relatively easy process and I am happy to assist you in finding the appropriate forms for your carrier, but I will not bill or make submissions for reimbursement to your health insurance provider. As I am a Licensed Mental Health Counselor, it is very likely that I will be covered by your insurance carrier as an out-of-network provider. That generally means that they will reimburse you for 50%-80% of my fee. You are responsible

for the remainder. Check with your carrier, though, for your specific plan details and specifically ask them if they will cover your sessions with me. There are benefits and drawbacks to using insurance and we can discuss these at our first session.

■ Record-keeping: I will keep a confidential file containing your private health information (PHI) in my office. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. My purpose in maintaining records is to aid therapy by recording the topics discussed and my impressions. In addition, the Washington Department of Health instructs me to document according to a medical model, which they in part define as recording "what happens in a session." I make an effort to summarize what we discuss in each session (capture the essence), but I make no effort to record sessions verbatim. Washington State law requires the retention of records for five years after last contact for all Licensed Mental Health Counselors (seven years for Psychologists).

■ Emergency, Urgent, or Other Contacts: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within one business day. If you need to cancel or reschedule an appointment, please do so via phone at least 24-48 hours in advance. This is to ensure my ability to accommodate other clients and to maintain my work flow.

Please note that if there is information to communicate to me, it is necessary that you do it within our session time so that we have the opportunity to process what is emerging. For this reason, I usually do not return email messages once we have begun our counseling relationship. Please also remember that anything you send over email is not confidential.

If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or the King County Crisis Clinic at (206) 461-3222. The Crisis Clinic has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information. I am not able to provide on-call crisis or emergency services.

If I will be out of town or otherwise unavailable for an extended period of time (generally if longer than two weeks), I will provide you with alternate contact information should you need support during my absence. This is usually in the form of trusted associates of mine licensed in my field.

■ My Supervision and Consultation: I engage in regular ongoing consultations with Karen Weisbard, PsyD, and Doug Hansen, MSW. Their contact information can be found easily on the internet. Additionally, I am part of several regularly held consultation groups in which I deepen my understanding of how I can provide the highest level of service to you as a holistic healing practitioner. I also am in mentorship under a shamanistic practitioner – I will provide further details for you about this if you wish.

■ Therapy Relationship and Professional Boundaries: It is my intention to maintain a relatively comfortable, safe, and professional environment where I consider your best interests my priority (safe enough to take risks). Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship. This is a legal boundary, not one of not caring.
2) Because my business does have an internet presence (listings on Yelp, Facebook, etc), it is possible for you to place unsolicited reviews on those sites of me and my business if you wish. It is very important to your treatment that you communicate your intent to do so prior to actually

doing it. This is to keep communication flowing between us. In other words, if you have feedback for me (positive, negative, or ambivalent) it is best for us to discuss them in person as they are likely very important for your treatment. I always appreciate word of mouth referrals to your friends and associates.

3) I will not, at any time, have physical or sexual contact with you. This excludes handshakes and the like, but only when or if you initiate. None of these are expected from you, though.

4) I will not, at any time, accept any gifts from you.

5) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. Again, if you initiate I will respond in kind, but no further than you offer.

6) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.

7) I will only provide appropriate referrals to other health professionals with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.

8) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

■ Therapeutic Work, Duration, and Termination: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. I believe doing so is part of the healing process in therapy.

When or if you would like to end therapy, I do ask that we first discuss this in person. This is due to the fact that sometimes when old wounds are reopened a natural human tendency can be to flee. Part of our therapeutic relationship is safely and comfortably looking at these wounds to find ways to heal them. The very notion that you might want to leave abruptly might be an indication that we are making great progress!

■ Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Julie Holt, MA LMHC
Julie Holt, LLC
2366 Eastlake Avenue East, Suite 417
Seattle, WA 98102
206-979-6764

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Julie Holt, MA, LMHC and I understand it.

_____ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

_____ I agree to follow the terms in the Disclosure Statement.

_____ I give my consent for treatment as outlined in this Disclosure Statement.

_____ I will receive a copy of this Disclosure Statement with my signature if I wish.

_____ I understand the 24-48 hour full-fee cancellation policy.

_____ I understand that my therapeutic relationship with Julie Holt, MA LMHC may be discontinued if the terms in this agreement are not fulfilled by either of us.

_____
Client Name (please print)

_____ _____
Client Signature Date

This form will be retained in the mental health record.

Acknowledgement of Receipt of Notice of Privacy Practices

Julie Holt, MA, LMHC
Julie Holt, LLC
2366 Eastlake Avenue East, Suite 417
Seattle, WA 98102
206-979-6764

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Julie Holt, MA, LMHC.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of Julie Holt, MA, LMHC with respect to my protected health information.

_____ _____
Signature of Client Date

This form will be retained in the mental health record.

* * * FOR OFFICE USE ONLY * * *

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

□ Individual refused to sign
□ Communications barriers prohibited obtaining the Acknowledgment
□ An emergency situation prevented me from obtaining Acknowledgment
□ Other: _____

_____