HAL PULLIN, MA

Licensed Mental Health Counselor

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Dear Client,

Welcome to my practice. The success of our work together will depend on clear expectations. I am a Washington State Licensed Mental Health Counselor (L.M.H.C.) and have been in private practice for almost 25 years.

Instructions

Communications

You can leave messages on my voice mail from 7 am to 8 pm. If there is emergency then please call anytime. You can leave a text at anytime. Please don't email me, as I don't check this very often.

Paper work

Before our first session begins, I will need you to complete all necessary paper work. If you are unable to print the new client forms you could come in to my office an hour early to fill them out. They are available on my office door. If the forms are not done, you will use valuable session time filling out paper work.

Payment

Whether you are private pay or insurance I will need you to register a credit card. If you have insurance, I will need a copy of both sides of your insurance card.

Check benefits

If you come to the first session without checking your benefits I will charge my regular session fee of $120 an hour for each session until we know. I will refund you what ever your company eventually pays. Note: I have provided a form to help you to check your benefits.

While I am a preferred provide for most insurances it is a good idea to check your benefits. If I am not a preferred provider then check to what rate they will reimburse you for an off net provider. If I am not a preferred provider then I will charge you my regular session fee (which is $120 an hour) and give you an insurance reimbursement receipt which you can bill your company. Many companies will reimburse you for off net providers at 50%.

Policy on no-shows and late cancellation

I will charge your card $120 for a no-show—I will call you first to see if there is some kind emergency. After 24 hours if I don't hear from you I will bill your card. Failure to return my calls is grounds for termination. Late notice cancellation is a call the day of the appointment. My fee is $60. I will notify you before I bill your card.

Bring to your first appointment the following:

1. Two page completed application form
2. Signed Psychotherapy Services and Agreement form
3. Signed HIPPA form
4. Insurance benefit form (if applicable)
5. Credit card
6. Insurance card or copies of both sides of card

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Pyschotherapy Services Agreement and Disclosure Statement

CLIENT'S RIGHTS: The Washington Administrative Code (WAC 275-55-241) has mandated that you be informed of the following rights: You have the right to be treated with dignity and respect, to be given adequate care and individualized treatment, to nondiscrimination in provision of treatment on the basis of race, sex, age, disability, national origin, language, creed, socio-economic status, marital status or sexual orientation, to have an individualized service plan reflecting problems and needs identified by yourself, to refuse any proposed treatment, to review case records with the therapist, to receive treatment fee of any sexual exploitation or harassment and to lodge a grievance with the provider if you have reason to believe your rights have been violated. The purpose of the law regulating counselors is to provide protection for public health and safety and to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

CONFIDENTIALITY: In addition to the above rights, you have the right to be protected from the invasion of privacy and to have all information and records held confidential except in the following circumstances: where there is reason to suspect child or elder abuse or neglect, where there is a clear threat to do serious bodily harm to self or others, when under court order, in the event you bring charges against me, and/or to my office manager for the purpose of billing. If you choose to use your insurance I need you to understand that there is a loss of confidentiality. If you have concerns or questions, please ask Hal. The most confidential way to pay for Hal's service is with cash or credit/debit cards. It is understood that both my wife and my office manager have access to the business aspects of my billing and records keeping systems and have signed confidentially agreements.

TREATMENT GOALS: I am interested in working with you to clarify and resolve the problems you are presenting, and I will work together with you to identify specific goals. Periodically, these goals of treatment will be reviewed and may be revised to suit your needs. Therapy involves change, and change is difficult, and some people feel worse before they feel better.

TREATMENT METHODS: I have Masters of Arts in Counseling Psychology from Antioch University. I have twenty-five years of experience and have attended many seminars and workshops in order to meet my continuing education requirements. I approach the therapy process from a cognitive and behavioral framework and use techniques from the schools of psychosynthesis, Gestalt Therapy, and EMDR. I am licensed in the State of Washington as a Mental Health Counselor, license number LH00004535. Counselors practicing counseling for a fee must be certified or licensed with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

FEES AND PAYMENTS: Individual appointments are 60 minutes in length. If you are unable to keep your appointment for any reason, a fee of $120 will be charged unless 24 hours notice is given. I charge $60 for a late cancellation. Payment is due at the time of service. I require that you register a card with me. I will give you a receipt so that you can be reimbursed from your insurance company. The fee for my professional time spent in therapy, consultation or evaluation for insurance work is $120.00 per hour. My private pay rate is $120 per hour for individuals, couples & families. All weekends and late evenings (after 6 p.m.) are $150/hr. I offer discounted fees when there are multiple family members involved and for defined people.

EMERGENCIES: Please use my phone as I do not text nor do I check my email reliably. I do not provide 24-hour coverage for emergencies. You are free at any time to leave messages on my cell phone (360-421-4858). I want to be kept informed if you are in crisis. In order to accept you as a client, I need you to agree not to harm yourself. You have three options in an emergency: (1) Call the crisis line at 1-800-584-3578, (2) Get yourself to the nearest E.R., or (3) Call 911.

I hereby authorize Hal Pullin to render psychological services to me. This authorization constitutes informed consent without exception. I have read and understand this agreement and disclosure statement and have received a copy if I have so requested.

SIGNATURE _____ **DATE** _____

Psychotherapy Services Questionnaire

Section I - Patient Information

Name_____

Address_____

City _____ State _____ Zip _____

May I send mail to you at this address? ☐ Yes ☐ No

Home Phone _____ Cell Phone _____ Work Phone _____

May I contact you and leave messages at these phone numbers? ☐ Yes ☐ No

Date of Birth _____ Age_____ SSN _____

E-mail _____ May I e-mail you? ☐ Yes ☐ No

Marital Status _____ # of Years_____ Gender ☐ Male ☐ Female

Employer or School _____

Emergency Contact_____ Phone _____

Primary Care Physician _____ Phone _____

Who referred you to my practice? _____

I need your permission to contact your primary care physician. This is a courtesy but may also involve the coordination of treatment.

Client Signature _____ Date _____

(if disagree, don't sign)

I need you to understand that I employ an office manager. She is bound by the same confidentiality that I am.

Client Signature _____ Date _____

Section II - Personal Information

Please describe why you are seeking counseling at this time and describe your goals: _____

_____

Place an "X" next to any of the following that apply:

__ Depression
__ Suicide Attempts
__ Suicidal Thoughts
__ Panic attacks
__ Eating disorders
__ Health problems
__ Sexual problems
__ PMS/Menopause
__ Anger
__ Parenting Difficulties
__ Alcohol/Drug Use (self)
__ Alcohol/Drug Use (others)
__ Tobacco use
__ Marital/relationship problems
__ Death/grief issues
__ Child behavioral problems
__ Toileting problems
__ Anxiety
__ Sleep Problems
__ Social isolation
__ Job related problems
__ Sexual abuse
__ Domestic violence
__ Difficulty making decisions
__ Blended Family concerns
__ Legal problems
__ Divorce/separation
__ School problems
__ Difficulty completing tasks
__ Nightmares
__ Flashbacks

Please be specific about the main issue you marked above: _____

I understand that the goal of therapy is to make changes. I also understand that the situation may become worse before I realize improvement.

Client Signature _____ Date _____

(over)

Are you currently on any medication? Please list and state what they are for.

Medication	For

Any known allergies or adverse reactions to medication? _____

_____

_____

Have you been in therapy before? ❑ Yes ☐ No

Name of therapist _____ Phone _____

When? _____

Current household members (list):

Name	Relationship	Age

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NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me, I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide/or offer you a copy of the Notice of Privacy Practices and to request that you sign the written acknowledgement that you were offered/obtained a copy of the notice. The notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, (print name) _____, acknowledge that I received, or was offered, a copy of the Notice of Privacy Practices for Hal Pullin, M.A., LMHC.

_____ _____

Signature of client (or personal representative) Date

CHECK YOUR INSURANCE BENEFITS FORM

Questions to ask your insurance company

1. Is Hal Pullin, L.M.H.C. a preferred provider on your plan? YES _____ No _____
   If no, then will they pay a reduced amount to Hal as an off-net provider? _____
   If yes, then what percentage will they pay? _____

2. Do you need to have your sessions preapproved or do you need a referral?
   Note: *All **Group Health** clients need a referral.*

   On your insurance card there is a telephone # to contact your medical insurance company to obtain this information. This approval/referral needs to be obtained prior to your first session or I will have to charge you $120 per session until a referral is in place.

3. How many sessions annually will be covered? _____

4. Do you have an annual decuctible? YES _____ No _____
   If yes, then how much of your deductible remains? _____ (If there is a remaining balance I will charge you $120 per one-hour session at the time of service until the deductible is met. We will bill your insurance company so you will get credit against your deductible.)

5. Do you have a co-pay and/or a coinsurance payment for each session? How much is this payment? _____

6. Don't worry is your insurance company tells you that they exclude marital or family therapy. I can explain this to you, or if you are concerned just call me.

7 Billing instructions: Some insurance companies have a variety of programs managed by a third party. Please get a phone number for billing instructions, or a billing address would be most helpful. Sometimes this information is located on your insurance card. The telephone number to call for billing instructions is _____ and the billing address is _____

8. BRING YOUR INSURANCE CARD TO THE FIRST SESSION.