Chris Chandler, MA, LMHC, CSAT, AF-EMDR
330 112th Ave, Ste 302 | Bellevue, WA 98004
Tel: 425-954-7494 | Fax: 619-790-7393

To New Patients:

In accordance with Washington state law, this document ensures that patients have the necessary information to make an informed decision, understand their rights and responsibilities, and agree to the service they will receive, and do so of their own volition.

An electronic version of this document will be shared with you via the patient portal. You will be asked to sign the electronic version before the initial meeting, so that we can spend our time together focused on the session rather than completing paperwork. By signing, you acknowledge receiving and reading a copy of this document and confirm you understand the information and agree to the information provided herein.

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Counselor Education, Training and Counseling Orientation

Training and Degrees: I received my Master of Arts in Counseling Psychology from Mars Hill Graduate School (now Seattle School of Theology and Psychology) in December 2005. This program is fully accredited by TRACS, a national accrediting agency that is recognized by the Council for Higher Education Accreditation. I received my Bachelor of Arts degree in Psychology from Western Oregon University. In began my clinical experience in 2004 working with adolescents and adults in a variety of contexts including inpatient and outpatient hospital settings. I am credentialed as a Washington State Licensed Mental Health Counselor (LH00011043). Chris Chandler, MA, LMHC, CSAT, AF-EMDR is affiliated and practices collaboratively at Christian Health Group Inc, PS and Seattle Christian Counseling PLLC ("SCC")/WA Christian Management, LLC ("CMS"). SCC/CMS provides office space and administrative support for Chris Chandler. Chris Chandler is responsible for all patient care.

Counseling Orientation: I approach counseling from a patient-centered and strength-based perspective. This means that I tailor my methods to the strengths and needs of each of my patients. In my first few sessions with a patient, I work to create a therapeutic relationship in which the patient feels safe to process his or her concerns openly, without fear of judgment; this way, we can determine together what the best approach will be for his or her treatment. In counseling, I think of myself as a personal trainer: I provide tools and resources that my patients can use to empower themselves as they go into the world to seek health and freedom. As a Christian counselor, I use the principles of the Bible and Christian doctrine where appropriate. Very often, I will work with patients on goal setting and assign homework to allow them to hone the skills learned in therapy. Working with children and adolescents, I emphasize family involvement and building positive relationships. My methods are informed by a variety of clinical theories including Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Existential, Psychodynamic, Object Relations, Gestalt Therapy, and Brief Solution Focused Therapy.

Informed Consent for Treatment

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Our relationship as counselor and patient is a collaborative one. So, please feel free to ask any question regarding this document or proposed treatment plan.

Risks and Benefits of Counseling

Counseling, when engaged in as a process, is beneficial. However, as with any treatment, there are inherent risks. During counseling, you will discuss personal issues, which may

bring up emotions such as anxiety, anger, guilt, and sadness. This can be uncomfortable. In addition, you will be asked to do work outside of your comfort zone. That said, the benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and gaining of specific problem-solving skills. There are no guarantees, of course, but it is my goal is to create a safe environment where together we develop a treatment plan, and work to achieve your goals. Some patients need only a few sessions to achieve their goals, while others may benefit from longer-term counseling.

Your Right as a Patient
Choosing a counselor is an important decision. You have the right to choose a counselor who best suits your needs and objectives. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

Confidentiality
The information shared and discussed in session will remain confidential except when I am required by law to disclose suspected abuse of a child, a developmentally disabled person, or a vulnerable adult; Other exceptions include:

- Reporting imminent harm to patient or others, including risk of physical harm.
- Reporting information required in court proceedings or by a patient's insurance company, or other relevant agencies.
- Defending myself against claims; and
- Consultations with other professionals regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

Disclosures may also be made if you sign a written authorization for me to release information to another person or agency, such as your physician or family.

In addition to this document, you will be provided with a separate document entitled Notice of Privacy Practices, which describes in more detail your rights regarding how medical information about you may be used and disclosed.

Appointments and Billing Policies

To schedule or reschedule an appointment, you may contact my office via the patient portal, by phone at 425-954-7494 or by email at manager.chg@cachristiancounseling.com.

Appointment Reminders

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We customarily provide an appointment reminder prior to your appointment; however, this reminder is a courtesy, and it is still the patient's responsibility to remember and keep track of scheduled appointments.

Credit Card on File
Although I accept payment via cash, check (made payable to WA Christian Management, LLC) or credit card, patients are required to keep an active credit card on file. By completing the credit card authorization form, the patient (or legal representative) authorizes my office to charge the card on file for payment of services rendered and/or products received, including late cancellations, and missed appointments.

Unless, otherwise agreed, we will process the credit card on file on a weekly basis. If the credit card we have on file for you changes, you agree to contact our office immediately to update the payment method on file.

This policy is necessary to keep the practice focused on your care and treatment versus collection efforts. In conjunction with HIPAA regulations and our office policy, all credit card information is maintained confidentially within your medical chart. Only authorized personnel will be able to access this information.

Fees – All my fees are listed in the Fee Schedule, attached.
The clinical hour appointments are 53 – 60 minutes in length. During a given year, fees will not increase more than 10% per year. If you are continuing in therapy with me at that time, I will provide you with thirty days advance notice of such increase. Patients will be charged in quarter-hour increments for telephone calls to discuss issues or concerns between sessions. Patients are not liable for any fees or charges for services rendered prior to receipt of the disclosure statement.

Case Management
Services provided outside your session, such as telephone interactions with attorneys, physicians, and others on your behalf, writing letters, coordinating adjunct services, and completing forms or reports at your request are not considered standard therapy and are not covered by insurance, as such, you are solely responsible for payment for these services.

Assessments
If we agree that your treatment plan includes evaluating issues such as trauma, dissociation, addiction, and or financial issues. I may recommend that you take an assessment test. These tests are typically completed online. The tests assess signs and symptoms; they are not necessarily diagnostic. This means that you may not receive an “official” diagnosis that has an “official” diagnosis code. As a result, none of the assessment tests I offer are billed to, nor reimbursed by insurance. I will not release the results of these tests unless the tests

and your account are paid in full and in no case will I release the test results without a counseling session to discuss the results. Patients will be responsible for full payment of the assessment, if it is started, even if it is not completed, since we're unable to cancel an assessment after it has started. In no event will the testing fees be refunded.

Cancellation Policy

I have a 72-hour cancellation policy and would appreciate as much advance notice as possible if there is a change in your schedule. Cancellations received with less than 72-hour notice are subject to the full session fee. I understand unforeseen scheduling conflicts may occur, if you must cancel an appointment at short notice, please contact my office, as we may be able to reschedule the session for another time that is mutually convenient. This fee may be waived if we can reschedule your appointment within the same week, based on my availability.

Missed Appointments

In the event that you are unable to keep an appointment, please notify me via phone a minimum of 72 hours in advance. If you miss your appointment for whatever reason and fail to give me adequate notice (72 hours), you will be responsible for the full session fee. If you are late, I will still stop at the scheduled end time to keep my schedule, and you will still be required to pay for the entire session. In the event of a late cancellation or missed appointment, the bill will reflect a missed appointment instead of a clinical session.

Insurance

I am not contracted with any insurance. If your plan covers out-of-network benefits, I will accept payment for the session and provide you with a record of your sessions showing receipt of your payments via a Superbill on the 15th of each month. You may submit the Superbill to your insurance company for reimbursement. I recommend checking with your insurance company to see what the reimbursement rate is so that there are no surprises.

Please note, health insurance companies will not pay for telephone calls, reports, letters, or interactions with attorney and others, as such, you are solely responsible for payment for these services.

Past Due Accounts: All balances billed are due and payable within 30 days. Unpaid balances greater than 30 days may be charged a monthly fee of 1% (annual rate of 12%). If your account becomes delinquent and all efforts have been made to collect on your balance, your account may be referred to an outside collection agency. If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees.

I reserve the right to postpone scheduling, or terminate treatment with you, if you have an on-going unpaid balance on your account. If I take this action, I will not provide any reports,

treatment records, respond to requests for release of information, or similar until the unpaid balance has been paid in full.

Returned or Nonsufficient Payments: There is a charge for payments returned for nonpayment, including insufficient funds, closed account, non-transaction account or invalid account or routing number. You will be notified if a payment made to your account does not go through once we are notified by the bank of the rejected payment. Payment of the outstanding balance and associated fees are due immediately. We may require future payments to be made by cash, credit/debit card or money order.

Court Preparation and/or Testimony (Legal Proceedings): I can only testify to the facts of the case and to my professional opinion. If I am to receive a subpoena, the attorney or office staff should call my office and set up a time for the subpoena to be served during office hours. I request a minimum of 72-hour notice of any court appearance so that schedule changes for my patients can be made within a reasonable time frame. An additional "RUSH" fee will be charged if a subpoena is received without a minimum of 72-hour notice. A retainer fee will be required in advance for court and legal proceedings, of which a portion is non-refundable. Please note, I am not a certified child custody evaluator and will be unable to testify in child custody cases.

Administrative and Billing Disclosure
I have a contract with Seattle Christian Counseling PLLC ("SCC")/WA Christian Management LLC ("CMS") and Keystone Admin Services, LLC ("Keystone"), practice management companies that manage my administrative and billing services. As required by HIPAA, I have a formal business associate agreement with SCC/CMS and Keystone, in which the individual managing your account including billing promises to maintain the confidentiality of information as specifically allowed and required by law.

Practice Policies

Minors & Parents
In the State of WA, minors have the right to confidentiality at the age of 13. This means parents do not have the right to access the minor's counseling records or conversations between therapist and child unless I have written authorization from the minor. I do not perform parenting or custody evaluations. I am not available to testify or provide forensic evidence in custody cases. I do not investigate child abuse/neglect issues, but I am legally mandated to report suspected abuse/neglect.

Marriage/Couples Counseling
If you are receiving marriage or couples counseling, anything you say to me in one-to-one conversations will not be considered confidential from your partner. If a legal case emerges, confidentiality may be jeopardized. Both parties must sign an Authorization for

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Release of Information in order to release any records to one or both parties. I am not available to testify or provide forensic evidence on behalf of one or the other counseling participants.

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Patient Intake Forms
The Patient Intake Form provide essential background information to help me assist and support you in achieving your therapy goals. Please complete this form via the patient portal prior to the first session. If you are seeing me as a couple, I ask that both individuals complete a Patient Intake Form.

Termination of Treatment
When you wish to terminate treatment, please give me a minimum of one week's notice. You may terminate treatment at any time without moral, legal or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of the last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

Washington State Disclosures

State Registration: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health 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 does it necessarily imply the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (a) to provide protection for public health and safety, and (b) to empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

State Mandated Disclosure
I have broad discretion to release any information that I deem relevant in situations where I believe my patient or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Unprofessional Conduct: The brochure titled "Counseling or Hypnotherapy Patients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
PO Box 47869
Olympia WA 98504-7869
(360) 664-9098

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Contacting Me

I can be reached via the patient portal, phone or email as follows:

1. Patient Portal is the most secure method of contact.
2. Confidential voice mail at 425-954-7494. I check my messages periodically and will typically return your call within 24 hours.
3. Email at email at chrisc@bellevuechristiancounseling.com. Email is not a secure form of communication. I cannot guarantee the security of information given to me via email. For this reason, I ask that patients communicate with me in session or via the patient portal.

In Case of Emergency

If you are in an emergency situation and cannot reach me, please call one of the following numbers for help:

General Emergencies: 911
Crisis Clinic: (800) 244-5767 or (206) 461-3222

By signing below, I acknowledge I have received a copy of the attached Disclosure Statement, read the information contained herein and understand my rights and responsibilities. I understand my rights to confidentiality as well as the limitations. I have had an opportunity to ask questions and give my informed consent for myself and/or a minor child or legal dependent to begin treatment. I understand that either my counselor or I may terminate therapy at any time.

_____	_____	_____
Patient Name	Patient Signature *(or legal guardian)*	Date

If applicable, Legal Representative complete the information below:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf.

_____	_____
Legal Representative Name	Date

Legal Representative Signature _____

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FEE SCHEDULE

CPT Code	SERVICE DESCRIPTION	FEE
90791	Initial Diagnostic Session	$ 200.00
90832	Individual Therapy Session (16-37 minutes)	$115.00
90837	Individual Therapy Session (53-60 minutes)	$200.00
90846	Family Therapy Session without Patient (53-60 minutes)	$200.00
90847	Family Therapy Session with Patient (53-60 minutes)	$200.00
90853	Group Counseling (90 minutes) weekly for 12 weeks	$70.00

OTHER - Not Reimbursable by Insurance	FEE
Late Cancellation / Missed Appointment – Individual or Family session	$200.00
Late Cancellation / Missed Appointment – Group session	$70.00
Case Management - telephone interactions with attorneys, physicians, and others on your behalf, writing letters, coordinating adjunct services, and completing forms or reports at your request, per hour	$200.00
Case Management – "RUSH" Fee for requests before 7 business days	$10.00
Court Preparation/Testimony – Retainer Fee - required in advance, of which $350.00 is non-refundable	$500.00
Court Preparation/Testimony - including preparation, travel (to and from), and attendance (wait time and testimony/participation), per hour	$350.00
Court Preparation/Testimony – "RUSH" Fee will be charged if a subpoena is received without a minimum of 72-hour notice	$250.00
Non-Sufficient Funds (NSF) or Returned Payments	$30.00

ASSESSMENT / TESTING - Not Reimbursable by Insurance	FEE
Sexual Dependency Inventory (SDI)	$100.00
Money and Work Adaptive Styles Index (MAWASI)	$50.00
Post-Traumatic Stress Index, Revised (PTSI-R)	$50.00
Adult SASSI-4 or Adolescent SASSI-A3	$25.00
M.I.N.I Assessment	$25.00

Acknowledgment & Agreement

By signing below, I agree to the Fee Schedule provided and to pay the fee as specified in this disclosure statement. I understand I am expected to maintain a valid credit card on file, that will be automatically processed weekly for services rendered, unless I make a payment by other means (i.e., cash, check, etc.) at the time of service. I agree to contact Chris Chandler's office immediately to update the credit card on file, if it becomes inactive or invalid for any reason.

_____ _____ _____
Patient Name Patient Signature *(or legal guardian)* Date

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NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2022

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.

NOTICE

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by submitted a written request to our Privacy Officer.

Your health record contains Protected Health Information ("PHI"). Protected health information means individually identifiable health information, including demographic information, past, present, or future physical or mental health or condition, health care services including treatment, billing and payment for these services, that is:

- Transmitted by electronic media;
- Maintained in electronic media; or
- Transmitted or maintained in any other form or medium.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct our medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we 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 us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We 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). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get 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. We 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.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by writing to Chris Chandler at 330 112th Ave, Ste 302, Bellevue, WA 98004, calling 425-954-7494, or emailing chrisc@bellevuechristiancounseling.com.
- You can file a complaint with the Washington State Department of Health at 510 4th Avenue W, Suite 404, Seattle, WA 98119.
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us 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 us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission.

- Marketing purposes
- Sale of your information
- Fundraising efforts

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treatment - We can use your health information and share it with other professionals who are treating you.

- Information obtained by a nurse, physician, therapist, or other member of our healthcare team will be recorded in your medical record and used to determine the best course of treatment for you.
- We may also provide information to others providing our care. This will help them stay informed about your care.

Health Care Operations - We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example,

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

Payment – We can use and share your health information to bill and get payment for your health services.

- We give information about you to your health insurance plan so it will pay for your services.
- We may provide information to a third-party payor, or, in the case of unpaid fees, submitting your contact information and amount owed to a collection agency.

How else can we use or share your health information? We are 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. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - 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

With Medical Researchers

- If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

Comply with the law

- We 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 we're complying with federal privacy law.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We 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

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Incidental Disclosures

- We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

Limited Data Set Disclosures

- We may use or disclose a limited data set (PHI that has certain identifying information removed) for purposes of research, public health, or health care operations. This information may only be disclosed for research, public health and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

Psychotherapy Notes

Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes is required except if used by the originator of the notes for treatment, to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, if the notes are to be used in the course of training students, trainees or practitioners in mental health; to defend a legal action or any other legal proceeding brought forth by the patient; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by law.

Special Authorizations

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse Treatment Records (RCW 70.96A.150)
- Mental Health Services for Minors (RCW 71.05.390-690)
- Communicable and Certain Other Diseases Confidentiality (WAC 246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

If we need to use or disclose your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most important, if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future use and disclosure.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know n writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of Notice: October 1, 2022

Privacy Officer
Christopher A Chandler
330 112th Ave, Ste 302
Bellevue, WA 98004
Email: chrisc@bellevuechristiancounseling.com
Phone: 425-954-7494

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CREDIT CARD AUTHORIZATION FORM

By completing this form, I authorize Seattle Christian Counseling PLLC/WA Christian Management, LLC and/or Christian Health Group, Inc., P.S. to process the card indicated below for payment of therapy session fees, any fees related to therapy related materials (workbooks, assessments, and other materials, and/or fees), or for late cancellations and/or missed appointments. A receipt for any payments processed will be sent to the email provided below.

Patient Name		Date of Birth	
Cardholder Name		Relationship to Patient	
Billing Address		Telephone	
City		State	Zip
Account Type ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover			
Account No.			
Expiration Date	CVV	Email	

I understand that charges for ongoing services or materials will normally be charged to my credit card account within 7 days of each session date. Additionally, I agree that the card listed below may be charged by Seattle Christian Counseling PLLC and/or Christian Health Group, Inc., P.S. to settle any outstanding balances accrued by the above listed patient upon termination of therapy services including any materials (i.e., assessments, workbooks, etc.).

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact the billing department at 425-954-7494 for assistance and/or disclosure.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company as long as the transaction corresponds to the terms indicated in this form.

I authorize Seattle Christian Counseling PLLC/WA Christian Management, LLC and/or Christian Health Group, Inc., P.S. to charge the credit card indicated in this authorization form according to the terms outlined above.

_____ _____

Chris Chandler, MA, LMHC, CSAT, AF-EMDR
330 112th Ave, Ste 302 | Bellevue, WA 98004
Tel: 425-954-7494 | Fax: 619-790-7393

Patient Signature *(or legal guardian)* Date

VIDEO AND AUDIO RECORDING RELEASE
(OPTIONAL)

As an additional support for your counseling process, it is sometimes beneficial to use video feedback as part of our work together. This means that I may ask to video or audio record you during specific dialogues, exercises, or during entire sessions. This will give us the option to play back these tapes in session to help you see patterns of behavior in yourself or your significant other (if applicable). Because it usually takes some time to setup a video camera or audio recorder, I'm requesting that we do the paperwork for this on the front end so that we can devote as much time to working on the issues that bring you into counseling. By viewing the videotape or listening to the audio recording in session, it allows us to "stop action" and process how you might approach an issue in a more productive way. It also allows you to witness your progress with your counselor and/or your relationship.

In addition to in-session use, I occasionally may use the video footage or audio recording to receive consultation from other health care professionals that I consult with. This may occur during time of treatment or thereafter for purposes of peer review, education, and quality assurance. During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission, and it will be deleted when it is no longer needed for these purposes.

These recordings are the property of **Chris Chandler, MA, Licensed Counselor** and will remain solely in my possession throughout the course of your counseling and until they are destroyed. Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems always to ensure maximum confidentiality.

I hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts. *No recording is permissible without prior authorization.*

In no way, will the refusal to grant consent for this video or audio recording effect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and affect.

_____ _____ _____
Patient Name Patient Signature *(or legal guardian)* Date

Chris Chandler, MA, LMHC, CSAT, AF-EMDR
330 112th Ave, Ste 302 | Bellevue, WA 98004
Tel: 425-954-7494 | Fax: 619-790-7393

AUTHORIZATION TO RELEASE OF INFORMATION

Patient Name	Date of Birth

I hereby authorize Chris Chandler and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

Please list the name of person you authorize Chris Chandler to communicate with below:

Name of Provider/Person/Entity Authorized to communicate with Chris Chandler		
Address	Telephone	
City	State	Zip
Email	Relationship to Patient	

I understand that by signing this authorization I am authorizing Chris Chandler to disclose my health information to the persons and entities listed above and that any health information of other confidential information in the possession of the persons and entities listed above may be disclosed to Chris Chandler My health information includes any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Chris Chandler, where I am receiving counseling. I understand that my revocation of this authorization will not affect a disclosure that Chris Chandler has already made under this authorization.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below until _____, or until six months after my file is closed with Chris Chandler if not indicated otherwise.

By signing, I authorize Chris Chandler and the persons or entities listed above or their representatives, to mutually release and disclose my health information.

_____ _____
Patient Signature *(or legal guardian)* Date

Chris Chandler, MA, LMHC, CSAT, AF-EMDR
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