Shirley Lytle, M.Div., LMHC, CSAT
Professional Counseling for Individuals, Couples, Family & Premarital
2025 112th Ave NE Bld.2 Suite 100 Bellevue, WA 98004
(425) 243-2330

Welcome,

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I do have forms at the office in case for some reason you are unable to complete them before our meeting, but time will be spent completing the forms instead of discussing your concerns, so please review and complete it in its entirety.

- ✓ Please print your name in the space provided on this page.
- ✓ Please read the entire document thoroughly and sign-
  - o the Disclosure Statement (Page 3),
  - o the Client Acknowledgement and Financial Agreement Receipt of Notice (Page 8),
  - o Complete the Credit Card Authorization Form (page 9).
- ✓ Initial all pages in lower left-hand corner to indicate that you have read and understand the information provided.

I look forward to the opportunity to working with you to achieve your therapy goals. At the same time, in no way can any type of specific results be guaranteed. I look forward to meeting with you and beginning the journey to Purposeful living.

_____
Shirley Lytle, M.Div., LMHC, CSAT

(Please print)

Client Name: _____

Address: _____

City: _____ Zip: _____

E-mail: _____@ _____

Phone: Home: _____ Work: _____

OK to phone you at home? Y/N OK to phone at work? Y/N

Client Signature: _____

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DISCLOSURE STATEMENT
Counselor Training, Counseling Orientation, General Information, and Counseling Fees

Training and Degrees: I received my Master in Divinity with a concentration in Counseling and Family from Phoenix Seminary 2010. This program is fully accredited by the Association of Theological Schools. I received a post-master certification in clinical Pastoral counseling from Seattle University in 2012. In addition to my formal training, I have experience working with young adults, couples and families in a variety of settings over the past 25 years. I am a 3rd. level Gottman trained therapist. I am a Certificated Sex Addiction therapist (CSAT) through the International Institute for Trauma & Addiction Professionals. I practice under the title of a Washington State Licensed Mental Health Counselor (LH60441078). I consult weekly with other professional counselors to ensure quality performance for my clients.

Counseling Orientation: In my Christian counseling sessions, I desire to provide holistic care and I draw from cognitive behavioral, narrative and person-centered therapies. I use a task-based model for CSAT counseling. These approaches allow us to examine how your behavior, thoughts, emotions and spiritual beliefs impact your present concerns. My role as a counselor is to create a safe space for you to locate and live out your truest self. This can be achieved by cultivating and maintaining a strong counseling relationship between counselor and client. My intention is to work with you to identify processes and patterns that are counterproductive. I believe there are various dynamics in a person's life that hinder healthy growth spiritually and emotionally. Our focus will include exploration of other significant people in your life and how those relationships impact your life. We will work on establishing realistic boundaries and empowering you to live in a holistic manner. Your therapy is only as productive as the information communicated. Therefore, authenticity and transparency will greatly enhance the effectiveness of your therapy. I believe that certain problems can have a physical component. In such cases, medical consultation will be advised. If at any point you have questions or concerns about our relationship or the direction of our work together, please feel free to address these with me.

Fees: Each counseling session is approximately 50-minutes in length. The fee for counseling is **$150** per 50-minute session for individuals and $**170** per 50-minute session for couples and **$190** for families. Fees are adjusted annually on January 1 and will not increase more than $10 per year. Forms of payment accepted (cash, check or credit) are to be made at the beginning of each session. Credit Card payments will include a processing fee of up to 3.7% plus $0.15 per transaction. A $30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency. If you elect to use your insurance benefits you may ask for a receipt and diagnosis code so you can submit them to your insurance company for appropriate reimbursement.

Missed Appointments: In the event that you are unable to keep an appointment, please notify your counselor via phone a minimum of three days (72 hours) in advance from the date and time of the appointment. E-mail and text messages are not adequate notice. **If you miss your appointment for whatever reason and fail to give adequate notice, you will be responsible for the full fee for the session.** If you are late, the session will still stop at its regular ending time in order to keep the counselor's schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If your counselor has an emergency, you will be notified as soon as possible of if needed to reschedule your appointment.

Termination of Treatment: When you wish to terminate treatment, please give 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 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.

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Testifying in Court: If you become involved in any legal proceedings that require my participation, it is expected that you will pay for all of my professional time attending to the matter. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, the charge is $250 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

Choosing a Counselor: It is in your best interest to be proactive about your health. If you have any questions or concerns, please ask for clarification at any time. Also, if you should you choose not to enter therapy with me, I will provide you with the names of other qualified professionals whose services you might prefer. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

Outside Consultations: I consult with other professionals regarding Clients with whom I am working. Gaining other perspectives and ideas about how to better help you reach your goals may be used. These consultations are conducted confidentiality privacy is maintained.

Unprofessional Conduct: The brochure titled "Counseling or Hypnotherapy Clients" 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

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

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.

Contacting Me By Phone: You may leave me a voice message at **(425) 243-2330**. This message is checked periodically, and I will typically return you call within 24 hours. Please limit your phone conversation needs to appointment scheduling and emergencies.

Emergencies: 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

I have read and understand the information present in this form.

Date: _____ _____

Client Signature

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HIPAA COMPLIANCE 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. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical Records - Health Care Access and Disclosure." Please review it carefully.

Your privacy is respected, and your personal health information is very sensitive. Your information will not be disclosed to others unless you approve the release, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information that is created and obtained in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

Protected health information means individually identifiable health information:

- Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

Examples of Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations-
Treatment. I 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. I may use your PHI in connection with billing statements I send you. I may use your PHI for the purpose of tracking charges and credits to your account. Unless you have requested and I have specifically agreed to restrict disclosure of your PHI to your health plan, I 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. I may use and disclose your PHI for the health care operations of my 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 me in my delivery of your health care.

Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object Required by Law. I 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. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

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

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Your Health Information Rights:

The health and billing records created and stored are the property of the Living With Purpose Counseling and the health care provider. The protected health information in it, however, generally belongs to you. The following are rights you have regarding PHI that I 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 I maintain. I may charge a reasonable, cost-based fee for the copying process. As to your PHI that I 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 (e.g., PDF). Your copy request may also include transmittal directions to a third party.

✓ **Right to Amend.** If you feel the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information although I am 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.** I am required to create and maintain a prescribed accounting of certain disclosures I 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. I am generally not required to agree to such a request. If I have been paid in full for all of the services covered by such a request, then I will honor a request to restrict disclosure to your insurance.

✓ **Right to Request Confidential Communication.** You have the right to request that I communicate with you in a certain way or at a certain location. I 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 me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. ***I will not retaliate against you for filing a complaint.***

I am my own Privacy/Security Official. So, if you have any questions about this Notice of Privacy Practices or complaints about how your PHI has been utilized, please contact me during normal business hours. My contact information is:

Shirley Lytle, M.Div., LMHC, CSAT
2025 112th Ave NE
Building 2 Suite 100
Bellevue, WA 98109
Tel: (425) 243-2330

Our Responsibilities:
We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

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Living With Purpose Counseling has the right to change its practices regarding the protected health information maintained. If changes are made, and this Notice is updated, you may receive the most recent copy of this Notice by requesting it from your counselor.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact us at the above address.

If you believe your privacy rights have been violated, you may discuss your concerns with how your request was addressed. You may send a written complaint to the Washington State Department of Health at:

510 4th Avenue W, Suite 404
Seattle, WA 98119

Other Disclosures and Uses of Protected Health Information Notification of Family and Others:

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. This would be limited to your name and general health condition (for example, "critical," "poor," "fair," "good" or similar statements). In addition, we may disclose health information about you to assist in disaster relief efforts.

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

You have the right to object to this use or disclosure of your information. If you object, it will not be use or disclosed.

We may use and disclose your protected health information without your authorization as follows:

- **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.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws -** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
- to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- to public health or legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

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- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.
- **To Coroners, Medical Examiners, Funeral Directors**. We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.
- **Organ and Tissue Donations**. If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.
- **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.

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 Clients (42 CFR Part 2)

Other Uses and Disclosures of Protected Health Information

If we need 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.

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

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CLIENT ACKNOWLEDGMENT:

WITH MY SIGNATURE BELOW, I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACYPRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by Living With Purpose Counseling. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to Living With Purpose Counseling and/or its staff. Living With Purpose Counseling shall not be liable for the acts or omissions of others.

AUTHORIZATION TO RELEASE INFORMATION – IF APPLICABLE: I, the undersigned, hereby authorize Living With Purpose Counseling and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to Living With Purpose Counseling for Living With Purpose Counseling's charges or who may be responsible for determining the necessity, appropriateness, or amount related to Living With Purpose Counseling's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the Client is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a Client, to be financially responsible to Living With Purpose Counseling for all charges. I understand this amount is due at the beginning of the session.

INSURANCE COVERAGE – IF APPLICABLE: I certify that the information given to me in applying for payment under government or private insurance is correct. I understand that it is my responsibility to determine the coverage limits of my insurance. If you elect to use your insurance benefits you may ask for a receipt and diagnosis code so you can submit them to your insurance company for appropriate reimbursement.

_____ _____
Client or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the Client Relationship
(Parent, legal guardian, personal representative)

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Living With Purpose Counseling, Inc.** to debit your credit card as listed below.

By signing this form, you give us permission to debit your account ***in the event of a cancellation (without 72-hour notice) for the amount of the session.*** This is permission for therapeutic treatment fees accrued while in treatment with **Living With Purpose Counseling, Inc.,** and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I,_____(full name printed) authorize **Living With Purpose Counseling, Inc.** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of **$150** per 50-minute session for individuals and **$170** for couples and **$190** for families; and charged up to 3.7% plus $0.15 for electronic processing of the charge. This is the exact same fee that I am charged by my credit card processing company.

Billing Address_____Phone# _____

City, State, Zip_____ Email _____

Account Type: Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

CVV2 (3digit number on the back of VISA/MC/Discover, or 4 digit number on the front of AMEX) _____

I authorize **Living With Purpose Counseling, Inc.** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. 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; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE_____ DATE _____