Sarah Woodall ARNP
roving body resting mind

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Treatment Consent and Agreement Regarding Services, Fees, and Policies

It is my goal to provide you with the highest quality of care and service. These agreements and policies support you and keep things runningly smoothly in the practice for the benefit of everyone.

Professional Standards and Ethics

I am licensed by the State of Washington Department of Health (DOH) and have fulfilled all of the requirements required to provide your psychiatric and mental health services. You may search my credentials on the DOH website at www.doh.wa.gov, or call (800) 525-0127.

Appointments

At your initial visit, I will begin a thorough review of your current concerns and of your background. By the end of the initial visit we will discuss preliminary impressions and your treatment options, however it may take 1-3 appointments to complete this process. In many cases, a combination of psychotherapy and medication management is optimal, however lifestyle and wellness factors will also be addressed and in some cases will be sufficient with therapy. The initial visit is also an opportunity for both of us to determine if my services arewell matched to your needs. If you determine it is not a good match I can assist you with referrals to other mental health professionals.

Appointment Frequency

At your initial visit, we will decide together the structure of your therapy. Appointments will be more frequent initially until symptoms have stabilized. If medications are prescribed, or changed, I prefer to conduct a 25-minute follow-up visit within two weeks. This is necessary to ensure proper administration, and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients who are stable and on maintenance therapy, follow-up visits can be held at three-month intervals.

Fees for Services

If I am credentialed with your insurance, the fee is determined by the contracted rate schedule set by your insurance plan.

Initial Evaluation: Allow 60-90 minutes for this office visit: $275-$300
25 minute Follow-up: $100-$180 Rates vary depending on medical complexity
50 minute Follow-up: $200 - $250 Rates vary depending on medical complexity

Ancillary services:

- Filling out forms and letters outside of appointments: $25 per 15 minute interval
  (I generally do not fill out forms for L&I, disability, custody disputes or court.)
- Calling in or refilling prescriptions between appointments: $25
- Non-emergent telephone calls outside of office hours: $25 minimum, $25 each additional 15 minutes

*There is no charge for routine telephone calls regarding scheduling, appointments, or billing, however please schedule your next appointment while you are here, or utilize the patient portal and the scheduling widget on my website: http://www.sarahwoodallarnp.com/schedule.html as much as possible. If these calls are made outside of office hours, they will be returned when I am in the office. My time is best-served providing high quality professional services to you while you are here in session.

Legal Testimony:

It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony can often be damaging to the relationship between a patient and his/her practitioner. Because of this, I require that you employ independent forensic psychiatric or psychological services should this type of evaluation or testimony be required. If for any reason I am deposed or subpoenaed on your behalf and required to testify or appear in court, you will be responsible for my court fees at a minimum of $1,080 for a half day or $2,160 for a full day. Any legal fees I acquire on your behalf will be your responsibility.

Cancellation and No-shows

I require **a minimum of 48 hours notice** when canceling or rescheduling appointments. If you did not have an emergency and did not provide 48 hours notice, you will incur a missed appointment/ late cancellation fee:

$ 75 per missed appointment

Exceptions to this fee will only be made for documented emergencies, or inclement weather.
Insurance does NOT cover this fee.

Please understand that this policy is in place as a means of respecting the time and efforts of your provider, as well as other patients who would have benefited from a visit during this time. **If a pattern of cancelled appointments develops (whether providing 48 hours notice or not), I may be unable to continue to provide services, and reserve the right to cancel future appointments.** I will always communicate about this with you, and determine if we're a good fit prior to making changes to your scheduled appointments. I will make every effort to provide you with adequate notice if I will be unavailable for a scheduled appointment and be more than happy to reschedule as needed.

Phone Consultations and Telemedicine

Most insurances do not cover telephone visits; these are billed at the regular in-office rate and payment is due via credit card at the end of each call. If you are unable to come to my office, your visit may be conducted via telemedicine depending on complexity and if you are already an established patient. An in-person visit is required before certain medications such as those used for ADHD can be prescribed.
*Please note non-emergent telephone calls lasting more than 5 minutes will incur a fee of $25 per 15 minutes.

Contact Information

Psychiatric treatments are individualized and often require multiple changes. For this reason, I do not offer extensive consultations via email and I do not communicate by texting on the phone. You may email me with short, concise questions that should be no more that 3-5 lines long and pertain to your current treatment plan. Email or nonurgent phone calls outside of appointment times are not a substitute for an office visit. **E-mail correspondence is intended for clarification or brief questions that can await response 7 days or more.** It is not a thorough or appropriate way to conduct your healthcare. *If you have a detailed question, are experiencing a change in your symptoms, or require advice on a new or existing issue, please make an appointment.*
My practice utilizes OnPatient, an online patient portal where you can send me secure HIPPA-compliant messages and access lab results, medication lists, and appointment scheduling. You must have an email address to use this portal and there is an OnPatient app available to send secure messages from your phone or tablet.

To report acute symptoms not requiring emergency care, please call my office. Urgent calls will be returned as soon as I am able within 48-72 hours and non-urgent calls are generally returned during current office hours. I do not answer my phone while I am with patients and at various other times. In an emergency, **do not** email, send an OnPatient message or call my office. **Call 911**, call the Suicide Crisis Line 1 (800) 273-8255 or proceed to the ER. Please note that email is not considered to be a secure form of communication and you are accepting the risk that your message may be intercepted or otherwise seen by an unauthorized third party.

Please note: Most clinical issues should be shared in your session. If calls and case management become excessive, I may charge for case management time, at an hourly rate. I will always inform you prior to providing this service and prior to billing for it. Many issues including insurance or billing questions, appointment changes, medication questions or medication refills can be resolved during normal business hours, Monday through Wednesday 9 am – 5 pm.

Out of the Office

If I will be out of the office, nonurgent phone calls, emails and patient portal messages will be responded to upon my return. The scheduling page on my website and the patient portal should be used for scheduling, and refill requests should be sent directly to your pharmacy. Please call the office for instructions regarding medication side effects. If you are **in crisis**, calling a crisis line is the best way to speak with a mental health professional immediately. A list of resources available in the community and their contact information will be provided via automated email response and also on my website. If you have specific concerns about contacting me while I am away, please bring them to my attention as soon as possible so that I may address them.

Insurance and Payment

Please provide full insurance information initially and bring your most current insurance card to every visit. I am currently in-network with Premera/Lifewise, Regence, Aetna and First Choice Health. It is your responsibility to determine eligibility of benefits, understand your coverage, and obtain authorization from your insurance provider when necessary *prior* to your first visit. If the visit is not covered, then you will be responsible for the bill. If you have a change in insurance, please let me know as soon as possible, so I can ensure payment. Many insurances have deductibles and it is your responsibility to pay your balance if you have not met your deductible.

It is your responsibility to pay in full at the time of each visit, including private pay amounts, copays, coinsurance and deductibles. You will be billed for any remaining balance and have the option to pay online via OnPatient. I accept exact cash, checks and all major credit cards. Bounced checks incur a $25 processing fee. I reserve the right to bill my standard fees for case coordination, clinical write-ups, and phone consultations exceeding 5 minutes per week.

Medication Refills

YOU ARE RESPONSIBLE TO MAKE AN APPOINTMENT BEFORE YOUR MEDICATION RUNS OUT.

Medication prescriptions should be written during a session, which allows us to discuss how they are working and how long you should take them. You will be given refills for your prescriptions during your medication management appointments. If you cancel this appointment, but need a refill, you will be responsible to provide me with **SEVEN BUSINESS DAYS** notice prior to you running out of your current prescription, and will need to be seen for further refills. Keep an eye on your dosage amount to avoid a rush, and to give the pharmacy and myself enough time to get your refill processed.

I will not authorize refills if you have no future appointment, as I am legally required to ensure that you are in active treatment if I prescribe medications. Please note that in the event of a missed, rescheduled, or cancelled appointment, your medications may not be refilled.

If a pattern of repeated cancellations and refill requests outside of appointments develops, I will not be able to continue providing your care as I need to see you to prescribe for you. I am unable to provide refills of medications provided by other doctors or for other medical conditions, including narcotic pain medications, and may not prescribe any medications on your first visit.

Certain medicines (primarily medications used for Attention Deficit Disorder) cannot be refilled by phone or fax. If a paper (hard copy) prescription is necessary, it should be requested by phone to the office at 425-245-7988. If the refill is approved, I will contact you to find out when you wish to pick up your prescription at the office, however you will be limited to my current office hours as I am not in the office daily.

Collections Efforts:

If an unpaid balance remains after 90 days, your balance may be turned over to a third party collections partner. If you believe that there is an error, and you should not have a balance, please let me know as soon as possible.

Unpaid balances without a payment plan initiated after 120 days may negatively impact your credit. It is very important that you update your contact information to ensure you are aware of your financial responsibility.

Dismissal/Termination of care:

You have the right to terminate care with me for any reason, however if you have any questions or concerns about your treatment, please feel free to discuss them with me. There are some situations in which I may terminate the Provider and Client relationship such as:

- **Remission of Illness**
  If treatment reaches a point of consistent symptoms remission and no further treatment is needed, you or your provider may decide to terminate care.
- **Stability Allowing Transfer of Further Care to Primary Care**
  If medication treatment reaches a point of consistent symptoms stability, there may be an option to transfer medication management to your primary care provider. This requires your primary care provider to be comfortable prescribing your medications and managing your mental health care. This option may be requested by you due to cost or convenience, or recommended by me if specialist care is no longer assessed to be required.
- **Transfer of Care**
  A transfer of care may be requested by you or your provider for many reasons. Reasons include, but are not limited to, you or your provider relocating, change in your insurance, change in insurance accepted by your provider, or a variety of treatment concerns (see below).
- **Lack of Improvement with Treatments Offered**
  If your symptoms do not improve with treatments offered by your provider, you may request or your provider may require termination of treatment and transfer of care.
- **Level of Severity/Need Exceeds Services Available**
  If your symptoms are outside of your provider's area of expertise, or severity of symptoms/level of treatment need exceeds services offered within my practice, you may request or your provider may require termination of treatment and transfer of care.
- **Lack of Adherence to Treatment Recommendations**
  If you are not following treatment recommendations given and/or are misusing medication prescribed by this practice, your provider may require termination of treatment and transfer of care, as this may impact treatment outcomes.
- **Lack of Return for Treatment**
  If you do not return for treatment for *two months* after your provider's recommended follow timeframe, your care will be considered terminated and your chart will be closed. If you only need to return for care as needed, your care will be considered terminated and your chart closed if you have not returned for treatment for *four months*.
- **Poor Fit for Practice/Provider**
  If you or your provider do not feel that the care relationship, or policies of this office, are a good fit, you may request or your provider may require termination of treatment and transfer of care.
- **Nonpayment**
  If your account is over 90 days past due, please be aware that if a balance remains unpaid, your account will be referred to a collection agency and you and your immediate family members may be discharged from this practice. If you are sent to collections, you will be notified by mail that you have 30 days to find alternative medical care. If needed, you will also be provided 30 day prescriptions of non-controlled substances. During that 30-day period, your provider will only be able to treat you on an emergency basis. Need for stimulant medication does not constitute emergency care. Thirty days after the notification is sent, care will be fully terminated and you will not be able to return to this practice for treatment.
- **Frequently Missed Appointments or Inappropriate Behavior**
  Two sessions in a row have been missed without 48 hours notice or appointments are frequently missed with or without contacting me
  Hostile, aggressive, or disruptive behavior by you, your family member or significant other on the premesis or to myself
- There may be additional reasons for termination of care that may be made at the discretion of your provider.

Confidentiality

Information discussed during the course of psychiatric treatment is confidential. By law, information concerning your treatment may be released only with the consent (written or verbal) of the person treated (or the person's guardian if applicable). In the event where there is suspected child or elder abuse or an imminent danger of harm to one's self or others, the law requires the release of confidential information. In these instances we are required to make a report to the appropriate authorities. In addition, the courts may subpoena treatment records in certain circumstances. Any type of release of confidential information will be discussed with you.

I am compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to personal health care information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices. This Notice, which is attached to this agreement, explains HIPAA in detail and its application to your personal health care information. An electronic copy is available by request and also in the check in section of the patient portal.

I may ask you to allow an intern or other licensed professional in training to sit in on your sessions or participate in your care. Any use of your information for teaching purposes will not be transferred outside of our practice, and your PHI will be protected in accordance with our Privacy Practices as described below. You may opt out of this at any time.

Age of Consent

In accordance with RCW 71.34.530: Any minor thirteen years or older may request and receive outpatient mental health treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

For adolescents age 13 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the adolescent's agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the adolescent of my intention to disclose information ahead of time and to discuss any objections that are raised.

Notice of Privacy Practices

This notice involves your privacy rights and describes how information about you may be disclosed, and how you can obtain access to this information.

I. Confidentiality:

My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. **This legal disclosure includes your health insurance company if you are using health insurance for payment.** However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship, or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality:

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization:

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, and some required by law. If you wish to receive mental health services from me, you must sign this form indicating that you understand and accept my policies about confidentiality and its limits. We can discuss these issues at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Washington law to report the matter immediately to the Washington Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Washington law to immediately make a report and provide relevant information to the Washington Department of Welfare or Social Services.

· Health Oversight: Washington law requires that licensed mental health providers report misconduct by a health care provider of their own or related professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Washington Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I may be required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information may not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, there may be no statute granting provider-patient privilege, although records can sometimes be protected on another basis.

· Serious Threat to Health or Safety: If I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment

hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: Washington has a number of laws that limit the confidentiality of the records of minors. For example, parents could, regardless of custody, not be denied access to their child's records; and CSB evaluators in civil commitment cases may have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me:
1) what information you want to limit;
2) whether you want to limit my use, disclosure or both; and
3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.

· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a copy of this notice. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The updated notice will contain the effective date and a updated copy will be provided to you.
Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

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Informed Consent For Telemedicine Services

There are potential benefits and risks of video conferencing that differ from in-person sessions. Confidentiality stil applies for telepsychiatry services, and neither party will record the session without permission from the other peron(s).

You agree to use the video-conferening platform selected for out virtual sessions, and an explanation of how to use will be available on the practice website sarahwoodallarnp.com and/or explained by your provider. You will need to use a webcam or a smartphone during the session and it is important to be in a quiet, private space that is free of distractions during the session.

It is important to use a secure internet connection rather than public/free wifi. If you need to cancel or change your telemedicine appointment, you will need to provide notification 48 hours in advance to avoid a late cancellation fee.

A back-up plan (e.g. phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems is needed.

A safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation is needed..

If you are not an adult, we need permission of your parent or legal guardian (and their contact information) for you to participate in telemedicine sessions.
You should confirm with your insurance company that the telemedicine sessions will be reimbursed if you are seeking out of network reimbursement.

It may be determined that due to certain circumstances, telemedicine may not be appropriate.

Confidentiality:

You have the right to withhold or withdraw consent to the use of telemedicine at any time in the course of your care.

The laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

There are risks and consequences from telemedicine, including but not limited to, the possibility, despite the reasonable efforts on the part of Sarah Woodall, ARNP, that transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face to face services.

Doxy.me, a web-based video communication platform is HIPAA compliant and a secure platform. Howevere, ther e is always a risk of private heatlh information being intercepted by an unauthorized party.

You agree, by engaging in service and signing the Client Consent to Treatment and Receipt of Privacy Practices on the following page to:

- **Communicate via Doxy.me in full knowledge of the potential risk**
- **Have read and understand the information provided above regarding telemedicine, have discussed it with Sarah Woodall, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.**
- **I hereby authorize Sarah Woodall ARNP to use telemedicine in the course of evaluation and treatment.**

Client Consent to Treatment and Receipt of Privacy Practices

I hereby acknowledge that I have read the Client Agreement for Services, Consent for Treatment and Notice of Privacy Practices and understand it. I have asked any questions that I had about this statement and consent to treatment under the terms described above with Sarah Woodall, ARNP (AP60282822). I understand that I have the right to terminate treatment at any time I desire.

I acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sarah Woodall at 425-245-7899. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm.l

By signing below you indicate that you understand the scope of services including Telemedicine services, session structure, fees, cancellation/no--show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

_____

Printed Name of Patient/Client

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative Date

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* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

- Patient/Client Refuses to Acknowledge Receipt

_____

Signature of Provider: Sarah Woodall, ARNP Date

Changes to the Terms of this Notice
I may change the terms of this notice, and the new notice will be available upon request, in the office, and on my web site.

Financial Responsibility

I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including: **copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees.**

If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature of Financially Responsible Party: _____
Date: _____