Cynthia Benedict Goering PT, MA, LMHC
1417 NW 54th Street
Suite 446
Seattle, WA 98107
206.922.4885
www.cynthiagoering.com
WA State Mental Health Counselor License: LH60468965

Disclosure, Practice Policies and Informed Consent

Welcome to my counseling practice. Before we start counseling, it is both my desire and a requirement of both state and federal law that I provide you with the following information. Signing this form establishes our contract for therapy services.

Degrees and Training

I earned my Bachelor of Science degree in Physical Therapy in 1999. For many years I worked as a Physical Therapist in acute care hospitals, rehabilitation facilities, skilled nursing facilities, outpatient clinics and home health with people of all ages. In 2008, I earned my Master of Arts degree in Counseling Psychology. I am a state-licensed Licensed Mental Health Counselor. I continue my post-graduate education through professional trainings, supervision and consultation. I have worked in private practice with adolescents and adults since 2009. My areas of specialty include, but are not limited to: depression, anxiety, grief and loss, abusive and traumatic experiences, intimate and familial relationship struggles, fertility issues including abortion, miscarriage and infertility, women's issues, life transitions and chronic illness.

Counseling Orientation

Our relationship is the primary context for change. My intent is to create a safe space for you to discover and live out your truest self. I view the counseling process as one that is based upon the formation of a dynamic alliance with you, the client(s), to explore the nature of your dissatisfaction or discontent. I believe that the struggles that bring people to therapy are often symptoms of deeper unsettledness. Thus, to address the current symptoms of your distress we often need to look beneath the surface and reflect on your life up to this point, and use that data to enhance your awareness and assist you in deliberately and consciously choosing who you want to be. I believe that relationships are immeasurably influential upon the development of your beliefs, ideas, thoughts, and therefore choices. We may explore the intricacies of these relationships and their influence on your specific struggles in an effort to find and address the sources of these struggles. We will explore how your way of relating contributes to the nature of your relationships, with the hope of cultivating awareness, acceptance, and volition. By seeking and attending to the source of your distress we will address the symptoms as well. We will work together to identify fears and obstacles stemming from the past that keep you from relating most authentically with others. Your ability to be open and honest with me will greatly enhance the effectiveness of your therapy.

Confidentiality

There is a legal privilege in the State of Washington protecting the confidentiality of the information that you share with me. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality. There are legal **exceptions** to client confidentiality. The following situations are those in which the information you have shared with me may be shared with others:

1. If you sign a Consent to Obtain and Release Information form.
2. If you are a minor, I may discuss with your parents or guardians some of the information from counseling.
3. If you are a minor and a victim of a crime, I may testify at an inquiry concerning the crime.
4. If you and your partner are both seeing me for couples counseling, I may, at my discretion, discuss information with your spouse that you have revealed to me. Please inform me of your wishes to keep any information confidential. I will honor these wishes unless there is a threat of harm to oneself or someone else that is perceived to be serious therein.
5. In the event of a medical emergency, information deemed necessary for treatment may be released.
6. In the event of a threat of harm to oneself or someone else that is perceived to be serious, the proper individuals must be contacted. This may include the individual(s) against whom a threat is made and / or law enforcement agencies. A counselor is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act.
7. In the event of suspected abuse of a child, dependent adult or elder, proper authorities must be contacted. The abuse does not have to be personally witnessed by the counselor.
8. If you register a complaint with the Washington State Department of Health, information will be released as requested or required by the State to resolve the issue.
9. If ordered by a judge or other judicial officers, information regarding your treatment must be disclosed.
10. If an attorney in the State of Washington duly subpoenas your records, they will be released unless you file a protection order within 14 days of the subpoena.
11. In the event of a client's death or disability, information will be released as authorized by the client's personal representative or

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beneficiary.

When it is possible, we will discuss any exceptions to confidentiality as they arise.

I use a secure, online bookkeeping software called QuickBooks. I will take all measures possible to protect your Personal Health Information (PHI) and minimize the amount of information stored within this program, however it is not possible to completely delete your personal information as it is linked with financial records. By signing this document, you are consenting to your information being stored in this program.

Choosing a Counselor and Termination
You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner, and you may terminate therapy at any time. It is every client's right to disengage from counseling with or without notice to the treatment provider. However, I request and appreciate notification, and I recommend one final session to discuss termination as well as counseling goals and progress. If we do not meet for a final session, I will terminate the episode of care 60-90 days after our last contact. I will make every effort to inform you of this. If, at any point, you have questions or concerns about our therapeutic relationship or the direction of our work together, I invite you to address them with me.

Consultations
I regularly consult with other health professionals regarding clients with whom I am working. This allows me to serve you better, gaining other perspectives and ideas that may help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

Scheduling Appointments
Appointments are generally made on a weekly basis. Subsequent appointments are scheduled at the beginning of each session as appointment times are not automatically held open for you from week to week. Typically, the session duration is 53-60 minutes. However, I do offer longer sessions of 90 minutes duration when the circumstances warrant longer session times. Additionally, there may be times when it may be appropriate to meet more or less often. We will discuss these variations on a case-by-case basis.

Please note that when we schedule an appointment, I am reserving that time for you. **If you are unable to be present for your scheduled appointment for any reason, please notify me at least 48 hours in advance of the scheduled time. If you fail to do so, payment or payment arrangements for that session will need to be made before or during our next scheduled session. Insurance companies do not cover fees in these cases. I waive fees associated with the missed session or late cancellation if it is due to sudden illness of you or a dependent family member or due to unforeseen emergency.**

Communication
I use a secure, HIPAA-compliant online platform for communication called Spruce. You may send a voice or electronic message for me by calling the phone number above or by accessing the Spruce app 24 hours a day, 7 days per week. I check that app on a regular basis, and I will make every effort to respond to you within 2 business days. Please know that all communication sent and received outside of our sessions become a part of your medical record.

If I need to contact you between sessions, typically for scheduling purposes, I will send a message or call you via Spruce. If I have not received a response from you, I may attempt to contact you via phone, text or email using the contact information and consent that you have provided on the Intake Form. These measures are to protect your privacy and confidentiality and are in accordance with the highest ethical standards of my profession.

Barring prior arrangement, our work will take place face-to-face. There may be circumstances in which it is appropriate to conduct one or more scheduled sessions by phone or video call. Ideally, we will arrange this during the prior session, though arrangements may need to be made by phone or messaging on Spruce. Unscheduled telephone conversations requested by a client may result in a fee

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being charged according to my rate schedule. Generally, phone calls up to 15 minutes are free of charge. Phone calls greater than 15 minutes in duration will be subject to a fee in 15-minute increments. Health insurance benefits may not cover sessions carried out remotely, thus payment arrangements may need to be made.

By signing this form, you are agreeing not to hold me, Cynthia Goering, responsible for any breach of confidentiality that may result from someone else accessing the information contained in any form of communication outside of in-person meetings. This release may be revoked at any time by writing a revocation and is valid until such revocation is received by my office.

Use of Electronic Devices During Sessions
Use of any kind of electronic audio or video recording device is not permitted during therapy sessions. On the rare occasion that I need to record a session or part of a session, I will request your written permission and provide you with the intent and purpose of the recording.

Legal Information
Those practicing counseling for a fee must be registered and licensed with the Washington State 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 would commit acts of unprofessional conduct. If you believe that I have been unethical in our work and still believe so after discussing your concern with me, you may contact the state:

Department of Health - Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.664.9098

Billing and Insurance Information
My fee schedule is provided in the Financial Agreement. Payments are to be made before or at the beginning of each session. Fees may increase periodically, and thus the fees are subject to change with minimum notification of two weeks.

You will be charged a no-show fee for missed or cancelled appointments unless I am notified at least 48 hours in advance. The fees for missed sessions or cancellations within 48 hours of a scheduled appointment are not reimbursable by insurance. Therefore, paying these fees in full are your responsibility. There are exceptions in the cases of sudden illness or emergencies.

If you have insurance coverage that you'd like to use to pay for your therapy, please inform me of this, so that we may make arrangements for payment. If I am a contracted provider with your insurance company, I will submit an electronic claim following our sessions. You will be responsible for your portion of the fees including, but not limited to co-payment, co-insurance, and deductible. These fees will be paid at the time of service. I will send you a receipt for your payment if you request this and if you consent to receiving those documents via email.

It is typical for an insurance company to require certain information to process a claim. This information includes, but is not limited to: dates of services, diagnosis, and procedure codes. Some insurance companies require additional information including, but not limited to: treatment plan or goals, prognosis, progress made and interventions used. Your signature at the end of this document authorizes me to contact your insurance company and to disclose your health information to the extent necessary for the purpose of processing your claims. I have no control over or knowledge of the use of that information by the insurance company or the access of that

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information. With this document, I am informing you that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy, or future eligibility to obtain health or life insurance. I do not have any control over any aspect of their governance or guidelines given that the health insurance contract is between you and the company, and possibly your employer. I encourage you to be an informed consumer of health care, and to be aware of the benefits and limitations of your health insurance policy. Please voice any concerns or questions that you have in this regard with me.

If I am an out-of-network provider with your insurance company, you may be able to receive some reimbursement for my services. I recommend that you contact your insurance company to find out the specific information required for you to receive reimbursement. It is your responsibility to provide this information to me. I will then prepare a document for you to submit to your insurance company. It is very important that you understand exactly what mental health services your insurance policy covers. It is your responsibility to obtain authorizations and referrals when required.

In the event that my services are not covered by your insurance company whether I am considered in-network or out-of-network, all charges incurred will be your responsibility.

Upon request, I will provide documentation including, but not limited to: requests for reimbursement from third party payors, receipts for fees paid. The preparation of these documents will incur a fee equivalent to my hourly therapy rate and is not typically covered by insurance.

Emergencies
I do not provide emergent services. If you are experiencing an urgent or emergent matter that requires immediate attention, please call one of the following numbers for help:

General Emergencies: 911
Crisis Line (King County): 206.461.3222
Crisis Line (Snohomish County): 425.258.4357 or 1.800.223.8145

Thank you for your interest in counseling with me. I look forward to working with you.

****

I have read and understand the information presented in this document. I agree to the conditions of this therapy contract. I understand that I may have a copy of this contract upon request.

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

_____ _____
Parent / Legal Guardian's Signature (if client is under 18 years of age) Date

_____ _____
Therapist's Signature Date

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Notice of Privacy Practices

This document describes how your medical record and health information may be used and disclosed, and how you can access this information.

The law protects the privacy of information we create and obtain in providing health care services to you under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). Your protected health information includes identifying information, diagnoses, treatment, information from other providers, and billing payment information related to these services. Federal and state laws allow me to use and disclose protected health information for payment purposes. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you authorize me to do so, or unless the law authorizes or requires me to do so.

Your Health Information Rights

The health care and billing records I create and store are the property of Cynthia Goering. The protected health information in it belongs to you. You have a right to:

- Receive, read, and ask questions about this document.
- Ask me to restrict certain uses and disclosures. You must deliver these requests in writing to me.
- Request and receive from me a paper copy of my most current Notice of Privacy Practices.
- Request that you be allowed to view and receive a copy of your records.
- Request that I review a denial of access to your records.
- Ask me to change something in your records. This request must be received in writing. If your request is denied, you may write a statement of disagreement. It will be stored in your medical record and included with any release of your records.
- Request a list of disclosures of your records without charge every 12 months. Requests made more frequently will require a fee to process. Please sign, date, and give me your request in writing. The list may not include disclosures for treatment, payment or health care operations.
- Ask that your records be given to you by another means.
- Cancel prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before I have the cancellation. If the purpose of an authorization was to obtain payment, the cancellation will not go into effect until payment has been received.

****

I have been informed of and understand Cynthia Goering's privacy practices.

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

_____ _____
Parent / Legal Guardian's Signature (if client is under 18 years of age) Date

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Financial Agreement

Client's Name:_____ Date of Birth:_____

Self-Pay / Out-of-network / Uninsured: Yes No
If **yes**, I understand that I am fully responsible for all fees incurred. I am responsible for paying full rate at the time of service and for submitting requests for reimbursement from my insurance company.

****

In-network Insurance: Yes No
If **yes**, I understand that I am responsible for any deductibles, coinsurances, co-pays as defined by my insurance policy. I understand that I am responsible for obtaining pre-authorization and referrals for services, and that failure to do so may result in the full fee being charged to me.

Primary Insurance Coverage
Insurance Company:_____ Phone Number:_____
Subscriber Name:_____
Subscriber Address (if different from client's address):_____
_____
Relationship to Client:_____ Subscriber DOB:_____
Insurance ID Number:_____ Plan or Group Number:_____
Subscriber's Employer:_____

Secondary Insurance Coverage
Insurance Company:_____ Phone Number:_____
Subscriber Name:_____
Subscriber Address (if different from client's address):_____
_____
Relationship to Client:_____ Subscriber DOB:_____
Insurance ID Number:_____ Plan or Group Number:_____
Subscriber's Employer:_____

Terms and Conditions

- **Missed Session / Late Cancellation Policy: I understand that I am agreeing to pay for the clinician's time. I understand that I will be charged a fee for missed or canceled appointments since insurance does not cover these fees unless I notify Cynthia Goering at least 48 hours in advance. The associated fees may be charged to my credit card if payment or payment arrangements are not made. I understand that there are exceptions in the cases of my or an immediate family member's sudden illness or emergency.**
- I authorize the release of medical information necessary to process my claim.
- I authorize my insurance carrier to pay Cynthia Goering directly. All in-network insurance payments will be disbursed to BeingWell PLLC, Cynthia Goering, 1417 NW 54th Street, Suite 446, Seattle, WA 98107. I agree to forward any in-network insurance payments I might receive directly to BeingWell PLLC / Cynthia Goering. **Having health insurance does not guarantee benefits. I am responsible for fees that are not covered by insurance.**
- There may be circumstances in which it is appropriate to conduct one or more scheduled sessions by phone or via Skype. Ideally, we will arrange this during an in-person session, though arrangements may need to be made via phone, text or email. Unscheduled telephone conversations requested by a client may result in a fee being charged according to my rate schedule. Generally, phone calls up to 15 minutes are free of charge. Phone calls greater than 15 minutes in duration will be subject to a fee in 15-minute increments. Health insurance may not cover sessions carried out by phone, thus payment

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arrangements may need to be made.

- It is my responsibility to inform my therapist of any changes in my financial status.
- I understand that my portion of the fee is due at the time of service, and I agree to pay all fees for which I am responsible promptly, and that failure to do so may result in termination of services.
- A $25 fee will be charged for returned checks.
- Unpaid fees are subject to collection.

Below are the rates for therapy services:

• Assessment and Re-assessment Session ○ 53-55 minutes	$200
• Session ○ 53-55 minutes	$150
• Extended Session ○ 90-105 minutes	$290
• Crisis Therapy ○ 30-75 minutes	$150
• Extended Crisis Therapy ○ 105 minutes	$270
• Missed Session / Late Cancellation Rate	$150

I offer a 10% discount to those clients who are paying privately at the time of service or within 7 days of the time of service.

****

I have read and I agree to the above conditions.

_____ _____
Client's or Responsible Party's Signature Date

_____ _____
Client's or Responsible Party's Signature Date

****

Administrative Use Only:
Insurance Card Copied: Yes No

*Spruce is the secure, HIPAA-compliant online platform that I use for all client communications and telehealth sessions.

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Emergency Notification

Please list the names and contact information for 2 individuals whom you would like me to notify, in case of emergency:

_____
Name

_____
Address

_____
Preferred phone number

_____
Secondary phone number

_____
Relationship to you

****

_____
Name

_____
Address

_____
Preferred phone number

_____
Secondary phone number

_____
Relationship to you

_____ _____
Client's Signature Date

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Internet and Social Media Policy

This document outlines my policies related to the use of the internet and social media. Please read it in order to understand how I conduct myself on the internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the internet. If you have any questions about anything within this document, I encourage you to ask me when we meet. As new technology develops and the internet changes, there may be times when I need to update this policy. If I do so, I will notify you verbally during a session.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. As of May 2017, my business Facebook page has been deleted after concluding that the potential risks of maintaining such a page outweigh any potential gains. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement regarding a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together during the therapy hour.

Interacting

Please do not use messaging on social networking sites such as Facebook or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging with me online if we have an already established client / therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your medical chart.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (attending appointments, phone, text or email) there might be an instance in which using a search engine (to find you, to find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations, and if I ever resort to such means, I will fully document it and discuss it with you when we meet next.

Business Review Sites

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients / patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. Please be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of

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this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client, and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I am your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Location-Based Services
If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular visits at my office. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

Conclusion
Thank you for taking the time to review my Internet and Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, please bring them to my attention so that we may discuss them.

****

I have read and understand the information presented in this document. I understand that I may have a copy of this document upon request.

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

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Intake Form

Date: _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____ Gender Identity: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Primary Phone: _____ Please circle: mobile home work

Secondary Phone: _____ Please circle: mobile home work

If I am unable to contact you via Spruce*, which modalities would you prefer I use to contact you: (please circle all that apply)

primary phone secondary phone email text postal service

(I use the least information possible in all communications in an effort to protect your Personal Health Information (PHI), however please know that there are risks of communicating using any of these methods.)

Employer / School: _____ Occupation / Studying: _____

Relationship Status: _____ Spouse / Partner's Name: _____

Names and ages of children: _____

****

Briefly tell me about the concerns that have brought you to counseling.

How would you like your life to be different as a result of counseling?

Please list any physical or mental health conditions for which you have received or are currently receiving treatment.

Are you currently under medical care? Yes / No
Name and Phone Number of Primary Care Physician:

Please list all prescribed and over-the-counter medications including naturopathic and homeopathic remedies?

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Please list any psychiatric / mental health medications you are taking or have taken.

Have you previously been under the care of a psychiatrist, psychologist, or counselor? Yes / No
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention:

Please circle any of the following matters that pertain to you:

Anxiety	Depression	Fears / Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation / Divorce	Relationship Stress
Finances	Drug / Alcohol Use	Career Choices	Anger
Impulse Control	Overall Stress	Insomnia	Religious Matters
Work Stress	Health Problems	Cutting / Self-Injury	Thought Patterns

Other:
Have you ever been hospitalized for a psychiatric or mental health reason? Yes / No
When? Where? For what reason? Outcome?

Have you ever been in a drug or alcohol treatment program? Yes / No
Where? How long? Outcome?

Have you ever attempted suicide? Yes / No
Please provide circumstances as able:

Do you currently have suicidal thoughts or intentions? Yes / No

Please rate your overall physical condition (*please circle)*: very good good average poor
Have you experienced recent: weight gain weight loss?
Is there anything else you would like to share with me prior to beginning your treatment?

How did you find me?
****

By signing below, I am confirming that the above information is true and accurate to the best of my knowledge. Additionally, I am agreeing to the methods of communication outlined above.

_____ _____
Client's Signature Date

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