DONALD USLAN, MA, MBA, LMHC, CRC, NCC
10330 Meridian Avenue North, Suite 250
SEATTLE, WA 98133
VOICE 206-368-6123 FAX 206-368-6178

DISCLOSURE AND CONSENT FOR TREATMENT

The following information is for your benefit so you can enter a therapeutic partnership in an informed manner. If you have any questions about this information, or if any questions arise in the course of our work together, please ask.

EDUCATION AND QUALIFICATIONS:

Education:
1972 – Bachelors of Arts, University of California at Los Angeles
1977 – Masters of Arts in Psychotherapy & Counseling from E.W. Cook Institute of Psychotherapy, a division of Antioch University, Faribault, Minnesota
1991-Master's of Business Administration, Healthcare Program Development, City University, Bellevue, WA
2015-Psy. D. (Doctor of Psychology), California Southern University, Irvine, California
Occupational:
1977-1983 – Mental Health Counselor/Program Manager, Seattle Mental Health Institute;
1983-1992 -- Vocational Rehabilitation and Mental Health Counselor, Trac Associates, Seattle (co-owner)
1992-present-private practice-Northwest Counseling Associates
2006-present-Medical and Rehabilitation Counselor, Seattle Arthritis Clinic, University of Washington Medicine/Northwest Hospital and Medical Center
Qualifications:
1985-present – National Certified Counselor (NCC#1550 I), National Board for Counselor Certification
1986-present – Certified Rehab Counselor (CRC #19443), National Board for Rehabilitation Counselor Certification
1996-present Diplomate (#9997), American Board of Forensic Examiners
1997-present; 1999-present – Diplomate (#9997), American Board of Forensic Counselors, Milwaukee, WI
2001-present – Licensed Mental Health Counselor (LMHC #020703 L00004894), State of Washington, Department of Health;
1993-2000 – Rehab Counselor, Chronic Fatigue Clinic, University of Washington/Harborview Medical Center;

THERAPEUTIC ORIENTATION: I am committed to using my education, training and experience to perform my services in a professionally competent manner. It is my intent to always treat you with kindness and respect. If you have any questions about your therapy treatment, I urge you to talk with me about your concerns. Most importantly, you have the right to refuse to participate in any aspect of therapy you find objectionable. My belief is that each client has the resources to cope with or resolve the emotional, occupational and lifestyle challenges with which he or she is presented. My responsibility is to assist the client in becoming aware of and using those resources.

As a "medical psychotherapist and rehabilitation counselor", my approach is to assist you in maximizing your self-management of you illness and your medical team, and to assist you in reducing those stressors which can impact or increase stress and pain. This approach can be characterized as "pragmatic" or "goal-oriented," with short, medium and long-term goals and time frames used for increasing work or lifestyle options. I use my experience in vocational rehabilitation, disability evaluation, patient education, health care systems and care coordination. I encourage clients to maximize the use of sessions by directing them in their own research, investigation, assignments, problem

identification and problem solving.

As a psychotherapist, my approach may be termed "multi-modal" with strong psychodynamic and family systems influences. I am interested in how past events and relationships impact on our current life situation. I place importance on social, family and work relationships, and personal responsibility in changing these. From this approach, I pay close attention to a client's thinking styles, belief systems and patterns of relationships. I try to understand in what way these are associated with prior life events and how these are reflected in the choices, behaviors and life circumstances a client experiences. Counseling is geared toward helping a client more realistically appraise their current life situation and thinking and belief systems. The specific methods I employ and the length of treatment will depend on your particular needs and goals. However, the success of treatment cannot be guaranteed because outcomes depend on many things, including your own actions and commitment to change.

It is my obligation for ethical, billing and practical reasons to avoid confusing roles or relationships with you. This is especially important because of the nature of my training, interests and qualifications. Thus, I will not bill health insurance for vocational rehabilitation services unless it is specifically allowable. If the nature of the mental health services is such that we are attempting to reduce your symptoms ("counseling") or directed toward resolution of longstanding issues ("psychotherapy"), then it may be appropriate to utilize rehabilitation concepts and techniques.

APPOINTMENTS AND FEES

- **Mental Health Counseling:** The first session of mental health counseling or psychotherapy is called an "interview session". At this time, we both assess if we are a constructive "fit", and what your initial treatment or rehabilitation needs may be. Typical individual sessions are 38-52 minutes, sometimes longer. Group therapy sessions are also available. For more details on session fees contact the front desk. I do not charge for brief courtesy calls or letters to the doctor or health care provider who referred you. Please be aware that I need to charge for services outside of counseling sessions that are longer than 5 minutes. This includes reports, letters, forms, correspondences or any other activity.

- **Payment:** Unless we have made other arrangements in advance we will process claims for you so that you may be reimbursed by your insurance carrier with your consent. You will be responsible for the amount the insurance company does not reimburse. **I charge a fee, $100, for missed counseling appointments or cancellations that are not made at least 24 hours, one business day, in advance**.

- **Forensic (Legal) Evaluations, Reports and Consultations:** These services, on referral by an attorney, are provided at an hourly rate of $225 per hour, or a portion of the hour as required. Extensive reports or evaluations, such as a "Rehabilitation Psychology Report" or "Psychological and Vocational Rehabilitation Report" may involve, in addition to interview time, indirect services such as case review, research, report preparation, and thus can be time consuming. If you, your attorney, or health care provider is requesting such a report, please be sure that you understand the changes in advance of services. Reports are not released without payment in full. Depositions and testimony are billed at $275 per hour.

- **Non-Covered Expenses:** Your insurance carrier will not pay for missed or late-cancelled appointments, testing, telephone consultations with you (or your doctor, lawyer, teacher, etc.), or for reviewing reports or records or writing letters. I write brief letters or communicate briefly with your physician as a courtesy. Consultation reports are not covered by insurance and will be privately charged.

ETHICS AND PROFESSIONAL STANDARDS: As a Licensed Mental Health Counselor (#020703) and Certified Rehabilitation Counselor, and a member of other national boards and professional organizations, I am accountable for my work with you. If you have concerns about the quality of my services or any administrative matter (e.g., fees, etc.), please discuss them with me first. I am committed to providing the highest quality professional services, managed in a fair manner. However, should you still feel that I have been unresponsive to your concerns, you may contact the State of Washington, Department of Health, Professional Quality Assurance Division, PO Box 47869, Olympia, WA 98504-7869.

CONFIDENTIALITY AND ACCESS TO RECORDS: I consider all information and issues presented in the course of therapy as confidential. By law, information concerning treatment or evaluation may be released only with the written consent of the person treated or such person's parent or guardian. An exception to this is if it is necessary for me to share information with your referring physician or other health care provider from whom you are receiving services. State law also requires the release of confidential information in these situations: (1) suspected abuse of children or incapacitated adults; (2) potential harm to self or others; or (3) if individuals are gravely disabled and not able to care for themselves. In addition, in certain circumstances, the court may subpoena treatment records or require a deposition or testimony from a therapist. The contemplation or commission of a crime or a harmful act is not confidential communication.

State law also required me to inform you of the following: **I keep a record of the health care services I provide you. "Psychological" records are kept separate from medical records at this clinic. I also separate "Progress Notes" (which can be audited for financial reasons) from "Psychotherapy Notes" to further protect your confidentiality. You may ask to see and copy of records. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get information about it by making your request in writing to me.**

NOTE: The Seattle Arthritis Clinic is a medical practice setting, and thus the session may be interrupted by a physician or other medical staff due to an emergent situation. Although such interruptions are rare, and I attempt to keep them to a minimum, please be aware they do occur, and it is not my intention to appear discourteous or inattentive to your needs during your time.

THIRD PARTY REFERRALS: For clients referred by a physician or other health care provider, it is usual and customary for a counselor to write a letter explaining general aspects of the case and proposed treatment, with letters updating the practitioner periodically.

EMERGENCIES: In the case of a life-threatening emergency, please call the Crisis Clinic at 461-3222, dial "9-1-1," or go to the nearest emergency room.

I have read and understand this "Disclosure and Consent for Treatment." I agree with its terms and have been offered a copy to keep.

_____ _____

Patient's signature Date

_____ _____

Donald Uslan, MA, MBA, LMHC, CRC Date

Revised 9/3/2014

The Seattle Arthritis Clinic

10330 Meridian Avenue North, Suite 250
SEATTLE, WA 98133
VOICE 206-368-6123
FAX 206-368-6178
www.theseattlearthritisclinic.org

FINANCIAL POLICY

Our financial policy is a necessary part of assuring that we can maintain this vital health care service for our patients and the community. Charges for services are due and payable at the time of treatment, unless other arrangements have been made in advance.

If you have health insurance, it should be understood that it is an agreement between you and your insurance company; your therapist's bill is an agreement between you and your therapist. You are responsible for the payment or co-payment of your bill at the time of service regardless of the status of your insurance claim.

To assist you in getting reimbursement as quickly as possible from your insurance company, we will be happy to submit a copy of your bill to your carrier if you provide the bookkeeper with the necessary information, or we will provide you with a copy of your bill at the conclusion of your office visit. In the rare case that clients fail to make payments, it is necessary to send accounts to a collection agency. Please be aware that if such a situation occurs, clients are responsible for attorneys' fees and costs, or collection agency fees.

We appreciate your promptness for appointments. In the event you need to cancel an appointment, we require at least 24 hours' notice. SINCE APPOINTMENTS ARE RESERVED FOR ONLY YOU, IT IS NECESSARY TO CHARGE THE FULL SESSION FEE FOR ANY MISSED APPOINTMENTS WHICH ARE NOT CANCELLED 24 HOURS (BUSINESS DAYS, NOT WEEKENDS) IN ADVANCE.

I have read and understood the above policy.

_____ _____

Patient's Signature Date

Revised 9/3/2014

The Seattle Arthritis Clinic

10330 Meridian Avenue North, Suite 250
SEATTLE, WA 98133
VOICE 206-368-6123
FAX 206-368-6178
www.theseattlearthritisclinic.org

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
PLEASE REVIEW THIS NOTICE CAREFULLY

As part of my professional practice, I maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. Protected health information ("PHI") is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Rights Regarding Your PHI.

The following are your rights regarding PHI 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 copy your PHI that I maintain. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend**. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures that I make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **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 a paper copy of this notice.
- **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.**
-

Revised 9/3/2014

My 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. To coordinate and manage your care, I may disclose your PHI to others of your current providers, and to the extent you have not raised an objection in writing, to your prior providers, or to other persons, including family members, involved in your care.
- **Payment.** I may use your PHI in connection with billing statements I send you and my system for tracking charges and credits to your account. In addition, but with your authorization, 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 and to disclose PHI for medical necessity and Quality assurance reviews.

- **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 may be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, and/or 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.
- **Health Oversight.** I may disclose your PHI to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me (such as third-party payers).
- **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.
- **Appointment Reminders.** I may use your PHI to contact you to remind you of your appointments with me.
- **Business Associates**. I may disclose your PHI to Business Associates that are contracted by me to perform health care operations or payment activities on my behalf which may involve their collection, use or disclosure of your PHI. My contract with them must require them to safeguard the privacy of your PHI.
- **Compulsory Process.** I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will also disclose your PHI if (1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid my compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand, and (4) such time has elapsed.

Uses and Disclosures of PHI With Your Written Authorization

I will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, 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.

This Notice

This Notice of Privacy Practices informs you how I may use and disclose your protected health information ("PHI") and your rights regarding your PHI. I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain

at that time. I will make available a revised Notice of Privacy Practices by providing you a copy upon your request, or providing a copy to you at your next appointment.

Contact Information

I am my own Privacy Officer, so if you have any questions about this Notice of Privacy Practices, please contact me

My contact information is:

10330 Meridian Avenue North, Suite 250
SEATTLE, WA 98133
VOICE 206-368-6123
FAX 206-368-6178

The effective date of this Notice is September 2014

Acknowledgement

I hereby acknowledge receiving a copy of this notice.

_____ _____

Patient's Signature Date

Revised 9/3/2014

The Seattle Arthritis Clinic

NAME _____ DATE_____

PATIENT INFORMATION FORM

CONFIDENTIAL INFORMATION: This form is intended to save time and to help provide the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible. If you require additional space, please continue your answers on the back of the page.

What do you hope to gain from this session?

1.

2.

3.

4.

5.

Health

List the five problems of greatest concern to you.

Revised 9/3/2014

Describe your problems in your own words.

Prior illnesses, accidents, operations:

Allergies:

Current Health:

Current Medications:

Names and addresses of all physicians and health care providers:

Treatments you had with each provider listed above (please include dates):

Have you received any prior psychiatric or other mental health evaluation or treatment? If yes, please describe.

Personal Data

Place and date of birth:

How many times have you moved in the past five years?

Do you drink alcoholic beverages?

If yes, please describe your drinking.

Do you use any other illicit drugs?

If yes, please describe their use.

Present interests, hobbies, and activities:

Educational History

	How many attended?	Completed?	Year Completed
Grade school			
Middle school			
High school			
College			

Military Service History

Branch: Discharge Status:

Dates of service:

Revised 9/3/2014

Outside USA? Where?

Hazardous or combat duty?

Occupational History

What is your current position?

Who is your current employer?

How long have you been in your current position?

Please list the jobs you have held in the past, going back 15 years.

Employer	Job Title or Description	Approximate Dates

Marital History

Marital Status: Single _____ Divorced _____ Widowed_____
Married _____ Separated_____ Remarried_____

If married or remarried, year of marriage:

If divorced, widowed, or separated, for how long?

Spouse's current age (or age at time of death):

Spouse's occupation:

Spouse's health (or cause of death):

Any previous marriages for you?

Any previous marriages for your spouse?

Children

Full Name	Sex	Age	Whereabouts

Legal

Have you ever had any involvement with the legal justice system, either criminal or civil?

If yes, please describe

If you have an attorney, please list the following:

Name:

Address:

City/State/Zip:

Telephone:

Family Data

Mother:

Living or deceased:

If alive, mother's present age:

Mother's health:

Whereabouts:

How often do you have contact with her?

Mother's occupation:

If deceased, your age at the time of her death:

Cause of death:

Father:

Living or deceased:

If alive, father's present age:

Father's health:

Whereabouts:

How often do you have contact with him?

Father's occupation:

If deceased, your age at the time of his death:

Cause of death:

Please place a checkmark in the appropriate box if the following conditions have been present in relatives

	Children	Sisters	Brothers	Mother	Father	Aunts/Uncles
Nervous problems						
Depression						
Drinking problems						
Drug problems						
Psychiatric treatment						

Siblings

Full Name	Sex	Age	Whereabouts

Other

Please list any other information which you think might be of assistance in understanding and helping you.

Revised 9/3/2014