GINA PALUMBO, M.A., LMHC PSYCHOTHERAPY

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DISCLOSURE OF REQUIRED INFORMATION

Welcome to my psychotherapy and counseling practice. I look forward to our work together. The following information is provided in order to clarify my clinical background and legal responsibilities. Successful therapy is the result of mutual effort and an effective working relationship between us. You have the right to choose a therapist who can best address your specific concerns and the responsibility to choose the provider and treatment modality which best suits your needs. You also have the right to refuse or discontinue treatment at any time. After beginning therapy, if you do not believe our work together is meeting your needs then please feel free to discuss your concerns so we can make appropriate changes. If I am not able to address your concerns then we can arrange for a referral to a different clinician who might. I welcome questions and feedback about our work together at any point throughout our process.

LICENSE AND EDUCATION

I am licensed in the state of Washington as a mental health counselor (LMHC). My credential number is LH60183272. I received my Master's degree in Counseling Psychology from St. Martin's University in 2008. I earned a B.A. in Psychology from Sonoma State University in 1993.

THEORETICAL ORIENTATION, PSYCHOTHERAPY, COUNSELING, DURATION OF TREATMENT

Adult development is of primary interest to me and my clinical focus is therapy for adults and couples. I provide a respectful, supportive, and appropriately challenging environment. My training incorporates Family Systems, Cognitive-Behavioral (CBT), Existential, and Solution-Focused techniques. The duration of therapy is based on individual needs of the client. Generally, until we spend time together I am not able to suggest what the duration of treatment will be; this can more accurately be determined once therapy has begun and will be discussed as it becomes apparent. Psychotherapy is based on medical necessity; it is for clients who need mental health treatment for diagnosable conditions such as mood disorders. Counseling is a process of healing and change not based on medical necessity. Counseling encompasses my years of clinical psychotherapy practice experience combined with coaching techniques. Because counseling can't be billed to insurance it is completely confidential.

CLIENT RIGHTS

Information discussed in the therapy setting is held confidential and I will not release any information without your written permission, with the following exceptions as required by law: I may be authorized or required to disclose information you provide to me if I suspect there has been child or elder abuse/neglect or if you are a threat of harm to yourself or others.

Additionally, with regard to insurance, information regarding your dates of services, diagnosis and treatment plans may be released to your insurance company if you choose to file insurance claims. I will, at times, share personal information with insurance companies (or other entities with whom you authorize me to share information) via electronic transmission including fax machines, e-mail, or cellular telephones. Despite my efforts, these transmissions cannot be guaranteed to be secure.

At times I will consult with professional colleagues about general aspects of your case. Your name and identifying characteristics will not be disclosed. Lastly, in case something happens to me, I have agreement with my colleague, Janey Mattson, LMHC, who can access your medical record and assist with a referral to another clinician should I become incapacitated and unable to work. Her contact information is as follows: phone number (253)752-5279 and address is 2412 N 30th St #102, Tacoma, WA 98407.

You also have the right to contact the Washington Department of Health. A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint
Post Office Box 47857
Olympia, WA 98504-7857

Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

PRACTICE POLICIES

COUNSELING FEES: Fee for sixty-minute appointment is $120.00; ninety-minute appointment is $180.00, and $240.00 for 120-minute appointment.

INSURANCE: For psychotherapy, insurance is billed at rate of $200.00 for intake appointment and $140.00 for subsequent sessions. I am currently an in-network provider for Blue Cross/ Blue Shield, Cigna, First Choice, Group Health, and Premera. I am considered an out of network provider for all other companies; it is your responsibility to contact your provider regarding out of network benefit coverage should you wish to submit for reimbursement.

PAYMENT: I accept cash, personal checks, and most credit/debit cards. In order to preserve time for therapy please have payment ready at the beginning of our session.

APPOINTMENTS: Making and keeping appointments is important to the therapeutic process. Please give 48 hours notice if it is necessary for you to cancel or reschedule an appointment in order to avoid being charged for the appointment; *regardless of your reason, the fee for cancellations with less than 48 hour notice or missed appointments is $120.00 and can not be billed to insurance.*

COUPLES THERAPY: Please note: many clients assume couples therapy will be reimbursed by their insurance provider when they have insurance benefits which include mental/behavioral health. Unfortunately this is rarely the case. Most insurance plans require both medical necessity and individual treatment in order for benefits to apply. According to most insurance plans, marital issues typically do not meet either of those criteria. Please consult your individual insurance coverage for more details.

BILLING: Payment is expected at time of our appointment; clients who owe money and fail to make payment arrangements may be referred to a collection agency.

LIMITS OF CONFIDENTIALITY FOR COUPLES AND FAMILIES: When more than one person participates in therapy together then either person, or all persons, may access the entire record of treatment.

ENDING: It is understood an expected goal of treatment is that our relationship will end: should you choose to end therapy prior to achieving goals then I recommend you consider participating in a full or abbreviated closure session. In the absence of an in-person meeting, for documentation purposes, I may call or send an email to confirm treatment has ended.

CONTACT INFORMATION: My priority is to be available to my clients; the best way to contact me is by telephone (253) 209-2661 or email ginapalumboma@gmail.com. I generally return voicemails and emails within 24 hours. *I prefer to utilize email and text messaging for scheduling purposes only. If you would like to communicate with me via email or text then please discuss with me in person first so that we can evaluate the risks and benefits.* Additionally, contact information for the clinician covering for me will be provided should I be out of town or unavailable for any reason.

CRISIS CONTACT INFORMATION: Your safety and well-being are important. If you are experiencing a crisis and need to speak with someone immediately then please call one of the following:

- Pierce County Crisis Line at (800) 576-7746
- SuicidePreventionLifeline.org 1(800) 273-TALK or 1(800) 273-8255
- 911 or go to the nearest emergency room.

RECEIPT OF DISCLOSURE STATEMENT, PRACTICE POLICIES, AND HIPAA NOTIFICATION

I certify that I have read, understand, agree to, and have received copies of Gina Palumbo's Disclosure Statement, Practice Policies, and HIPAA Rights Notification. These documents informed me of her counseling orientation and approach, education and training, professional licensure, and my rights as a client. I am now informed of her policies regarding fees, cancellation and rescheduling, and how to contact her. I consent to participating in psychotherapy and counseling under the terms described above.

Furthermore, I understand that all information and communication regarding my course of therapy is protected, private, and confidential, except as the limits of confidentiality are described in the Client Rights section above. I understand my health records will not be disclosed to anyone outside of Gina Palumbo's office; any exceptions must be jointly agreed upon, and a release of information will be provided.

With regard to privacy and records pertaining to therapy and counseling, my initials represent my understanding that:

___Communication via email or text message may be used to schedule or change appointments only.

___ Records pertaining to couples/family treatment are available to all participants.

With regard to my financial responsibility as outlined above, my initials represent my understanding that:

___All payments are due at the time of service (including cash fees and insurance co-pays).

___If applicable, I am responsible for paying my deductible and any amount not covered by insurance.

___I am responsible to pay appointment fee of $120.00 for missed appointments or cancelations with less than 48 hour notice; this fee cannot be billed to insurance.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Required backup payment if using insurance:

By signing the line below, you authorize your credit card information to be securely stored by Gina Palumbo, M.A., LMHC, until your file is closed. You also authorize Gina Palumbo, M.A., LMHC, to charge your credit card for any outstanding bills. Charges are typically made for items such as no show/late cancellation fees and deductible payments. You will be provided with a statement and notified of charges.

_____ _____

Signature Date

Name as it appears on your credit card.

_____ _____

First Last

Card Number:_____ Expiration:_____Verification Code:_____

CONFIDENTIAL INTAKE

Your Name:

Last_____First_____Middle_____

Address:

_____City _____State_____ ZIP_____

Please list preferred contact phone number(s):

Home: (___)_____Work: (____)_____Cell: (___)_____

Calls will be discreet; please indicate which number you prefer, and if there are any

restrictions on messages left at that number: _____

Emergency contact name/phone number:_____

Your e mail address:_____Ok to contact via email_____

Your Employer: _____How long: _____

Your age: _____ Birth date: _____ Birth place:_____

Education: No. of years:_____ Degree:_____ Field: _____

The following section should be completed only if using insurance:

Name of policy holder and date of birth: _____

Company name and customer service phone number: _____

Policy or I.D. number: _____Group number:_____

Please call your insurance provider to verify the following information prior to first appointment*:

Has annual deductible been met? _____ Copay/coinsurance amount per session: _____

*If annual deductible has not been met then you will be responsible for payment until your benefit is active.

Symptoms present within past two years:

_____

_____

_____

_____

Medications: _____

_____

_____

_____

What is your current reason for seeking psychotherapy or counseling?

Describe the issues that are important to you, regardless of size; include ambitions and desires as well as challenges and difficulties. Please be specific and brief.

How long have these issues been important to you and how have you already tried to explore them?

Which goals, hopes, or dreams are currently influencing you?

What will be different in your life, or how will you know that our work together has been successful?