

Martin Knutson, M.A., LMHC

Emmaus Counseling Center

P: 425.869.2644, ext. 54

License No.: LH00011002

Disclosure Statement

Purpose of This Disclosure: Welcome to my practice. Your client rights are important both legally and ethically. In order to provide the best care possible, I want my clients to have as much pertinent information as possible.

Disclosure of Information, Policies, and Client Agreement: "Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor does it necessarily imply effectiveness of treatment." (WAC 308-109-040)

Counselor Credentialing Act: The purpose of this law is to provide protection for public safety and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

I, Martin Knutson, MA, LMHC, am a Licensed Mental Health Counselor and am registered with the WA State Department of Health. My credential number is: LH00011002.

Client Rights and Confidentiality

1. You have the right to refuse treatment.
2. You have the right to choose the provider and treatment modality that best suits your needs.
3. You have the right to confidentiality to the extent that it is protected by law. This means that what is discussed during sessions will be kept between the client and the professional staff of this agency. Information will not be released without your written consent with the following exceptions:
 - a. A communication that reveals the contemplation or commission of a crime or harmful act
 - b. There is a clear threat to do serious harm to self or others
 - c. Any evidence of abuse or neglect of a child, dependent adult or a developmentally disabled person
4. You have the right to know my education, training and treatment orientation
5. You have the right to know the proposed course of your treatment
6. You have the right to know all financial requirements
7. You have a right to see a copy of the treatment record that I keep of our sessions. You have the right to request me to correct that record. I will not disclose your record to others without your written consent unless the law authorizes or requires me to do so
8. You have the right to lodge a grievance with the State of Washington Department of Licensing if you feel your rights have been violated

Court subpoenas: My testimony may be subpoenaed by a court of law or by the director of the Department of Licensing. Confidentiality is null and void in the event you bring legal charges against me.

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It is standard practice for me to consult with a supervisory consultant about your case. Your name and any identifying information will be kept strictly confidential.

Licensure: As a Licensed Mental Health Counselor, I receive ongoing supervision from Israella Kleiman, LMFT, AAMFT. I participate in peer review and case consultation with other professional therapists to ensure that I am providing the best care possible, in the most ethical way possible. I do not disclose names or details that would allow identification of clients during this process.

Therapist Background Information: I received my Bachelors of Arts (BA) from Western Washington University in Communications and Psychology. I then went on to receive my Masters in Mental Health Counseling from Argosy University, Seattle. I completed a 12-month internship following course work, and then worked for 10 years at Sound Mental Health, a community mental health agency. I have been in private practice for approximately 3 years. I am contracted and practice at two group practices: Counseling Services for Wellbeing and Emmaus Counseling Center. My counseling experience is with adults and couples. Part of my background includes work as a volunteer in the call center at the King County Crisis Line and worked as an emotional support volunteer at Bailey-Boushay House.

Therapy Techniques and Approaches: My approach is focused on the unique needs of each of my clients. I draw from a variety of theories. My primary approach comes from the Humanistic and Person-Centered theories that emerged from the work of Carl Rogers. I create a safe place for my clients in what can be an unsafe world. We'll work as a team to overcome what is getting in your way of being happy and content. I am down to earth, easy to talk to, and I believe humor is a good thing. I work with adults and couples.

Billing Rates and Procedures: My private pay rates for therapy vary by practice location:

Emmaus Counseling Center: Initial intake session is \$150 Individual and couples' sessions are \$130 per hour.

Payment is due at the time of service: There are a limited number of reduced fee session blocks available for those clients who qualify. Qualification for a reduced fee session is based on gross income and number of dependents. I have a firm 24-hour cancellation policy. You will be charged \$80 for cancellations with less than 24 hours' notice or missed appointments.

Fee Collection: *Fees are ordinarily due and payable upon the delivery of services.* Please let me know promptly if you are unable to pay in a timely manner and we can negotiate a payment plan. Although all reasonable or ordinary efforts will be made to aid you in the processing of insurance claims, responsibility for payment of fees incurred rests with the client. Time lost due to sessions beginning later than scheduled may be charged against the client's account. Late cancellation or missed appointment fees cannot be billed to insurance.

Insurance: I do accept insurance and have billing specialists to verify and bill for insurance. Co-pays and co-insurance must be paid when you come in for each session. As a provider, I must emphasize that my relationship is with the client, not the insurance company. While the filing of insurance claims is a courtesy that I extend to our clients, all charges are ultimately the client's responsibility.

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For clients who pay at the time of service and would prefer to submit the bill to their insurance company for reimbursement, I can give you a receipt of payment for services provided and you can send it into your insurance for reimbursement based on your agreement with your insurance company. You will be contacted by my billing specialists by phone and/or mail for unpaid balances that exceed 60 days. Unpaid balances that exceed 90 days are assigned to a collection agency for recovery; some identifying confidential information will be released in this process.

NOTE: Health Insurance Coverage changes and updates are the sole responsibility of the subscriber. My billing professionals will verify coverage with the information provided by you. I offer no guarantees in this regard nor assume any responsibility to guarantee the availability of such coverage.

Telephone Conversations: There is an expectation that phone conversations are not an extension of therapy. Occasional (less than once a week) short conversations (usually less than ten minutes) may be appropriate and necessary. Further consultation via phone or email in excess of this will be subject to my case consultation fee at the rate of \$130/ hour and will be billed privately. I make every attempt to return urgent calls within 1 hour and non- urgent calls within 24 hours.

Emergency Contact: If you are in crisis please contact the **King County Crisis Line at 206-461-3222** (open 24/7) and then follow up with me as soon as possible. If you believe you are in imminent danger to yourself or others call 911 immediately.

Vacations/Leave of absence/Illness: I will give you reasonable notice. If possible, I will provide a referral to a colleague in the event that you should need assistance in my absence. Please follow above protocol for emergency care.

The Privilege of Confidentiality and its Exceptions: According to state and federal laws and/or the ethics of my profession, what a client discloses in therapy is confidential information. However, there are exceptions under which confidentiality is legally waived: Disclosure of abuse or neglect of dependent persons, disclosure of a client being dangerous to themselves or others, and when a therapist is ordered by a court to disclose information about a client.

Since maintaining confidentiality between family members may reduce my ability to work effectively on behalf of all my clients, I request that domestic or intimate partners and/or married persons or divorced parents (when working on issues related to their children), and members of the same nuclear family waive their right to confidentiality among themselves or among each other. This does not mean that I will necessarily disclose to one or more family members what another family member(s) discussed in a counseling session. It does mean that I may do so, if I deem it necessary for the success of the work in progress. The client's(s') waiver(s) of the privilege of confidentiality in this regard is (are) thereby given by the signature(s) below.

The client's(s') waiver of the privilege of confidentiality as regards to any release of information to a designated insurance company and/or to professional collection agencies and/or to other relevant professionals utilized by Martin Knutson, LMHC as consultants on any issue that may arise in conjunction with services provided to the client(s) is (are) also given by the signature(s) below.

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The client also acknowledges and accepts that other than the occasional use of designated questionnaires, the occasional notation, notes taken during therapy, and occasional email correspondence (see below), it is not the usual practice of Martin Knutson, LMHC to provide such notes to third parties.

Risks Associated with the Use of E-mail, Texting or any form of Electronic Communication: I (we) understand and accept that confidentiality, otherwise provided by Martin Knutson, LMHC according to the terms above, may be at risk by his using and/or our using email and/or Skype and/or other internet means of communication and/or telephone for the transmission of information related to our healthcare and treatment. For instance, I (we) realize that unknown or third parties may electronically intercept our personal information. I (we), hereby, accept all such risks and Martin Knutson, LMHC to communicate electronically by using Skype and/or the telephone and/or the email address(es) provided below as well as any email addresses provided by my (our) insurance carrier.

Notice of Privacy Practices: *Your Information. Your Rights. Our Responsibilities.*

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask me to limit the information I share
- Get a list of those with whom I've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

My Uses and Disclosures: I may use and share your information as I:

- Treat you
- Run my business
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

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- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask me how to do this
- I will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee

Ask me to correct your medical record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this
- I may say “no” to your request, but we’ll tell you why in writing within 60 days
- Request confidential communications
- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address
- I will say “yes” to all reasonable requests

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or our operations. I am not required to agree to your request, and I may say “no” if it would affect your care
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or our operations with your health insurer. I will say “yes” unless a law requires me to share that information

Get a list of those with whom I’ve shared information

- You can ask for a list (accounting) of the times I’ve shared your health information for six years prior to the date you ask, who I shared it with, and why
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- I will make sure the person has this authority and can act for you before I take any action

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting me using the information on page 1
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- I will not retaliate against you for filing a complaint

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Your Choices: For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

- In these cases, you have both the right and choice to tell me to:
 - Share information with your family, close friends, or others involved in your care
 - Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases I never share your information unless you give me written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- I may contact you for fundraising efforts, but you can tell me not to contact you again.

Our Uses and Disclosures: How do I typically use or share your health information? I typically use or share your health information in the following ways:

- Treat you
- I can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Bill for your services: Your health information can be released to bill and get payment from health plans or other entities. Example: Release information about you to your health insurance plan so it will pay for your services. How else can I use or share your health information? I am allowed or required to share your information in other ways; usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: I can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

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- I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- Respond to organ and tissue donation requests
- I can share health information about you with organ procurement organizations
- Work with a medical examiner or funeral director
- I can share health information with a coroner, medical examiner, or funeral director when an individual dies
- Address workers' compensation, law enforcement, and other government requests

I can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

I can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- I am required by law to maintain the privacy and security of your protected health information
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- I must follow the duties and privacy practices described in this notice and give you a copy of it
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell us I can, you may change your mind at any time. Let me know in writing if you change your mind. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Referrals to other providers: If I assess that a client requires support that does not fall within my scope of practice, I will consider other options and refer them to another service provider. I take time and careful consideration in doing so and I will endeavor to find the best provider(s) to adequately meet the needs of the client before making the referral.

Conflicts of interest: Ethical standards dictate that therapists' will always avoid entering into a "dual relationship" with a client. Examples include but may not be limited to: Your therapist is seeing someone else in your family, a close friend, or has a close relationship with one of those people. Your therapist has an existing or former relationship with you, your family, or a shared mutual friend. In some instances, I reserve the right to and may not share with you the specific issue that prevents me from working with you.

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Contractual Agreement Between Client(s) and Martin Knutson, MA, LMHC

Addendum: All clients receiving mental health services at Emmaus Counseling Center are welcome to contact the clinic director, Richard Wemhoff, Ph.D., with any concerns about their treatment at the Center.

Notice of Disclosure statement and agreements: *I have carefully read and understand* the above and I understand and agree to *the conditions* specified above regarding the cost of services, the collection of fees, and the waivers of my right to confidentiality.

I also understand that I may rescind the waivers of my right to confidentiality at any time I choose to do so by notifying Martin Knutson, MA, LMHC, in writing.

Notice of Privacy Practices: I acknowledge that I have received the full Privacy Notice. I have also received the Privacy Notice of the King County Mental Health Plan.

Client’s printed name (please print clearly) _____
Age

Client’s signature _____
Date

Client’s printed name (please print clearly) _____
Age

Client’s signature _____
Date

Therapist’s signature _____
Date