Vancouver EMDR Therapy PLLC
and Neurofeedback

Dear new client,

Thank you for your interest in my counseling and Neurofeedback practice. I've included paperwork with this welcome letter that will help us get started in our work together.

Please complete the following forms and bring them to your first appointment. When we meet, I will review the information in these forms and answer any questions that you might have.

- Client Information
- Electronic Appointment Reminder Form
- Credit Card Authorization Form (if paying with a credit card or Health Savings Card)
- Mental/Medical Health History Questionnaire
- Authorization for Treatment Form
- Release of Information is optional (for coordinating services with other medical/mental health providers)
- Sensitivity Questionnaire
- CNS Functioning Assessment Form

Please keep the following forms for your records. These documents will provide you with important information about my practice including my office policies and your rights as a client.

- Office Policies, Client Disclosure Statement and Privacy Practices
- HIPAA Notice of Privacy Practices

I accept cash, check, credit/debit, cards and HSA (Health Savings Account) cards for payment of services. I am an in-network provider with First Choice Health. I am "out of network" for all other insurance companies. Please be aware of your benefit plan and contact your insurance company directly to ask about your coverage. If I am in network with your insurance company (First Choice Health) then your co-payment is due at the time of session. If I am an out of network provider for you then the full session fee is due at the time of session. If you are using out of network benefits then I will provide you with a "Superbill" for you to submit to your insurance company for reimbursement.

Your initial neurofeedback appointment will last 50 minutes. Follow up neurofeedback and counseling appointments will last 50 minutes. Neurofeedback (only) appointments will last 30 minutes. Your appointment time is scheduled especially for you. Therefore, if for any reason you are unable to keep your appointment or need **to reschedule please call me at least 24 hours in advance**. It is my policy to charge for missed appointments without 24 hours notice.

My office address is **800 Franklin Street Suite #200 Vancouver, WA 98660.** When you enter the parking lot please park in the reserved spaces labeled **VWS** on the right side of the lot. I am located in the **Vancouver Wellness Studio Suite #200**. You will see my name listed on the outside of the glass door. Please walk up the stairs and make yourself comfortable in the waiting area. I will meet you in the waiting room at your appointment time.

Please contact me at **360-521-4500** or send me an email if you have any questions. Please be aware that I do not communicate with clients through text messages. I would be glad to answer any questions for you that might arise before your appointment. I look forward to meeting you!

Sincerely,
Lemecia Lindsey, LICSW

Vancouver EMDR Therapy PLLC and Neurofeedback

Client Information

Name	Middle Initial	Sex M / F	Date of Birth / /
Street Address			Marital Status and Length
City	State		Zip
It is O.K. to send billing statements to this address? Y / N and to your email? Y / N			Email:
Home Phone	Cell Phone		Work Phone

It is O.K. to leave messages related to my therapy (appts, msgs) on my	Home Ph Y / N	Cell Ph Y / N	Work Ph Y / N	E-mail Y / N
Employment Status:	Employed Y/ N	Full Time Stud. Y / N	Part Time Stud. Y / N	Other _____

Employer Name & Street Address		
City	State	Zip
When did your current symptoms appear? (e.g. 3/4/2009)		

Spouse or Partner (if participating in couples or family therapy)

Name	Cell Phone	Work Phone	
It is O.K. to leave messages related to client's therapy (appts, msgs) on my	Cell Phone Y / N	Work Phone Y / N	
Employer Name & Street Address			
City	State	Zip	

Immediate Family (please list everyone living in your home except client)

Name	Age	Relationship	Occupation

Who should be contacted (friend/relative) in case of a emergency?

Name	Relation	
Street Address		
City	State	Zip
Home Phone	Cell Phone	Work Phone

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Insurance (if applicable)

Primary Insurance Company:		Claims Address:		
Insurance ID Number:		Insurance Group Number:		
Effective Date:	Clients relationship to insured: ____ self ____ spouse ____ child ____ other			
Insured Name:		Middle Initial	Gender	Birth date:
Insured Address:		City	State	Zip
Insured Phone:		Insured Employer:		
Deductible $	Pays At %	Co Pay $	Visit Limit =	
Pre-Cert Required: Y / N	Pre-Cert By Whom:	Pre-Cert Phone:	Authorization #	
Certification Start Date:	Certification Start Date:	Spoke with in Benefits:	Spoke with in Authorizations:	

How do plan on paying for your therapy?	Cash or Check	Debit/Credit HSA Card	Insurance

Client History

Have you received neurofeedback or counseling previously? Y / N	If yes, name of practioner or counselor:
How long were you in neurofeedback or counseling? Years _____ Months _____	
Was your previous treatment for the current symptoms or problem? Y/N	
What do you want to accomplish in our work together?	
What changes would you like to see in your life as a result of our work together?	
How did you hear about Vancouver EMDR Therapy and Neurofeedback?	
Were you referred to Lemecia Lindsey? Y / N	If Yes, by whom:
Is it okay to thank them for the referral? Y / N	

This form was completed by (sign) _____ Date _____

800 Franklin Street Suite #200 Vancouver, WA 98660 | p 360.521.4500 | f 844. 840.7303 | lemecia@vancouveremdrtherapy.com
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Electronic Appointment Reminders and Email Communication

You can receive a computer generated appointment reminder to your home phone, cell phone, text, or email the day before your scheduled appointment**.** Appointment reminders are complimentary. In the event that a reminder fails to go through you are still responsible for your appointment time. To reschedule an appointment please call me **(360) 521-4500** or email me at lemecia@vancouveremdrtherapy.com. **Please be advised that appointments cancelled with less than 24 hours notice will be charged $150.00.**

Please do not text me. I do not use text messaging to communicate with clients, except for automated appointment reminders.

Where would you like to receive your automated appointment reminders? (check **one** below**)**

☐ Via an automated telephone message to my home phone	☐ Via a text message on my cell phone (normal text message rates will apply)
☐ Via an email message	My cell number: _____
My email address: _____	☐ None of the above. I'll remember my appointments on my own

Email Communication- Would you like to communicate by unsecure email to discuss appointment scheduling or billing/payment information?

Please check one: ☐ **YES** or ☐ **NO**

If yes, my email address is: _____

If yes, please agree to the following: I consent to using email communication to transmit information related to the scheduling of my appointments and information related to billing and payment. I understand that this is not a secure means of transmitting information. I will not use email to discuss Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment. I will not use email to cancel an appointment less than 24 hours in advance or for emergency purposes.

Electronic Appointment Reminders and Email Communication Disclaimer- Appointment and billing information is considered to be "Protected Health Information" under HIPAA. Be informed that electronic methods, in their typical form, are not confidential means of communication. Therefore, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to: 1.) People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages, 2.) Your employer, if you use your work email to communicate with the therapist, 3.) Third parties on the Internet such as server administrators and others who monitor Internet traffic.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature _____ **Date** _____

Appointments cancelled with less than 24 hours notice will be charged $150.00

Newsletter- Are you interested in receiving the Vancouver Wellness Studio Newsletter? This is a monthly newsletter that provides information related to mental/physical health. If so please enter your email address: _____	**Holistic Services-** Would you like to learn more about the holistic services offered at Vancouver Wellness Studio? Services include: counseling, neurofeedback, acupuncture, massage, nutrition, fitness & naturopathic medicine. Yes ____ No ____

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Credit Card Authorization Form

Please complete the form below if you will be paying for your counseling with a credit card or Health Savings Card. Your completed form will be stored in your confidential and secure clinical file.

I, _____, authorize **Vancouver EMDR Therapy and Neurofeedback** to charge my credit card for services as follows:

Please initial below:

_____ Initial Neurofeedback session **$170** for (History, Brain Map, LENS treatment) (50 minutes).

_____ Recurring charges of **$85** for Neurofeedback (20-30 minutes).

_____ Recurring charges of **$170** for Neurofeedback and EMDR therapy or counseling (50 minutes).

_____ Recurring charges of **$150** for EMDR therapy or counseling (50 minutes).

_____ If I cancel an appointment with less than **24 hours notice**, I understand and agree that my card will be charged the **full fee of the visit**, as agreed to in the Client Consent and Disclosure form, I have signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance company, such as deductibles and co-pays.

VISA ☐ MasterCard ☐ Debit Card ☐

Card # _____ Expires:_____

CVV code (on the back of card) _____

Name Printed on Card: _____

Billing Address: _____

City, State, Zip: _____

E-mail address: _____

By signing I understand that this form is valid unless I cancel the authorization in writing. I will not dispute charges for visits that I received or appointments that I missed as outlined in the above policy.

_____ _____ _____

Signature Printed Name Date

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MENTAL/MEDICAL HEALTH HISTORY QUESTIONNAIRE Date __/___/__

All questions contained in this questionnaire are strictly confidential and will become part of your mental health record.
Use back of page if you would like to add any additional information

Name (Last, First, MI):		☐ M ☐ F	DOB:
Household:	# of children if any: Age Range:	Do they live in your home? ☐ Yes ☐ No ☐ Some of the time	
Education:	Highest Grade: ☐ High School ☐ Some College ☐ Bachelor's ☐ Masters ☐ Doctorate ☐ Post Doctorate		

Why are you seeking counseling now?	How long has the problem/ issue occurred?

AXIS-IV - current stressful events – Within the last 6 month period: Check all that apply

Check all that apply	☐ Family Problems ☐ Social Problems ☐ Educational / Occupational ☐ Economic / Housing / Health ☐ Legal ☐ Interpersonal ☐ Life Transitions ☐ Crime Victim ☐ Trauma / Abuse ☐ Substance Abuse / CD
Other Not Listed:	

MEDICAL PROBLEMS

Check any that apply in the past 6 months	☐ Cardiovascular ☐ Seizures ☐ Cancer ☐ Stroke ☐ Diabetes ☐Arthritis ☐Asthma ☐ Mental Illness ☐ Alcoholism / CD ☐ Confusion ☐ Frequent Urination ☐ Menstrual Difficulty- PMS ☐ Body Aches / Chronic Pain ☐ Thyroid Disease ☐ Other:
Serious Illnesses:	
Known Allergies	☐ None ☐ Environmental ☐ Food ☐Medication Specify / Reactions:
Overall Health:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unsure Date of last physical exam:
Primary Care (PCP)	Physician's Name: Phone: ( )

MENTAL HEALTH HISTORY

Check One: ☐ NO I have never seen a Mental Health Provider before ☐ YES I have seen a Mental Health Provider in the past

Previous Mental Health & Chemical Dependency Treatment / Date if known	☐ Detox		☐ Residential RTC	
	☐ Inpatient		☐ Intensive Outpatient (IOP)	
	☐ Partial (PHP)		☐ Outpatient Psychotherapy	

List your prescribed medications / over-the-counter drugs, (vitamins, inhalers) Reason prescribed if known

Prescribing Dr's Name: **Phone:**

Other hospitalizations / Surgeries – Use back of page if more space is needed

Year	Reason	Hospital

Other problems you may have experienced including throughout childhood: Check all that apply

☐ Head Trauma ☐ Seizures ☐ Childhood Malnutrition ☐ Limited Access to Healthcare ☐ Developmental Delays ☐ Learning Disabilities ☐ Trauma Victim
☐ Foster Care ☐ Abuse ☐ Domestic Violence ☐ Child Protective Service s ☐ Juvenile Confinement ☐ School Expulsion ☐ Teen Pregnancy

Other Problems (specify):

FAMILY HISTORY OF MENTAL HEALTH: ☐ Depression ☐ Anxiety Disorders / Panic Disorder ☐ Bi Polar (Manic Depressive)
☐ Obsessive-Compulsive Disorder ☐ Schizophrenia ☐ Psychosis (not otherwise specified)
☐ Substance Abuse / Dependency ☐ ADD/ ADHD ☐ Personality Disorders

Have you ever tried to harm yourself? ☐ No ☐ Yes How many times? _____ Last time, how long ago? _____

Has anyone in your family committed suicide? ☐ No ☐ Yes Whom: _____When:_____

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SUBSTANCE ABUSE / CHEMICAL DEPENDENCE HISTORY:
Please complete for each substance used including past use or substances not currently being used.
Include over-the-counter medications, prescriptions, controlled substances, nicotine / tobacco products and alcohol.

☐ No Substance Abuse History ☐ Past Substance Abuse History, Abstinent_____days ☐ Currently Using

SUBSTANCE	AMOUNT FREQUENCY	AGE BEGAN LAST USED

If you drink alcohol or use drugs please answer:	Have you ever thought you should **Cut Down** on your drinking / drug use?	☐ No	☐ Yes
Average # of drinks per occasion:	Have people **Annoyed** you by criticizing your drinking / drug use	☐ No	☐ Yes
Average number of occasions per month:	Have you ever felt bad or **Guilty** about your drinking / drug use?	☐ No	☐ Yes
Have you ever attended an AA meeting? ☐ **No** ☐ **Yes** Any other 12 step program? ☐ **No** ☐ **Yes**	Have you ever had a drink/ used drugs in the morning (**Eye Opener**) to steady your nerves or to get rid of a hangover?	☐ No	☐ Yes

MENTAL HEALTH CHECKLIST

BEHAVIOR SYMPTOM INVENTORY On a scale of 0-4 (0 = No distress, 1 = a little distress, 2 = moderate distress, 3 = severe distress, 4 = extreme distress) in the past 30 days. Leave blank any symptoms that do not apply. Please place number beside the applicable symptom(s).

__ Headache	__ Low Self-Esteem	__ Poor Concentration
__ Dizziness	__ Feel Tense	__ Can't Make Friends
__ Low Energy	__ Feel Panicky	__ Afraid Of People
__ No Appetite	__ Fears / Phobias	__ Home Conditions Poor
__ Over-Eating	__ Job Problems	__ Unable To Have Fun
__ Stomach Distress	__ Depressed	__ Worried / Anxious
__ Bowel Disturbances	__ Sexual Problems/Sex Addiction	__ Guilty Feelings
__ Always Feel Tired	__ Hallucinations / Delusions	__ Can't Make Decisions
__ Sleep Disturbance	__ Irritability	__ Over-Ambitious
__ Insomnia	__ Unexplained Medical Issues	__ Financial Problems
__ Unable to Relax	__ Angry Outbursts	__ Trauma / Abuse History
__ Eating Disorder	__ Unmotivated	__ Obsessive Thoughts
__ Nightmares/Flashbacks	__ Cutting /Self Harm Behaviors	__ Can't Keep A Job
__ Feel Far Away or Unreal	__ Missing Time	__ Standing Next to Self/Watching Self

Therapist's Notes:

In the last 30 days has there been a period of time (of 2 weeks or more) when you were feeling depressed or down MOST of the day or nearly every day?	☐ YES ☐ NO
Have you felt a lot less interested in things or unable to enjoy the things you used to enjoy? (Was it most of the day nearly every day or at least two weeks?)	☐ YES ☐ NO
For two years or more, have you been bothered by depressed mood most of the day, more days than not?	☐ YES ☐ NO
In the PAST TWO WEEKS, have you experienced any of the following? Please check all that apply:	
Pronounced weight loss or weight gain	☐ YES ☐ NO
Difficulty concentrating/indecisive Sleeping too much or too little	☐ YES ☐ NO
Recurring thoughts of death, dying	☐ YES ☐ NO
Hurting yourself Fidgety/Agitated or restless behavior	☐ YES ☐ NO
Making a plan for suicide	☐ YES ☐ NO
Taking some action toward suicide	☐ YES ☐ NO
Feeling slowed down	☐ YES ☐ NO
Feelings of worthlessness or excessive guilt	☐ YES ☐ NO
Fatigue or loss of energy	☐ YES ☐ NO

Neurofeedback Informed Consent

You are seeking the LENS (the ***Low Energy Neurofeedback System***, a form of biofeedback) treatment for a problem. Although various forms of LENS have been used since 1990, the current LENS configuration has been used since 1998 with enough success to warrant respect from former and current patients, as well as from some of the top scientific institutions in the U.S., although controlled studies are only now being performed. Although no significant negative side effects have been observed so far, the non-significant ones that we have seen will be listed later. Your understanding of them will help us work together to provide successful treatment.

As with any treatment, you must be comfortable that while the overall record of the use of LENS is quite successful, there can be no guarantee of success in your particular instance. You are therefore invited to consent to be treated on the basis of this information. Before you give your consent to be treated, we want you to read the following and ask as many questions as are necessary for you to understand this process.

1. LENS is not psychotherapy, although the results can sometimes evoke both negative and positive feelings. If you are engaged in counseling with myself then, it will probably be necessary for you to maintain your regular appointments. If you are being treated by a different therapist then you will want to stay in close contact with them.

2. LENS is not a medical treatment and is no substitute for effective standard medical treatment. If you need medical treatment, you are encouraged to seek it.

3. If you are taking the following medicines, it will be necessary to stay in close contact with your physician. It has been observed, so far, that the need for these medications often decreases. They remain in your system unused, and people often start experiencing side effects from them because of the decreasing tendency of the body to rely on them. **The types of medication include:**

- medicine for sugar problems (diabetes)
- medicine for thyroid problems
- medicine for migraines and other headaches
- medicine for seizure problems
- medicine for emotional, thinking, or perceptual problems
- medicine for movement problems and spasticity
- medicine for low or high blood pressure

4. Anyone who is medically unstable should ask the therapist to consult your physician before you undertake this process.

5. You will be asked to report any odd or uncomfortable sensations or experiences to the therapist and to your physician.

WHAT IS LENS?

LENS involves measuring and recording electrical signals from the scalp, and using the frequencies of those signals to guide the speed of a feedback signal from a feedback unit near you. The extremely weak electromagnetic pulses come from the EEG cables and will be neither visible nor will you be able to feel them. The recorded EEG signals influence the electromagnetic feedback. The feedback, in turn, changes the quantity and frequency of the recorded brainwave signals. In contrast to other brainwave biofeedback procedures, the LENS does not maintain that faster brain waves are better for some problems, or that slower brain waves are better for other problems. Rather, LENS supports the brainwaves, at rest, becoming quieter, and at work, more

flexible in their functioning. It has been used with more than 500,000 patients with a wide variety of symptoms, and at this time we are closely examining the short and long-term safety of this procedure.

THE LENS PROCEDURE:
The brainwave recording process may require the use of a mild abrasive gel or witch hazel to clean the skin. After that, some electrode gel or cream will be applied to ear clip sensor, and attached to both ears, to improve the quality of the recording. A third sensor will then be pressed to your forehead or other scalp sites, and held there with a wax paste. ***In consenting to LENS treatment, you are consenting to allow me to touch your ears, head and scalp areas in order to clean the skin and place and remove electrodes***.

No needles, shocks, skin penetrating, or other invasive procedures are used. The equipment assesses a client's brainwaves -- extremely faint electrical signals measured at discrete locations on the scalp. After a short assessment of the nature of these brainwaves by a clinician, the equipment itself then generates and disburses extremely faint, battery-generated signals that the brain may respond to in beneficial ways. During the sessions, your eyes will be closed and you will be asked to sit quietly. Your brain can detect the feedback, although you will not see anything. The speed of the feedback will be controlled by the signals picked up at the scalp.

Your only instructions will be to close your eyes and rest. You will not be asked to think of anything in particular, or to learn anything. You will be asked frequently if you are comfortable with the feedback in order to adjust it most effectively. This is a passive process. You will be asked to keep track of discomforts or side effects experienced during your treatment.

You will also be asked about your five most prominent symptoms before treatment, and asked to rank them. In addition, you will be asked, both before treatment and every few sessions, to complete a questionnaire about your symptoms.

DURATION:
You will have as many sessions as you need, each session lasting between one second and several minutes duration. The rest of the time will be spent, as needed, talking about what effects, if any, the feedback has had on you. These sessions will occur on a weekly or biweekly basis.

It is difficult to predict how many LENS sessions will be required. The following estimates are based on my experience. Some patients have needed fewer sessions, and occasionally a few more:

1. If your problem came on suddenly after a life of high functioning and you are comfortable with the longer periods of feedback, you can expect 6 – 20 sessions. This is only an average range. However, treatment may require more or less than the average figures.

2. If you have a lifelong history of multiple problems and are very sensitive to the feedback, you may need over 40 sessions.

3. In a very few circumstances such as stroke, spinal cord injury, very severe head injury, or genetic physiological disturbances, the number of sessions can easily be in the hundreds of sessions to keep achieving increasing function.

RISKS:
LOW ENERGY NEUROFEEDBACK SYSTEM (LENS) AND SEIZURES:
The electromagnetic feedback is invisible – although the feedback signal's influence on the signals measured at the scalp (EEG) is clearly present on the screen of the video monitor. Seizure activity has not been a primary reason to seek treatment with LENS. There have been reported seizures in those who have had prior

seizures. These seizures may have initially been brought about by allergies and/or inhalant hypersensitivities, asthma, orthostatic hypotension, blood sugar changes, fatigue, overwork, and/or changes in medication. LENS has never aggravated seizures.

One of the biggest sources of seizure is the hasty and medically uncontrolled decrease in anticonvulsants by the patient in attempts to decrease their side effects. I do not recommend such decreases, and urge clients to consult their physicians and our therapists about their desires to decrease their medications of any kind. It is important that you realize that entering this treatment alone will not abruptly stop your seizures if you have a history of them. In other words, you will continue to have seizures as you have had them in the past until treatment begins to take effect. Furthermore, they may be more intense for periods of two to three weeks before they decrease in severity and frequency. This can be a cause of concern to those in your life, personal and professional. You are advised to speak with them about this issue and be aware of and comfortable with their potential reactions before you start.

Electromagnetic Field Side Effects:
The long-term effects of using electrical field feedback as we use it is unknown. The intensity of our field is less than a trillionth of a watt and is on for a few seconds during each session. A background signal approximately a thousand times less than the feedback signal is also present as soon as the EEG begins to read the brainwaves. For reference, a cellular telephone generates a signal at least millions of times greater than the power of the LENS feedback signal. **No instances of problems with the emissions from the feedback have ever been recorded.**

Other Potential Concerns:
Brief Reactions:
There are some potential risks of discomfort involved in participating in this treatment. On the rare occasions when the feedback is too intense or the feedback periods are too long, you may feel uncomfortable, irritable, tense and/or anxious. When this happens, please tell the operator and the settings on the equipment can and will be changed to make the feedback less intense and shorter in duration, to the extent that you are once more comfortable.

Longer Lasting Reactions:
You may experience one- or two-week periods of anger, fear, and irritability during the treatment. You may feel as if you have tremendous energy to do things, or feel very tired. These longer-lasting reactions have especially tended to occur with particular feelings that people have been struggling to control for a long time. While these feelings can be intrusive and bothersome, it has been the experience of previous patients that they can still function. At times, however, support from your own therapist or physician may be useful and should be relied upon.

If you have some degree of spastic paralysis after a stroke or other brain injury, it is almost certain that you will experience severe pain in paralyzed parts of your body, typically for a period of a week. This pain occurs as the muscles soften around the spastic fibers, and these fibers no longer have stiff muscle fibers to keep these fibers from spasming. As the muscles continue to soften, the spasms stop, sensation starts to return, and muscle control starts the long process of improving. Those who have problems taking pain medication, perhaps because of adverse side effects, are advised to consider what they need to do to comfort themselves during this painful period. Those who can take medication, are advised to do so and consult your physician. If your LENS clinician has access to a photonic stimulator or laser, this type of pain is usually completely avoided. Ask about these devices. You must report any and all medications you use while you participate in the treatment, and are not to change your medications without informing your therapist and your physician.

When is Something a Side Effect or a Benefit?
While we have had experience since 1990 with the LENS and its antecedents, and are familiar with many of its

benefits and side effects, it is sometimes difficult to know when a feeling, benefit, or other problem is due to LENS, or due to something else happening, such as an on-coming cold, allergy, a stress in your life, or some other kind of physical change in you, completely unrelated to LENS. In addition, your own background can play a very big part in the kinds of feelings you have while receiving LENS.

Here's a guide for thinking out what a feeling, benefit, or problem is due to: If you find yourself wondering or guessing more than three times about why you are feeling something, it is probably due to either LENS or another physical reason. If, on the other hand, you think you know why you are feeling the way you do, trust yourself. You do not have to know whether something may be due to LENS, or whether it may be due to something else. If you notice something and wonder about why you are experiencing it, make note of it for later discussion with us. Please write notes about your feelings and questions, and bring them with you to your sessions.

A Perspective on Side Effects from LENS Treatment:
Although the unexpected is always a possibility, we have always found that any side effects that have occurred in LENS treatment were already familiar ones. In other words, the feelings and medical problems that arose have always been something that the patients have experienced and have had some trouble with in the past. Those whose medical status is unstable are advised to consult with their physician about becoming more medically stable before undertaking this treatment. LENS tends to lower blood pressure, which can complicate some kinds of problems such as orthostatic hypotension. It is also important to know that when the problems have occurred during LENS treatment, many have been a fraction of their former intensity, which means that often they have been more manageable than in the past. And while none of these problems have been overwhelming to patients receiving LENS treatment, your comfort is of great importance to us: so sharing your feelings at any time will help make sure we can best cooperate with your therapist and/or physician.

If there is a medical emergency, call us with the particulars, including the location of the emergency room you will be going to, and when, and go there. If the clinician is informed, he or she may be able to meet you at the emergency room. An example of a problem which may need emergency care would be a severe asthma attack in someone with unstable asthma or blood sugar problems in a diabetic. These problems are usually unrelated to the reasons that a person is seeking LENS treatment, but may none-the-less be affected. It will be useful for the emergency room physician to know about the LENS treatment and decide for him or herself whether the treatment itself may present a problem needing clinician thought.

Between Sessions:
While many people feel energy, ease, clarity, and calmness after a LENS session, these positive feelings may initially wear off between sessions. This "wearing off" of the good feelings may cause clients to become discouraged and doubtful about their ability to finish treatment. The wearing off appears to be the brain's way of struggling to remain in the old, familiar, and dysfunctional state. As people continue with LENS, the period during which the positive feelings occur becomes longer and the "wearing off" periods become shorter until they no longer occur. To date there have been no exceptions to this pattern. Instead, people become clearer about the entire range of feelings they have, instead of staying numb and flat in their emotional responses.

Problem Cycles:
Research with the LENS has shown that especially long-lived anxiety symptoms correspond with certain complex patterns of signals recordable at the scalp. Although we do have some technology to identify and develop treatment plans with these patterns of brain activity, we do not yet have the technology to easily and efficiently identify them. Therefore, relief from some kinds of life-long problems is often uneven, with rises and falls in the level of the problems. The symptoms can feel sharper, at times, than they were before; they then pass, and tend to rise less in subsequent cycles of rising and fallings. It has been our experience that during each cycle, both therapist and person receiving this treatment can become anxious and filled with doubt about the wisdom of this treatment. It is important to know that 97% of those treated have improved, while 3% have

remained the same. No one has reported being worse. There is no guarantee that you will remain free from these problem cycles.

Considerations After Treatment:
It will be time to discontinue the LENS when you stabilize and achieve consistently better functioning. You may, however, become used to the stimulation that LENS provides you, and go into a slump after you discontinue it. The slumps that have occurred have lasted between a few days and a month, and have been less of a problem than those that brought people into LENS treatment. During this period your body will become accustomed to being open to its own internal useful stimulation. Most of those who have received LENS have continued to improve long after LENS has ended.

BENEFITS:
The LENS system has been shown in clinical use to bring about significant improvements in a relatively brief process of therapy in physical and emotional rehabilitation. Significantly shorter rehabilitation is of great importance in time, money, and patient hopes

- You may experience an end to the problems affecting you since your head injury and/or psychological trauma, and to the problems that have interfered with your ability to function in your work and personal life.
- The return of clarity, energy during the day, sleeping at night, a sense of humor, motivation to get things done, ease of getting things done, memory, ability to read and listen with little or no distraction, and the absence of depression, irritability, impatience, and explosiveness have been observed repeatedly.

ALTERNATIVES:
There are other treatment approaches to the LENS. Other forms of brainwave biofeedback, also known as EEG biofeedback, are also being used to treat the effects of head injuries. However, EEG biofeedback, which has also not been subject to controlled studies, appears to take longer, and appears considerably less effective than LENS for problems with mood.

PROBLEMS OR QUESTIONS:
You may ask questions at any time.

VOLUNTARY PARTICIPATION:
You are free to withdraw your consent and discontinue participation in the treatment at any time.

CONFIDENTIALITY:
Your identity will not be disclosed without your separate consent, except as specifically required by law. Examples of legal requirements for breaking confidentiality are:

- under court order
- in the case of unlawful behavior such as suspected child abuse
- in the case you bring legal action against the clinician

With these exceptions, any data released or published will not identify you by name.
If you cannot sign, through physical disability or illiteracy, but are otherwise capable of being informed and giving verbal consent, a third party, not connected with the treatment, or next of kin or guardian may sign for you.

LIMITATIONS OF THIS CONSENT:
This signed form may not be used as consent for any other treatment. Participation in any other treatment requires a separate form. All procedures performed under the protocol will be conducted by individuals legally and responsibly entitled to do so.

Vancouver EMDR Therapy PLLC
and Neurofeedback

PERMISSION FOR TREATMENT

I, a prospective client, give my full permission to **Lemecia Lindsey, LICSW** to use any data collected during the preparation and participation in the LENS sessions, and I give up all implied and actual ownership of any data collected. I understand that when data is used, my confidentiality will be protected, and that my identity will not be revealed unless required by law (as outlined previously).

I acknowledge that I have been given an opportunity to ask questions regarding this new treatment and that these questions have been answered to my satisfaction. ***Initial here:_____***

I acknowledge that I have read and understand the above information, and agree to participate in this treatment. ***Initial here:_____***

My consent to participate in this treatment is given voluntarily and without coercion. ***Initial here:_____***

I understand that I may discontinue treatment at any time, and that I may refuse to consent without penalty. ***Initial here:_____***

Lemecia Lindsey, LICSW has my permission to contact my physician or health care provider to both inform him/her of the circumstances and outcomes of my treatment, and request pertinent medical information about me. ***Initial here:_____***

I hereby give my consent to **Lemecia Lindsey, LICSW**, to record both benefits and unpleasant effects from LENS. ***Initial here:_____***

I have read and understood the contents of this Consent document, and consent to receive this treatment. ***Initial here:_____***

_____ _____
Signature of Patient or Representative Date

Vancouver EMDR Therapy PLLC
and Neurofeedback

Authorization for Treatment

I have been given a copy and have read and agree to the terms stated in the **Office Policies, Client Disclosure Statement**, **Privacy Practices, and HIPAA Notice of Privacy Practices.**

I understand that I may end treatment at any time.

I understand that I (not my insurance company) am financially responsible for fees related to my treatment.

When you sign this document, it will represent an agreement between us and will be retained in your counseling records.

I agree to pay for the following services:

- Neurofeedback and counseling (50 min) **$170.00** per session.
- Neurofeedback only (30 min) **$85.00** per session.
- Counseling only (50 min) **$150.00** per session.
- If using insurance or requesting a Superbill, I authorize Lemecia Lindsey, LICSW to furnish my insurance company any/all information requested or necessary concerning my claim including a mental health diagnosis.
- I understand that I will be charged a **$150.00** for sessions missed or cancelled with less than 24 hours advanced notice.

By signing below I hereby give Lemecia Lindsey, LICSW consent for my treatment.

_____	_____	_____
Client #1 Signature	Client #1 Printed Name	Date
_____	_____	_____
Client #2 Signature	Client #2 Printed Name	Date

Vancouver EMDR Therapy PLLC and Neurofeedback

Release of Information

*Please complete this form only if you would like for me to coordinate your care with another health professional.

I, _____, _____ /_____/_____, do hereby authorize **Lemecia Lindsey, LICSW**
(Client #1 Name) *(Date of Birth)*

I, _____, _____ /_____/_____, do hereby authorize **Lemecia Lindsey, LICSW**
(Client #2 Name) *(Date of Birth)*

☐ to disclose to; ☐ to obtain from; or ☐ to exchange with

☐ written ☐ verbal or ☐ both verbal & written

	Lemecia Lindsey, LICSW (Vancouver EMDR Therapy and Neurofeedback, PLLC)
Name & Affiliation	*Name & Affiliation*
	800 Franklin Street Suite #200
Address	*Address*
	Vancouver, WA 98660
City *Zip*	*City* *Zip*
	360-521-4500 844-840-7303
Phone	*Phone* *Fax*

The type of information to be released is:

☐ Diagnosis
☐ Treatment Plan
☐ Course of Treatment/Summary
☐ Chemical Dependency Info
☐ Evaluations
☐ Psychological/ Medical Tests Results
☐ Medical/Hospital Records
☐ Mental Health Record Summary
☐ Psychotherapy Notes (Client Initials) _____
☐ Other _____

The purpose of such disclosure:

☐ Ongoing Treatment
☐ Evaluation
☐ Consultation
☐ Medical Care
☐ Transfer Care
☐ Legal Issues
☐ Health Benefit Utilization
☐ Coordination of Care
☐ Collaboration of Care with Vancouver Wellness Studio Team
☐ Other _____

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I understand that I have a right to revoke this authorization, in writing, at any time. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations. By my signature below I hereby voluntarily authorize the provider to use or disclose my health information in the manner described above. My consent will remain valid until I request that it be terminated at which time I will do so with a written notice.

Client#1 Signature *Printed Name* *Date*

Client #2 Signature *Printed Name* *Date*

"Sensitivity Questionnaire"

People are so different. Below is a list of statements that other clients have made about themselves. Please pick a number between 0 and 10 to describe how frequently you are bothered by them. "0" means *Not ever,* and "10" means *All the time*. Please give an answer for each of the statements listed below.

	RESILIENCY (To assess consequences of moving too fast):	Frequency (0 – 10)
1.	I have severe problems with the weather.	_____
2.	I have little if any of physical energy/stamina.	_____
3.	I can do little thinking/planning without getting tired.	_____
4.	I have great problems with foods.	_____
5.	I have great problems with medications.	_____
6.	I get upset easily.	_____
7.	Pain prevents me from working.	_____
8.	When life hits me hard, it take me a very long time to get back on my feet.	_____
	REACTIVITY (To assess whether extra support is needed):	
1.	I can and do have strong reactions to weather changes.	_____
2.	I have unpleasant reactions to certain foods.	_____
3.	I have unpleasant reactions to certain medications.	_____
4.	I can have unpleasant reactions to certain smells.	_____
5.	I can have unpleasant reactions to certain sounds and lights.	_____
6.	I can have unpleasant reactions to not eating when I need to.	_____
7.	I can be shocked by my reactions.	_____
8.	My friends/family have a hard time being around me.	_____
	SENSITIVITY (To select treatment duration and offset number):	
1.	I feel when the weather is about to change.	_____
2.	I can easily tell if a medication is going to work or not.	_____
3.	I can sense unhealthy environments and then take care of myself.	_____
4.	I can sense my need for food before I even feel hungry.	_____
5.	I can sense smells and scents that others seem not to notice.	_____
6.	I can feel beforehand when I'm about to come down with a cold or flu.	_____
7.	I have a wide appreciation for tastes in different foods.	_____
8.	I can feel the difference between quietness and stillness.	_____
9.	I can feel the difference between relaxation and comfort.	_____
10.	I select my friends by how I feel when I'm with them rather than by appearances.	_____
11.	I sense mood, energy shifts, and attention changes in people around me.	_____
12.	I need to do things at my own pace.	_____
13.	I am very creative.	_____
14.	I know quickly when something is going to work out – such as a job or relationship.	_____
15.	I have some abilities that some people consider psychic.	_____

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The CNS Functioning Assessment

Below is a list of problems. How frequently are you currently bothered by them? Please pick a number from 0-10. "0" means Not at all, and "10" means All of the time. If one or more of your parents had this issue, place a P in the column titled "**Parents**?" If the problem came on suddenly, put a S in the column titled **Suddenly**?"

Sensory	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Light, in general, or lights, bother you			
Problems with a sense of smell			
Problems with vision			
Problems with hearing			
Problems with a sense of touch			
Emotions	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Problems of sudden, unexplained changes in mood			
Problems of sudden, unexplained fearfulness			
Problems of unexplained spells of depression			
Problems of unexplained spells of elation			
Problems with explosiveness			
Problems with suicidal thoughts or actions			
Clarity	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Feel "foggy" and have problems with clarity			
Problems following conversations "with good hearing"			
Problems with confusion			
Problems following what you are reading			
Realize you have no idea what you have been reading			
Problems with concentration			

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Problems with attention			
Problems with sequencing			
Problems with prioritizing			
Problems with not finishing what you start			
Problems organizing your room, office, paperwork			
You cover up that you do not know what was said or asked of you			
Energy	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Problems with stamina			
Fatigue during the day			
Trouble sleeping at night			
Problems awakening at night			
Problems falling asleep again			
Activation or Anxiety	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Restlessness			
Problems with irritability			
Day dreaming			
Worrying			
Always moving			
Cold hands or feet			
Palpitations			
Memory	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Forget what you just heard			

Forget what you are doing, what you need to do			
Problems with procrastination and lack of incentive			
Problems not learning from experience			
Movement	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Problems with paralysis of one or more limbs			
Problems focusing or converging eyes			
Pain	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Head pain that is steady			
Head pain that is throbbing			
Shoulder and neck pain			
Wrist pain			
Tender areas of muscles			
All over pain			
Joint pain			
Other pain _____(specify)			

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Symptom Information

Most Prominent Problems: How Long:

_____
_____
_____
_____

How were you before these problems occurred (if relevant)?

_____
_____
_____

Previous symptoms throughout your entire life:

_____
_____

Current medications, reasons for taking them, and their effects on you:

_____
_____
_____

Basis for Incomplete Problem Resolution: (Please answer "Yes" or "No" for Past and Present.) Past? Present?

1. Unpredictable things had a big effect on me._____
2. Situations were embarrassing for me._____
3. Friends and/or family had a hard time being around me._____
4. I was troubled by emotions/feelings._____
5. I had problems like migraine/tics/seizures/explosive episodes._____

Please answer these additional questions:

Do you have a history or are you currently experiencing any of the following symptoms?

Seizures, Tics, Migraines, Headaches, Cluster Headaches, Stuttering, Tourette's Syndrome or Explosive Episodes. **Yes or No, if yes which ones:** _____

How will you know you are done?

_____
_____
_____

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Vancouver EMDR Therapy PLLC and Neurofeedback

Office Policies, Client Disclosure Statement & Privacy Practices

Please keep a copy of this policy for your records. A signed Authorization for Treatment Form will be kept in your file.

Introduction. Welcome to my Counseling and Neurofeedback practice. I appreciate you giving me the opportunity to be of help to you and look forward to starting our work together. This document contains important information about my business policies, professional services and privacy practices. Please read it carefully. I will be glad to answer any questions that you might have. You will be asked to sign an *Authorization for Treatment* so that we can begin our work together.

Qualifications. I am a Licensed Clinical Social Worker in Washington (LW00008944). I abide by the National Association of Social Workers Code of Ethics. I received a Bachelors of Social Work in 1999 and a Masters of Social Work in 2001 both from San Jose State University in California. I have over fifteen years of clinical experience. I am a Certified EMDR therapist and an EMDRIA approved EMDR Consultant. I am trained in **LENS (Low Energy Neurofeedback System**), My areas of specialization include: trauma, chronic stress, Post Traumatic Stress Disorder, dissociation, healing from abuse: physical, sexual, emotional, and neglect; depression, anxiety and mood disorders; grief, low self-esteem, stress, relationship concerns (couples' issues, marriage and divorce), recovery from addiction; and healing from dysfunctional family systems. I've worked in a variety of settings including, community mental health agencies, residential and day treatment facilities, and schools.

Approach to Therapy. I combine therapy and Neurofeedback for the most effective results. The decision to seek treatment can be a difficult one. If you will be receiving therapy please know that therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. My goal in working with you is to address the concerns that you have and tailor treatment to your specific personality and needs. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. The length of therapy varies and is determined by each client's specific goals and needs.

My therapeutic approach is trauma informed and holistic. During your Neurofeedback treatment I am available to provide you with therapy or work with another therapists of your choice to coordinate your care. My primary therapeutic modality is EMDR (Eye Movement Desensitization and Reprocessing). The AIP (Adaptive Information Processing) model explains how EMDR works. AIP states that when negative life experiences overwhelm our natural ability to process what has happened to us, then the information (thoughts, feelings, body sensations) of the event is stored dysfunctionaly in our brains and body, creating current life triggers that are both conscious and unconscious. This can cause depression, anxiety, panic, chronic stress and difficulties in relationships. EMDR therapy helps to process and release the dysfunctionaly stored information and allows people to let the past stay in the past and to be able to move forward in their lives with freedom and ease. Besides EMDR Therapy I also draw from Mindfulness practices, Somatic (body-centered) Therapy, Ego State Therapy (for trauma and dissociation), Attachment Theory (how we connect to others) and (EFT) Emotionally Focused Therapy for Couples. Information on these clinical approaches is available on the web at www.goodtherapy.org. Although a successful outcome to therapy cannot be guaranteed, I will use my best abilities to help you overcome the difficulties that led you to seek professional help. If you feel that you are not receiving what you want or need from our sessions, please let me know so we can work better together. You have the right to ask questions about what we are doing, to request changes in our approach, and to take a break or end counseling at any time. If your concerns are beyond my area of expertise, or at your request, I will refer you to another professional for treatment.

Vancouver Wellness Studio. As a professional team member at the Vancouver Wellness Studio I participate in collaborative team meetings. If you are using more than one service at VWS and you have authorized me to collaborate care on your behalf with another provider(s) I will do so at our team meetings. At these team meetings we will discuss your clinical goals, progress and treatment. Also, if you are a shared client, with your permission VWS professionals will have access to your records in a shared record keeping system in order to provide you with the most up to date care. Names and phone numbers of all of my clients are listed in the shared VWS scheduling system. This system allows for VWS colleagues to see my schedule for the day and for clients to be contacted by the receptionist if needed. Please be

aware that VWS is a holistic office and at times you may smell natural fragrances such as essential oils, incense, candles or Moxa (used in Moxibustion for Acupuncture). Please do not wear heavy perfumes or colognes to your appointments.

Course of Neurofeedback Treatment and Therapy. Our first few sessions will involve an evaluation of your needs. I will conduct a history of your symptoms, use Neurofeedback to "Map Your Brain" and identify a treatment plan for you. Then in a collaborative effort you and I can begin setting treatment goals with a treatment plan to follow. I normally provide a combination on Neurofeedback and EMDR therapy together. This can include some sessions only providing you with Neurofeedback, other sessions proving you with Neurofeedback and EMDR therapy/counseling and some sessions only providing EMDR therapy/counseling. Some clients benefit by receiving Neurofeedback two times per week. We will discuss if this will be helpful to you. The duration of Neurofeedback and therapy is different for each individual based on his or her personal history, life experiences, personality style, coping skills brain functioning and symtpoms. Most individuals benefit by evaluating their treatment progress after 10 Neurofeedback sessions.

Appointments. When you schedule an appointment, you are asking me to set aside a time especially for you. Therefore, a 24-hour advance notice is required if you must cancel or reschedule any appointment. **It is my policy to charge you for your missed appointment 85.00-150.00 for a missed session, no show or a late canceled appointment when less than 24 hour notice is given.** Insurance companies will not reimburse for missed sessions. Payment will be expected **on or before you next session**. If you are running late for an appointment, then please call me. If an appointment starts late, it still must end at the usual time. After 15 minutes without notification that you are running late your appointment is considered cancelled and the full fee applies.

Fees and Payment Policies. Fees for my services are as follows:

- **Initial Neurofeedback session** $ 170.00 (50 minutes)
- **Neurofeedback** $85.00 (30 minutes)
- **Neurofeedback and EMDR Therapy/Counseling** $150.00 (50 minutes)
- **Individual and Couples therapy** $ 150.00 per session (50 minutes)
- Please make your payment at the beginning of each counseling session. I accept cash, checks, debit/credit cards and Health Saving Accounts cards.
- If I am an "out of network" provider to you then payment for the full session is due at the time of each service. If you request, I will provide you with the necessary paperwork a **(Superbill**) for you to submit to your insurance company. Your insurance company will send a reimbursement check directly to you for any payment that you are eligible to receive per your insurance plan.
- **First Choice Health clients**- as a "in network" provider with your insurance company sessions are billed at the contracted rate of **$ 155.00** per EMDR therapy/counseling session and your co-pay or co-insurance amount is due at the time of your session.
- Longer therapy sessions, telephone consultation which lasts longer than (10 minutes), reports, attendance at meetings that you have authorized, or other services made on behalf of clients will be charged at a pro-rated rate.
- A $25.00 fee will be charged for any returned or unpaid check.
- Past due accounts for more that 60 days may be sent to collection. If your account is turned over to collection, you may be charged a collection fee in the amount allowed by the law at that time. In addition, you will be charged an additional $5.00 per month until the account is paid. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. If such legal action is necessary, the costs will be included in the claim. If unusual circumstances make it impossible for you to meet these financial arrangements then please talk to me directly. This will avoid misunderstandings and enable you to keep your account in good standing.

Insurance Coverage. If you plan on using your insurance, please check to find out the limits and specifications of your plan because you (not your insurance company) are responsible for full payment of my fees. If using insurance, I will be required to release information regarding your treatment and diagnosis; in other words, I must diagnosis you with a mental illness in order for any insurance company to reimburse for therapy. Sometimes I am required to provide additional clinical information such as treatment plans, or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for reimbursement. The form titled, "HIPPA Privacy Practices" is available for you to review regarding my privacy practices and should help clarify how information is shared with your insurance provider. By signing the *Authorization for Treatment* form you understand that you are giving me permission to contact your insurance company for the purpose of payment of services.

Professional Records. The laws and standards of my profession require that I keep treatment records for 5 years after your last visit. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests, as well as a record search and copying fee. If you participate in couples' therapy, I will not disclose confidential information to a third party about your treatment unless both partners provide their written authorization to release such information. In couples' therapy, both partners must provide their written consent to release marital counseling records or any information regarding treatment learned during a conjoint therapy session. If one party does not provide consent, then the records cannot be released.

Litigation Limitations. Due to the nature of the therapeutic process and that it often involves full disclosure with regards to many matters which may be confidential in nature, it is agreed that should there be legal proceedings (such as but not limited to divorce and custody disputes, injuries lawsuits etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested. If my services are required in a legal matter my hourly rate is $300.00 per hour.

Emergencies. You may reach me by leaving a message on my voicemail at 360-521-4500. **I check my voicemail during my business hours which is Monday, Tuesday and Wednesday 10:00 am to 5:00 pm**. My office is closed on Thursdays and Fridays. I will return your call as soon as I am able (that may mean the next business day). **If your call is urgent or life threatening, call the Clark County Crisis Line at 360-696-9560 or call 911, or go to the nearest hospital emergency room.**

Confidentiality. All information that you disclose in treatment is confidential unless you specifically request a release of information in writing. It is important however that you are aware that the law provides certain exclusions from confidentiality that include, but aren't limited to: 1.) child, elder, dependent adult, or developmentally disabled person suspected abuse. 2.) when a client makes a serious threat of violence towards a reasonably identifiable victim. 3.) when a client is dangerous to himself/herself or the person or property of another 4.) when there is a court order.

To ensure quality service to you I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I will not reveal your name or other identifying information so as to maintain confidentiality.

Electronic Communication. Great care is always taken to maintain your confidentiality although it is very important to be aware that e-mail, phone, and fax communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Please limit your communication to appointment information only and do not use any or all of the above-mentioned communication devices to communicate to me personal information. Please do not use e-mail for emergencies. Please note that the business number for Lemecia Lindsey, LICSW is a cell phone. **I do not communicate with clients via text. I use phone calls and email to schedule appointments.**

No Secrets Policy in Couples Therapy. I utilize a "no-secrets" policy when conducting couples' therapy. This means that if you participate in couple's therapy, there may be times that I meet with each partner individually. I am permitted to use my professional discretion to disclose information obtained in an individual session with one partner if I feel it is in the best interest of the couple. I will give the partner seen individually the opportunity to make the disclosure first.

Encounters Outside of the Office. At times we may run into each other in the community. I will protect your confidentiality by not speaking to you, or acknowledging you in any way. If you wish to talk with me, you are welcome to initiate that contact. If you do wish to talk with me, I will keep our encounter as brief as possible. In addition, ethical guidelines discourage social or business interactions between counselor and client outside of the context of therapy.

Ending Therapy or Treatment. Usually, ending therapy happens naturally and takes place over several weeks in the process of treatment. Should you wish to stop therapy at any time, I ask that you allow yourself to have a final session, regardless of the reason for ending. Closure is an essential element in the process of good therapy, which I highly value. If you request, I will refer you to another provider. I may make a decision to terminate treatment under rare circumstances, such as if I am not able to provide therapy that fits your specialized needs, if you are not benefitting from our work

together, if you don't pay your bill, if you become violent, abusive or litigious, or if the therapy relationship is compromised in any way due to unforeseen circumstances. If I terminate services with you, I will provide an appropriate referral for you

Ethics and Accountability. I am licensed in the state of Washington, and am accountable for my work with you. If you have any questions about your treatment, bring them to my attention immediately. If your concern is not resolved, or if you believe that I have been unethical or unprofessional (RCW 18.130.180) you may contact the Department of Licensing in Olympia at Health Professions Quality Assurance Customer Service Center, P.O Box 47865 Olympia, WA 98504. Telephone: (360) 236-4700 Fax: (360) 236-4818 Email: hqpa.csc@doh.wa.gov.

HIPAA 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.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I 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.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to the Privacy Officer of this private practice, Lemecia Lindsey, LICSW:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **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 unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Privacy Officer Lemecia Lindsey, LICSW at 800 Franklin Street Suite #200 Vancouver, WA 98660 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint. The effective date of this Notice is September 23, 2013