To new clients:

I am excited for the opportunity to join you in your journey. This packet of information will help us get started. It provides information about myself and the therapeutic process. Additionally, I have included forms to complete and bring to the first appointment. These documents will provide an opportunity to tell me about yourself and the reason for seeking therapy. I invite you to thoughtfully read this packet in its entirety, as it includes necessary and helpful information. It culminates with your signature, indicating that you have read and agree to the terms. If you are unable to do so prior to your initial session, I will have copies available in my office. Please give yourself adequate time to read through this packet as it must be completed before we can meet.

With Regard,
Kyle Gerry, MACP, LMHC

This packet includes:

- Informed Consent for Treatment
- Disclosure Statement
- The benefits, risks, and responsibilities associated with the counseling process
- Confidentiality Agreement
- Professional Fees and Payment
- My Communications Policy
- Intake Form
- HIPAA Notice of Privacy Practices
- Authorization to Release Information (If applicable)

Please print your full name and initial each page to confirm that you have read this packet in its entirety. Thank you.

Client Name: _____ Date: _____

VERITAS INITIATIVE, LLC
KYLE GERRY | MACP, LMHC

Informed Consent for Treatment

Informed Consent regards a process whereby the client and counselor have agreed to work collaboratively on behalf of the client's best interest.

Do not sign this form if you happen to have any questions regarding the information provided in this packet.

I have read and understood the information provided in this packet. Specifically, I have read the following: Disclosure Statement, Communication Policy, Professional Fees and Payment, and Confidentiality Agreement. By signing this form, I agree to the terms provided, and consent to treatment in accordance with the policies presented. (A signed copy of this agreement can be provided upon request.)

Client's Printed Name	Date
Client Signature (or Legal Guardian)	Date
Kyle Gerry, LMHC, on behalf of Veritas Counseling	Date

Disclosure Statement

Licensed Mental Health Counselor #LH60813341

My Background:
For the past seven years I have worked as a Licensed Mental Health Counselor in the state of Washington. Prior to that, in 2012, I received a Master of Arts in Counseling Psychology from The Seattle School of Theology and Psychology. This degree included nine months and 300+ hours of supervised internship with Compass Health, where I provided counseling to adults. This agency then provided my pathway into the field of counseling. In 2013 I began working for PATH (Program Aiding in the Transition from Homelessness), where I provided mental health counseling, education, and consulting for individuals and agencies within Snohomish County. While I had an office, I spent most of my time in community shelters, encampments, hospitals, and rehab facilities. Later that year I moved into an Adult Outpatient Program with Compass Health, where I continue working today. I have been blessed with the opportunity to provide 4,000+ hours of counseling to adults and couples. Additionally, I have completed over 500 hours of clinical assessments for incoming clients. In 2018 I took the position of Clinical Supervisor with Compass Health, which enabled me to supervise other counselors in this field. My company, Veritas Initiative, LLC was launched in 2019 with the goal of furthering the pursuit of truth and action through private practice therapy. At this time, I exclusively meet with individuals as my private practice, Veritas Counseling.

My Therapeutic Orientation:
I believe that all individuals long for a life of meaning, found in connection with others. Unfortunately, in a world so divided, people often find themselves isolated and broken in this quest. In response to brokenness caused by betrayal, neglect, and abuse, people pursue familiar efforts to avoid the pain. Individuals may try to avoid or even convince themselves that they don't need relationships, but people are only deceiving themselves and postponing the life they were intended for. Your life is meant to be shared. The non-judgmental and caring approach of relational counseling provides a context for these unhelpful strategies to be experienced, reflected upon and grieved, and for new ways of being to emerge. The process is a collaboration between the two of us that involves interacting with feedback about what is being experienced emotionally in the ongoing therapeutic relationship. The work we do together weaves the past, present, and future.

In my counseling approach, I aim to provide a personal and supportive therapeutic relationship, reinforced by strong and safe boundaries. My hope is to use empathy and curiosity to guide you in the pursuit of fulfillment and success, while also helping you to effectively regulate emotions and increase functioning in all aspects of life. My therapeutic philosophy is most influenced by training and education in Relational, Existential, and Attachment theories. However, I will also incorporate aspects of Cognitive, Brief Solution-Focused, and Dialectical-Behavioral approaches to therapy as needed.

My counseling orientation is grounded in Biblical foundations and Christian faith. This leads me to believe that all persons reflect the image of God, therefore obtaining infinite worth and value. I believe all individuals are full of the potential for self-actualization. With compassion and tenderness, I seek to be direct when calling out the best in individuals. I hope to help you obtain full responsibility for your health and well-being.

Choosing a Counselor:
It's important that you feel empowered to choose the counselor best suited for your needs. Your story is unique and deserving of honor. You get to choose who you decide to share it with. While I look forward to the possibility of working together, I recognize your right to seek a second opinion at your discretion. If there comes a point in our partnership where you feel it is no longer of benefit, you can choose to terminate treatment at any time. However, I would ask you to consider scheduling one final meeting to discuss your process and goals for the future (See *Termination Phase* below).

Benefits and Risks associated with Counseling:
While there can be no guarantees in this process, mental health counseling has been shown to offer many benefits. These include, but are not limited to:

- Improved emotional and mental states
- Clarity in matters of identity formation, purpose, and meaning
- Deepened understanding of the connection between past experiences and present circumstances
- Establishing and maintaining interpersonal relationships and capacity for intimacy
- Reducing feelings of loneliness, detachment, and alienation
- Identifying and pursuing solutions to specific challenges

As the process of counseling often involves sharing challenging and painful life experiences, uncomfortable feelings may arise for you over the course of our work together. These may include, but are not limited to: sadness, anger, fear, guilt, shame, and helplessness. Although these feelings can be a distressing part of treatment know that they are a part of the healing process. Additionally, you may experience disruption within current relationships. This may occur as you pursue positive change in your life, recognizing that those around you can remain resistant. Participating in counseling can be difficult, but foregoing treatment may prolong your discomfort and pain.

Introductory Consultation:
Finding the right therapist can be key in your journey toward change. I offer one complimentary 20-minute consultation with no financial obligation to you. This can be our way of determining if we are the right fit for each other. You will not be charged for this first meeting unless you choose to remain for the full hour, in which case you will be charged the hourly rate (see Professional fees and Payment). If, at the time of this introduction, I determine that your concerns would best be suited for another counselor or community resource, I will make a referral at that time. Prior to this consultation, I will require that this New Client Information Packet be completed.

Course and Length of Treatment:
Treatment varies from one individual to another. As individuals' stories are unique, so should be the plan for healing. I understand that lives are busy, and people seek to resolve matters as quickly as possible. However, changing styles of relating and disruptive patterns of behavior, which develop over time, requires patience and purposeful engagement in the therapeutic process.

Together, you and I will determine the course and length of treatment best suited for your needs. This will include the frequency of our sessions. Appointments are typically scheduled on a weekly or biweekly basis. However, accommodations can be made either for increasing or decreasing the frequency of visits. I do not automatically hold specific time slots for clients, but appointments can be scheduled up to one month in advance. It is your responsibility to reschedule appointments.

Termination Phase:
Ending counseling well is an important part of the therapeutic process. Termination occurs when you have realized maximum benefit or have obtained a desired outcome in accordance with your initial pursuit of counseling. Upon termination, I ask you to consider scheduling 1-3 additional sessions to address the following: issues surrounding termination, summary of treatment progress, developing a plan for self-care, and providing any necessary referrals.

You may terminate treatment at any time without legal or financial obligation beyond payment for services already rendered. I ask that you provide notice of your decision to terminate treatment. If you have not made contact within 30 days to either schedule an appointment or discuss plans for future appointments, I will assume you have terminated treatment. I will have no further obligation to you once treatment has been terminated. Should you contact me at a later date requesting additional services, I reserve the right to refer you elsewhere for mental health treatment. Additionally, I reserve the right to terminate services if I determine that the counseling process is no longer productive, or if I believe you would be better served by another medical or mental health practitioner. If I am unable to reach you, I will mail a 30-Day Notice of Intent to Terminate to the address provided at intake.

State Information:
Professionals practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of public health and safety. Licensing of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is to provide protection for public health and safety and to empower the citizens of the State of Washington by providing a complaint process against counselors who would commit acts of unprofessional conduct. If you believe that I have been unethical in our work and still believe so after discussing your concerns with me, you may contact:

Department of Health—Counselor Programs
P.O. Box 47869
Olympia WA 98504-7869
(360) 664-9098

Confidentiality Agreement

There is a legal privilege in the state of Washington protecting the confidentiality of the information you provide me. As a professional in the field of counseling, I can assure you that I adhere to the highest ethical standards of practice and confidentiality. I keep record of the mental health services provided to you; this includes: date and time of appointment, as well as a brief clinical summary of content discussed. You may request to review your records at any time. A printed copy of your records may be provided to you at the cost of $ .10 per page. Should you request that treatment records not be kept, at a minimum, state regulation requires a written request to that effect, a signed Disclosure Statement, name and date of service, and a record of fees for service.

I will not disclose your records to any individual or corporation unless you have provided me written permission (*Authorization to Release Information*). However, there are a few legal exceptions. In the event of the following circumstances, the information you have provided may be shared with others:

1. The Uniform Health Care Information Act may provide for disclosure of information to another health care provider who is serving you.
2. You may provide written consent for me to share your confidential information with a third party. However, before I can do so, you must sign an *Authorization to Release Information* form.
3. If you have provided information that leads me to suspect you will either harm yourself or another individual, I am required by law to report this.
4. Known or suspected abuse of a child, dependent adult, or elderly, including neglect for one's basic need for health, food, clothing, or shelter.
5. In the case that your information is subpoenaed, or court ordered.
6. If you and your spouse are both seeing me for marriage counseling I may, at my discretion, discuss information with your spouse that you have revealed to me, unless you specifically indicate that information is confidential.

I provide couple and marital counseling, which may include individual sessions with parties involved. Information disclosed during these one-on-one sessions is considered confidential from the other individuals involved, except in circumstances noted above, or in situations where your actions directly affect the health of the other. I will encourage disclosure of significant information between parties, within the therapeutic setting, except in cases where that disclosure may put someone at risk of harm.

Professional Fees and Payment

My standard counseling session is 50 minutes, but it will be listed as 1 hour for invoicing purposes. If you wish to meet for a shorter or longer duration, that can be arranged. Please discuss in advance how payment for these sessions will be structured. Fees may be adjusted annually, on January 1, but they are never to increase more than 3% (cost of living increase).

Fees are as follows:
Individual session: $120 per session
Couples/Marriage Counseling: $120 per session
Supervision and Consultation: $120 per session

Bundled sessions are also available, at the rate of $110 per session. These bundles include either 5 or 10 sessions. Bundles are to be paid for in full, up front. No refunds will be provided.

The following forms of payment will be accepted: cash, check, and debit/credit card. For card payment I use Ivy Pay, a HIPAA compliant payment processor. Payments are to be made at the time of each session. Checks can be made out to "Veritas Initiative, LLC" or "Veritas Counseling." Returned checks will be charged $25.

Cancellation Policy: You are expected to provide 48-hour notice for cancellation. You will be responsible for full payment upon late cancellations. Please note that upon late arrival, appointments will still end at their scheduled time and full payment will be required. Please notify me by phone. Please do not text or email cancellations.

Additional Professional Services Fee: For any additional professional services rendered at your request, your hourly rate will be charged on a prorated basis. This includes: Phone calls over 5 minutes, consultations with other professionals (at your request), and special documentation requested (e.g. formal letters, court-related documentation). For brief phone calls related to scheduling or canceling appointments, there will be no additional charge. My rate for court appearance is $200/hour, including travel and wait time. Whether by your request or by subpoena on behalf of a third party, the full rate will apply.

Communications Policy

When contacting Kyle Gerry on behalf of Veritas Counseling, for any reason, please use the contact information below. Please directly address any concerns you may have regarding the following policies.

My Website | www.pursueveritas.com | All contact information and documentation can be found on my website.

By Phone |425-243-6153| This is a confidential line and you may leave a voicemail as I am the only one with access. It is the quickest and most reliable means of contacting me, whether for scheduling or any other reason. Please limit calls to scheduling and emergencies, unless prior arrangements have been made. Unscheduled phone conversations will be billed on a prorated basis, as stated in the *Professional Fees and Payment Form* provided in this packet.

By E-Mail |vcinitiative@gmail.com| This is not the preferred method of communication. E-mails will not be considered for urgent matters. This e-mail is provided for new client communication and client scheduling requests only unless otherwise stated. This e-mail is NOT HIPAA compliant and therefore should not be used for counseling purposes. Please note that all e-mail correspondence will be printed and added to your file.

Social Media Policy: Please refrain from contacting me using social media systems such as Facebook, Twitter, Instagram, LinkedIn, or any other social media platform. These forms of communication are not considered to be secure. If a friend request is sent, please know that it will not be accepted for your confidentiality and that of this practice.

Response Time: Voicemail is checked daily and clients can expect a response within 24-hours, Monday—Friday. If you attempt contact over the weekend, you can expect to hear from me by the end of the following Monday. In the event of an emergency, please refer to the *Emergency Contact Form* provided in this packet.

If I am out of town or on vacation, I will be sure to let you know in advance. Please note that I will not be available during these times. For any emergencies, please refer to the *Emergency Contact Form* provided in this packet.

Locations

Lake Tye Location
14090 Fryelands Blvd. SE, Suite #234
Monroe, WA 98272

Blakeley Location
203 North Blakeley Street, Suite #101
Monroe, WA 98272

Please send all mail correspondence to the Lake Tye location.

Emergency Services

In the event of an emergency or mental health crisis, you can contact:

- ✓ General Emergencies: Dial 911
- ✓ Crisis Line for Snohomish County: (800) 584-3578
- ✓ Crisis Line for King County: (866) 427-4747
- ✓ National Crisis Text Line: Text CONNECT to 741741
- ✓ Teen Link: (866) 833-6546, Available evenings 6-10 PM
- ✓ Washington Recovery Help Line (Substance Abuse): (866) 789-1511
- ✓ Domestic Violence: (800) 562-6025

You can also contact North Sound (operated by VOA), for referrals and information regarding crises, housing, shelter, or other services. To reach them, you can call:

- From Washington based phone numbers: Dial 211
- From all other phone numbers: 1-877-211-9274

If you need to contact me regarding an emergency, please call me at 425-243-6153. If I cannot be reached, please leave a voicemail and contact one of the emergency numbers provided. Be informed that I may not be available to answer your call or respond to voicemail right away, as I may be in session or out of cellular range.

Please note that SMS (phone text messages) are not designed for emergency contact. SMS text messages can be delayed and/or lost. So, please refrain from using SMS as your method of communicating your emergencies.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I, _____, acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for Kyle Gerry, MACP, LMHC and Veritas Counseling.

Client signature (or Legal Guardian): _____ Date: _____

Client signature (or Legal Guardian): _____ Date: _____

VERITAS INITIATIVE, LLC
KYLE GERRY | MACP, LMHC

Client Information Form

Date: _____/_____/_____ Birthdate: _____/_____/_____

_____ _____ _____
Last Name First Name Other Names Used

_____ _____ _____ _____
Home Address City State Zip Code

_____ _____ _____ _____
Mailing Address (If different) City State Zip Code

Primary Phone # _____ Messages OK: Yes _____ No _____

Secondary Phone # _____ Messages OK: Yes _____ No _____

Email Address (optional): _____

Gender: Male _____ Female _____ Transgender _____ Other _____

Marital Status: Single ____ Married ____ Couple ____ Separated ____ Divorced ____ Widowed _____

Sexual Orientation (Optional):

Heterosexual _____ Gay/Lesbian _____ Bisexual _____ Questioning _____ Other _____

Preferred Language: _____ Interpreter Needed: Yes _____ No _____

Are you currently pregnant (Optional): Yes _____ No ____ Religious Affiliations (optional): _____

Parent/Legal Guardian (If applicable):

(Last Name) _____ (First) _____ (Phone) _____

How did you hear about Veritas Counseling? _____

Introduction

The following information is not required. However, it can help me to more accurately identify your struggles and enable me to better guide your path towards healing. All information provided is confidential. You are free to skip over any question(s) found in this assessment.

Please check any past or present concerns that still affect you today.

- ☐ Depression
- ☐ Suicidal thoughts/impulses
- ☐ Self-harm behavior (cutting, burning, etc)
- ☐ Separation/divorce
- ☐ Anger
- ☐ Conduct issues
- ☐ Substance abuse
- ☐ Addictions
- ☐ Self-control
- ☐ Eating disorder
- ☐ Grief/loss
- ☐ Adult trauma/abuse
- ☐ Pornography
- ☐ Anxiety
- ☐ Fears/Phobias
- ☐ Nightmares
- ☐ Psychosis
- ☐ Insomnia
- ☐ Pregnancy Issues
- ☐ Employment/Career choices
- ☐ Religious concerns
- ☐ Finances
- ☐ Academic issues
- ☐ Health problems
- ☐ Childhood trauma/abuse
- ☐ Relationship concerns

Other concerns not listed above:

Current Functioning

Please describe what brings you into counseling. Include information relating to present issues or concerns, including their duration and severity. You may also include any past issues or traumas relevant to present concerns.

Who provides you with emotional and relational support? Include their relationship to you.

What do you do to relax when you become distressed? Include coping skills, hobbies, and any other information relevant to self-care.

Have you ever engaged in counseling/psychiatric treatment? If so, where? Please describe duration and reason for treatment. Did you find it helpful?

Present Symptoms

Please identify any of the following symptoms you are currently experiencing or have experienced within the last month, more days than not.

_____ Sadness
_____ Flattened mood/affect
_____ Tearfulness
_____ Anger
_____ Irritability
_____ Hopelessness
_____ Feeling helpless
_____ Suicidal thoughts/impulses
_____ Low self-worth
_____ Fatigue/low energy
_____ Difficulties concentrating
_____ Loss of interest in activities previously enjoyed
_____ Isolation/Social withdrawal

_____ Nightmares
_____ Flashbacks
_____ Easily startled
_____ Hypervigilant (always aware of your surroundings, exits, etc.)
_____ Feelings of guilt
_____ Intrusive thoughts
_____ Restlessness
_____ Feeling on edge
_____ Self-doubt
_____ Mental Confusion
_____ Fear of dying
_____ Seizures

_____ Anxiety
_____ Specific phobias/fears
_____ Panic attack
_____ Dizziness/light-headed
_____ Numbness/tingling
_____ Nausea/vomiting
_____ Chest pain
_____ Tightness in chest
_____ Difficulties breathing/shortness of breath
_____ Accelerated heart rate
_____ Choking sensation
_____ Hot/cold flashes

_____ Decreased need for sleep (less than 4 hours per night)
_____ Pressured speech
_____ Hallucinations
_____ Delusional thinking
_____ Paranoia
_____ Sexual preoccupation
_____ Rush of adrenalin
_____ Increased talkativeness
_____ Increased goal activities
_____ Feeling invincible
_____ Increased addictive behavior

_____ Loss of appetite
_____ Significant weight loss
_____ Increased appetite/overeating
_____ Significant weight gain

_____ Muscle tension
_____ Insomnia
_____ Hypersomnia (oversleeping)
_____ Difficulties staying asleep

Past or Present Symptoms

(Optional) Have you ever been a victim of trauma? This includes: Sexual, physical, and emotional abuse, as well as physical or emotional neglect. Please identify below, including any information you are comfortable sharing. Remember, this is confidential.

Abuse

Sexual: _____

Physical: _____

Emotional: _____

Neglect

Physical: _____

Emotional: _____

Are you experiencing, or have you ever experienced suicidal thoughts or impulses? Please identify past or present.

Have you ever acted on suicidal thoughts? Please include number of attempts, age, and means.

Have you ever had thoughts of self-harm (e.g. cutting, burning, etc.)? Do these thoughts exist now? Please detail below.

Are you now or have you ever acted on these thoughts?

Have you ever experienced homicidal thoughts, impulses, actions? Are you experiencing these now? Please detail below.

Psychosocial / Demographic

Please briefly describe your housing arrangement. Who do you live with? Is it considered to be safe, stable, and supportive?

Are you currently employed? Please include employer, duration of employment, job title and duties.

Are you disabled? If so, do you hope to return to work?

Do you have significant work history? Please describe.

Describe your educational experience, including last grade level completed, degrees/licenses, and any concerns related to education.

Substance Abuse History

Do you suffer from substance abuse, past or present? Please identify substances of abuse, duration of abuse, duration of current sobriety (if applicable).

Have you ever received inpatient or outpatient chemical dependency treatment? Include locations and estimated dates.

Does anyone in your family suffer from substance abuse, past or present? Please describe.

Please list any other present addiction issues, including: internet, pornography, gambling, etc.

Legal History

Have you ever had a DUI? Please explain:

Do you have any significant criminal history?

Do you have any current legal matters or concerns?

Are you on parole or probation?

Are you currently court ordered to treatment?

Medical/Psychiatric Health History

Do you have any medical issues either receiving or in need of receiving care? Please describe.

Are you currently taking medications prescribed for medical needs? Please list:

Are you currently taking medications prescribed for mental health needs? Please list:

Do you have a Primary Care Physician?

Name: _____ Phone Number: _____

Facility Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Kyle Gerry, in affiliation with Veritas Counseling, will have no communication with identified medical care professionals, outside the context of an emergency or duty to warn.

Emergency Contacts

PRIMARY CONTACT

Name: _____

Relationship to client: _____

Primary phone #: _____

Secondary phone #: _____

Do I have permission to leave a message? ☐ Yes ☐ No

SECONDARY CONTACT

Name: _____

Relationship to client: _____

Primary Phone #: _____

Secondary Phone #: _____

Do I have permission to leave a message? ☐ Yes ☐ No

Client Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

Effective October 10, 2019

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.

Introduction

The terms of this Notice of Privacy Practices apply to Veritas Initiative, LLC, its affiliates and employees. As an affiliate with Veritas Initiative, LLC, I will not disclose your records to any individual or corporation unless you have provided written permission *(Authorization to Release Information),* or if the law authorizes or requires me to do so.

The Health Insurance Portability and Accountability Act, also known as HIPAA, requires that I inform you about how I may use the information you provide me with, in order to offer you the highest standard of health care possible. This federal law requires me to provide you with the attached Notice of Privacy Practices and to obtain your signature as an acknowledgement that you have received it. This Notice describes how Veritas Initiative, LLC may use and disclose your protected health information to carry out treatment, payment, health care operations, and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information.

It is my legal duty to safeguard your Protected Health Information (PHI)

Veritas Initiative, LLC is required by law to maintain the privacy of your Protected Health Information (PHI). PHI constitutes information provided by you and documented by me that can be used to identify you. It includes all demographic/psychosocial information; your past, present, and future physical and mental health condition(s); the provision of health care services to you; and the payment for such health care. I am required, by law, to abide by the terms of this Notice for as long as it remains in effect. I reserve the right to change the terms of this Notice and my privacy practices, as permitted by law, effective for all PHI previously maintained by Veritas Initiative, LLC. You will be informed of any changes made to this Notice. Additionally, a copy of the updated Notice will be made available to you.

I am required to notify you in the event of a breach of your unsecured PHI. I am also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (HIPAA).

Uses and Disclosure of your Protected Health Information (PHI)

Authorization and Consent: Except as outlined below, Veritas Initiative, LLC, and its affiliates, will not disclose your PHI for any purpose other than treatment, payment, or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke this consent at any time by signing and dating a formal request, which will take effect once Veritas Initiative, LLC has received the formal writing. The revocation will not pertain to any actions already taken in reliance upon it. The authorization prohibits further use of disclosure of the information being released, beyond the specific limits of the signed consent.

Please note, uses and disclosures related to treatment, payment, or health care operations do not require your prior written consent.

Veritas Initiative, LLC may use and disclose your PHI without your consent for the following reasons:

1. **Uses and Disclosures for Treatment:** Veritas Initiative, LLC and its affiliates may use your PHI as necessary for your mental health treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other license health care professionals who provide you with health care services or are otherwise involved in your care. Example: If you receive medication from a psychiatrist, I may disclose your PHI to that professional in order to coordinate your care.
2. **Uses and Disclosures for Payment:** Veritas Initiative, LLC and its affiliates may use and disclose your PHI as necessary to obtain payment for services rendered to you. During the normal course of business operations, I may forward your PHI to your insurance company to arrange payment for the services provided to you. I may also use your information to prepare a bill to send to you or to the person responsible for your payment.
3. **Uses and Disclosures for Health Care Operations:** Veritas Initiative, LLC will make use and disclosures of your PHI as necessary, and as permitted by law, to facilitate the efficient and correct operation of this practice. This may include: clinical improvement, professional peer review, business management, accreditation, and licensing. Example: Your PHI may be used to help evaluate the quality of services provided to you by Veritas Initiative, LLC and its affiliates. I may also provide your PHI to an attorney, accountants, consultants, and others, ensuring our compliance with applicable laws.
4. **Disclosures to Individuals Involved in Your Care:** I may use or disclose your PHI as necessary to designated family, friends, or other individuals you have indicated to be involved in your care, or responsible for the payment of your services provided by Veritas Initiative, LLC, unless you object in whole or in part. Additionally, use and disclosure may be permitted if you are unavailable, incapacitated, or facing an emergency medical situation and I determine that a limited disclosure of your PHI is in the best interest of your wellbeing, unless previously objected to in whole or in part.
5. **Uses and Disclosures for Treatment:** I will use and disclose your PHI as necessary for your treatment and the coordination of your care with a third party. Example: I may disclose your PHI, as necessary, to an assisted living facility in charge of your care. Example: Your PHI may be provided to a psychiatrist or physician to whom you have been referred, to ensure he/she has the necessary information to diagnose and/or treat you.
6. **Other Disclosures:** I may use or disclose your PHI if you are in need of emergency medical treatment and you are unable to communicate with me. Example: I may contact necessary emergency services if you are unconscious, having a stroke, seizure, or heart attack.

<u>Other Uses and Disclosures That Do Not Require Your Consent</u>

Veritas Initiative, LLC is permitted and/or required by law to make certain other uses and disclosures of your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judiciary proceedings, licensing agencies; or by law enforcement agencies.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued by a governmental law enforcement agency.
4. If disclosure is compelled by the client or client's representative pursuant to Washington health and safety codes or to corresponding federal statutes or regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. Veritas Counseling and its affiliates may provide PHI to law enforcement agencies able to prevent or mitigate serious threat to the health or safety of an individual (e.g. adverse reaction to medications).
6. If disclosure is compelled or permitted in the event that your mental or emotional condition constitutes danger to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If I suspect that you are a victim of abuse, neglect, or domestic violence.
8. If disclosure is mandated by Washington child abuse and neglect reporting laws. Example: If I have reasonable suspicion of child abuse or neglect.
9. If disclosure is mandated by Washington elder/dependent adult abuse reporting laws.
10. For coroners and/or funeral directors consistent with the law.
11. If you are a member of the military or military veteran, I may disclose your PHI for reasons of national security or intelligence activities.
12. Your PHI may be used or disclosed in cooperation with Workers' Compensation laws.
13. Veritas Counseling may use PHI to provide appointment reminders, inform on alternative treatment options, or other health care services or benefits to you.
14. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum. Example: A subpoena for mental health records.
15. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: If compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
16. If disclosure is otherwise specifically required by law.

Your Rights Regarding Your Protected Health Information (PHI)

1. **Access to your PHI:** You have the right to access or request a copy of your PHI that we retain on your behalf. For PHI we obtain or maintain in any electronic designated record set, you may request a copy of such PHI in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You can make this request by completing a "Client Access to Health Information" form, which can be provided to you upon inquiry. If you request a copy, you will be charged at the rate of $25/hour for processing time. For hard copies, there will be an additional fee of $0.10/page. You will be charged postage if you choose to have these documents mailed to you. I may provide a summary or explanation of your PHI and services rendered by Veritas Initiative, LLC, upon advanced request, at the rate of $25/hour.
2. **Amendments to your PHI:** You have the right to request that amendments be made to your PHI should you find error or omission of important information. It is your right to request that I correct the existing PHI or add the missing PHI. This request and the reason thereof must be made in writing, signed by you or by your legal representative. I am not obligated to make amendments, but all requests will be carefully considered. My denial will be issued in writing, along with the reasons for denial. I may provide a written objection to this denial. If and when amendments are made to your PHI, I will notify you of these changes and I will advise all others who need to know of said changes.
3. **Choosing how you receive your PHI:** It is your right to request how your PHI is sent to you. You can request that your PHI be mailed to an alternate address to the one we have on file (e.g. work address) or by an alternate method (e.g. fax or email). I am obliged to agree to your request providing I have the means.
4. **Copy of this Notice:** You have the right to request a copy of this Notice by email or by hard copy.
5. **Accounting for disclosures of your PHI:** You have the right to receive an accounting of disclosures of your PHI made by Veritas Initiative, LLC. The list will not include uses or disclosures to which you have already consented; these include: treatment, payment, and health care operations; as well as PHI sent directly to you or to those responsible for your care; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. Disclosure records will be held for 6 years. This request must be made in writing and signed by you or your legal representative. I will respond to your request for accounting within 60 days of receiving your request. The list will include disclosures made in the previous 6 years, or since the date of your last request. You may indicate a shorter period in your written request.

The list will include the date of disclosure, to whom PHI was disclosed, a description of the PHI disclosed, and the reason for the disclosure. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting which will be discussed upon receiving your request.

6. **Restrictions on use and disclosures of your PHI:** You have the right to request restrictions on uses and disclosures of your PHI for treatment, payment, or health care operations. I am not legally required to agree to most restrictions, but I will attempt to accommodate reasonable requests when appropriate. If I agree to your request, I will put those limits in writing, but I reserve the right to remove such restrictions as I appropriate. You will be notified, in advance, if restrictions are removed. You also have the right to withdraw, in writing, any restriction previously requested.

Notifications of Breaches in Your PHI

I take seriously the confidentiality of your PHI and I am required by law to protect the privacy of your PHI through appropriate safeguards. In the case of a breach I am required by law to notify you and each affected individual whose unsecured PHI has been compromised.

PHI After Death

The protection of your PHI expires when your have been deceased for more than 50 years. Following death, I may disclose your PHI to individuals involved in the care or payment for health care provided by Veritas Initiative, LLC prior to your death. However, such disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any expressed preference made by you, prior to your death.

Notice of Privacy Practices

Kyle Gerry, in affiliation with Veritas Initiative, LLC, must provide a Notice of Privacy Practices that contains a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

Complaints

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is to provide protection for public health and safety and to empower the citizens of the State of Washington by providing a complaint process against counselors who would commit acts of unprofessional conduct. If you believe that I have been unethical in our work and still believe so after discussing your concerns with me, you may contact:

Department of Health—Counselor Programs
P.O. Box 47869
Olympia WA 98504-7869
(360) 664-9098