Summary of Washington Notice of Privacy Practices, Financial Policies and Consent to Treat

Kenneth L. DeSeve, PhD

WA State and Dr. DeSeve's Privacy Policies: We understand that psychological and medical information about you is personal. We are committed to protecting that information. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal and ethical requirements. The **Washington Notice of Privacy Practices** explains how psychological and medical information about you may be used and disclosed and how you can get access to this information. You are encouraged to visit the above hyperlink for Summary or Detail regarding:

I. Uses and Disclosures for Treatment, Payment and Health Care Operations
II. Uses and Disclosures Requiring Authorization
III. Uses and Disclosures with Neither Consent nor Authorization
IV. Patient's Rights and Psychologist's and Therapist's Duties
V. Complaints
VI. Effective Date, Restrictions and Changes to Privacy Policy

We keep a record of the mental health care services we provide you. You may ask to see and receive a copy of the record. We have up to 5 business days to provide this information to you. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office and signing a disclosure form.

Dr. DeSeve's Financial Policies: Intake appt. $245, thereafter $210 per hourly session

We do not accept Medicare or State Insurances. All payments are received by credit or debit card. Payment will be automatically withdrawn from your account between the 1st and 10th monthly after your insurance claims have been processed. Receipts will be provided by request only. Missed appointments cancelled with a week of the appointment will be charged $100. It is your responsibility to confirm your insurance coverage prior to scheduling.

PLEASE INITIAL YOUR ACKNOWLEDGEMENT AND CONSENT REGARDING THE WA NOTICE OF PRIVACY PRACTICES, DR. DESEVE'S PRIVACY POLICIES, SERVICES AND PAYMENT

• I have read, or have had read to me, or been given access to **Dr. DeSeve's Privacy Policies** and the **Washington Notice of Privacy Practices**.
• I have had the opportunity to ask questions about the information provided above. I understand my rights to privacy, the exceptions to my rights to privacy and that there are risks associated with treatment.
• I also agree to abide by the **Service and Payment Agreement** outlined above and accept full responsibility for any and all fees incurred in my care.

Client: (PRINT NAME) _____

Client Signature: _____

Date: _____

DOWNLOAD THIS FORM, COMPLETE, AND TEXT, EMAIL OR FAX AN IMAGE TO drkdeseve@frontier.com or 208-773-6730