Tracy Clason, MN, ARNP, BC
Board Certified Psychiatric Mental Health Nurse Practitioner

Appointments:
Appointment times vary in length depending on the type of service. An initial (new client) visit is 60 minutes in length. Medication Evaluation/Management appointments are 10-25 minutes and Psychotherapy sessions are approximately 16-45 minutes.
Your appointment time has been reserved especially for you, therefore I require a 24-hour cancellation policy. You will be charged the full fee if a 24-hour notice is not given for Non-Emergency appointments. Your insurance will not cover missed appointments. Please arrive on time for your appointment in order to maximize our time together. If you need to make an appointment or reschedule your appointment, please call my confidential business number at 360-882-7603. Please be aware that I handle all phone calls, scheduling and billing. As a result, I prioritize all calls and will return your call as soon as I am able. I am in the office Monday-Thursday, from 9:00am-5:00pm. I am out of the office on Fridays, Saturdays and Sundays.

On Call:
I share a call rotation with a group of Psychiatric Nurse Practitioners during my time off. You will be notified by calling my voicemail if another Nurse Practitioner is on-call for urgent needs.

Billed Fees:
99205 = $400
99213 = $400
90833 = $400
90836 = $400
90838 = $400

Phone Consults:
- I0-20 minute phone consult (this is an out of pocket expense as insurance does not cover phone consults) - $100 fee
- 20-30 minute phone consult (this is an out of pocket expense as insurance does not cover phone consults) - $200 fee

Payments:
All copays, coinsurance and deductibles, or cash-pay client fees are due at the date and time of service. Please bring a form of payment at each visit. I accept cash and credit/debit cards through Square card services.
Please call your insurance to verify your benefits prior to your appointment. Mental Health benefits may be through another insurance carrier than your medical plan.

The crisis line can be reached at 360-696-9560. For medical or mental health emergencies, please call 911 or proceed to the nearest Emergency Room.

INFORMATION INTAKE

CLIENT INFORMATION **DATE: _____**

Client name:_____
Partner's name (if being seen as a couple): _____
Address: _____ City, State, Zip: _____
E-mail address: _____
Telephone: _____ Okay to leave message? _____
Telephone: _____ Okay to leave message? _____
Telephone: _____ Okay to leave message? _____
Gender: _____ Age: _____ Birth Date: _____/_____/_____ Marital Status: _____
Others living in home: _____, _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client)

_____, _____, _____
(name, birthdate, relationship to client) (name, birthdate, relationship to client (name, birthdate, relationship to client
Education – Self: _____ Partner: _____
Occupation – Self: _____ Partner: _____
Client's employer: _____ Primary care doctor: _____
Emergency contact: _____ Phone: _____
Referred by: _____

INSURANCE INFORMATION

Name of insured: _____ Insured date of birth: _____
Address of insured person: _____ City, State, Zip: _____
Relationship of insured person: _____ Employer of insured person: _____

Insurance company: _____ Phone: _____
Insurance company address: _____ City, State, Zip: _____
Insurance identification number: _____ Group number: _____

Secondary insurance: _____ Phone: _____
Name of secondary insured: _____ Date of birth: _____
Secondary company address: _____ City, State, Zip: _____
Secondary identification number: _____ Group number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature: _____ Date: _____

Tracy Clason, MN, ARNP, BC

7600 NE 41st Street, Suite 310 phone (360) 571-2081
Vancouver, WA 98662 fax (360) 253-3196

Consent to Use or Disclose Clinical Information

I authorize Tracy Clason, ARNP to use and disclose the health care information for the purpose of ***Treatment*** (such as coordinating your care with your primary physician or other health care professionals), ***Payment*** (such as billing your insurance company and determining eligibility of your health benefits) and routine ***Health Care Operations*** (such as scheduling appointments or calling to remind you of an appointment).

This consent form is being provided to you with an attached ***Notice of Privacy Practices.*** Please review this ***Notice of Privacy Practices*** for additional information about the uses and disclosures of protected health care information described in this Consent prior to signing this Consent.

A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of the current copy of this document. As more fully explained in the Notice of Privacy Practices, you have the right to request restrictions on how your health care information may be used for treatment, payment, and routine health care operations. You also have the right to request a review of your records or to amend your records; this is more fully explained in the Notice of Privacy Practices.

Please verify that you received the ***Notice of Privacy Practices*** by initialing here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing, except to the extent that this office has already used or disclosed information prior to my decision to revoke consent.

_____ _____
Signature of Client Date

_____ _____
Signature of legal guardian (if client is a minor) Date

_____
Relationship to client (if client is a minor)

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Notice of Privacy Practices

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

How I may Use and Disclose Protected Health Information (PHI):

By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
For Treatment: I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
For Payment: I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party. It is my policy to release only demographics, diagnosis, date and type of service when I bill third party payers. If more information is required by a payer, I will request your written consent for that disclosure.
For Routine Health Care Operations: I may use health information about you in order to run my practice, i.e., appointment reminders. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time.

If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

Special Situations:
I may use or disclose health information about you without your permission for the follow purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
Required by Law: Based on professional judgment, I may disclose health care information about you when required by federal, state or local law.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
Law Enforcement: I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Family and Friends: In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:
Research: Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
Military, National Security, and Intelligence: If you are a member of the armed forces, or part of the national security or intelligence communities, military command, or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation: Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
Public Health Risks: Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
Health Oversight Activities: Health information may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Information Not Personally Identifiable: Health information may be disclosed in a way that does not personally identify you or reveal who you are.

Other Uses and Disclosures of Health Information:
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Protected Health Information:
Right to Review Records: You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative proceeding.
Right to Amend: If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that:
- I did not create.
- Is not part of the health information that I keep.
- You would not be permitted to review, inspect, or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures”. This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a confidential way, such as asking that I only contact you at home.
Right to a Paper Copy of this Notice: You have the right to a paper copy of this privacy notice. Even if you agreed to receive it electronically, you are entitled to a paper copy.

Changes to this Notice:
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face:
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services:
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure:
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telehealth arrangement. Initial each line below to indicate that you understand and agree to these actions:

_____ You will only keep your in-person appointment if you are symptom free.

_____ You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.

_____ You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.

_____ You will wash your hands or use alcohol-based hand sanitizer when you enter the building.

_____ You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.

_____ You will wear a mask in all areas of the office (My staff and I will too).

_____ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff).

_____ You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

_____ If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.

_____ You will take steps between appointments to minimize your exposure to COVID.
_____ If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff) know.
_____ If your commute or other responsibilities or activities put you in close contact with others {beyond your family), you will let me [and my staff] know.
_____ If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure:
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick:
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff) believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.
If I [or my staff) test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection:
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent:
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.
Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Signature **Date**

_____ _____
Provider Signature **Date**