Sunrise Center For Wellness
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Federal Way, WA 98003
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Welcome! I appreciate this opportunity to work with you! This overview is intended to provide you with information about me, about your rights as a client, and what you can expect. When you feel you are completely informed, please sign the last page.

Therapeutic Approach

My personal approach to therapy is an eclectic one – drawing primarily, but not exclusively, from the following therapies: Cognitive Behavioral, Solution Focused, and EMDR (Eye Movement Desensitization and Reprocessing). I often utilize an educational approach because I believe it can be powerful in helping clients achieve change. By an educational approach, I mean that we can all benefit from learning to identify and replace our irrational beliefs and unhelpful thinking patterns that are not serving us well. There are no magic cures for serious problems. However, as you learn new ways of looking at them, other significant, positive changes can also occur. Also, I am a strong believer in the importance of the relationship between client and therapist. I will make every effort to build a positive, therapeutic relationship between us that fosters openness and honesty. If you have concerns or feedback for me, I welcome and appreciate it. As a client, you also have the right to file a complaint with the Department of health if you believe a therapist has demonstrated unprofessional conduct.

Confidentiality

Under the Health Insurance Portability and Accountability Act (HIPPA), I am required to protect the privacy of your personal information, provide this Notice of policies and procedures, and abide by the terms of the Notice. Your personal health information includes your name, social security number, address, telephone number, employment, claims information, etc. Your protected health information may be used or disclosed only with your consent – for such purposes as collaboration of care with other health care providers, etc.

Appointments

All appointments are made directly with me. Generally, psychotherapy appointments are made for 45- 55 minute sessions. The duration will depend on your needs, and also varies with insurance coverage. I also believe that consistency is important to the psychotherapy process. If you are unable to keep an appointment, I require 24 hours advance notice, or you will be charged $95 for the missed appointment – this amount is not covered by insurance. If you need to cancel, please leave a voice message on my phone – an email notice is *not* adequate as I don't check it as frequently. If you prefer to leave me a text, it is very important that you identify yourself on the text.

I do not employ a receptionist. Therefore, I rely heavily on my voicemail system, and texts. I check both frequently and will respond as soon as possible. *However, if there is a crisis or emergency please call the 24-hour Crisis line (206) 461-3222 and/or 911.*

Fees and Payments

When paid at time of service, rates are $165 for the initial 45 minute visit. Follow up visits are $125 for 45 minutes. (If paid later the rates are $200 for initial intake and $165 for follow ups). Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand the benefits provided by your policy. As a courtesy, I will bill your insurance. You are responsible for your co-payment portion at the time of service.

NOTICE OF PRIVACY PRACTISES

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.

I, Kay Studevant, LMHC, respect your privacy. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you authorize me to do so, or unless the law authorizes or requires me to do so. I am required to keep your health information private.

The law protects the privacy of the health information we create and obtain in providing my care and services to you. For examples, your protected health information includes your symptoms, diagnoses, treatment information, billing and payment information relating to those services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations. I am required to get your authorization to disclose this information for payment purposes.

EXAMPLES OF USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

FOR TREATMENT:
Information that I obtain will be recorded in your medical record and used to help decide what care may be right for you. I may also provide information to others providing you care to help them stay informed about your care. (These are with your signed consent only).

FOR PAYMENT:
I may request payment from your health insurance plan. Health plans need information from me about your care. Information provided to health insurance plans may include your diagnosis, therapeutic interventions, or recommended care.

FOR HEALTH CARE OPERATIONS:
I may use your medical records to access quality and improve services. I may contact you to remind you about appointments and give you information about benefits and services. I may use and disclose your information to conduct or arrange for services, including:
Medical quality review by your health plan
Accounting, legal, risk management and insurance services

YOUR HEALTH INFORMATION RIGHTS:
The health and billing records I create and store are my property. The protected information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask me to restrict certain uses and disclosures.
- Ask me to change your health information. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- Cancel prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

TO ASK FOR HELP OR COMPLAIN
If you have questions or complaints about the handling of your protected health information, please contact myself, Kay Studevant, at 253-334-7715. You may also deliver a written complaint to me. You may also file a complaint with the US Secretary of Health and Human Services. I respect your right to file a complaint with myself or the US Secretary of H & H Services.

Please circle all that apply:

Depression	Irritability	Excessive Stressors
Disturbed Appetite	Panic attacks	Restlessness
Relationship Problems	Nightmares	Self harm (please describe)
Sleep Disturbance	Chronic worry	
Poor Concentration	Mood swings	

Other:

Kay Studevant, LMHC

REGISTRATION FORM

Today's Date:				EMAIL ADDRESS:	
PATIENT INFORMATION					
Patient's last name: First:		Middle: Mr. Mrs. Ms.		Marital status: [Choose an item]	
Is this your legal name? ◯ Ye ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.: [Phone]		
How did you hear about my office:					
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the professional at the time of service)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here?	◯ Ye ◯ No	Is this patient covered by insurance?	◯ Ye ◯ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:					
Subscriber's name: Spouse	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kay Studevant, LMHC or insurance company to release any information required to process my claims. I have received, read and understand copies of the following documents:
Disclosure statement describing office policies and procedures,
Notice of Privacy Practices (HIPPA)

Patient/Guardian signature ______________________ Date ____________