

# Request for Services



## TULALIP TRIBES BEHAVIORAL HEALTH MENTAL WELLNESS INTAKE COVER SHEET FOR FRONT DESK STAFF

**TODAY'S DATE**

**SECTION A PATIENT DEMOGRAPHIC INFORMATION**

FULL LEGAL NAME (FIRST)		(LAST)	(MIDDLE INITIAL)	SOCIAL SECURITY #
PREFERRED NAME	PREFERRED PRONOUNS	DATE OF BIRTH	AGE	
LEGAL GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/ Male-to Female <input type="checkbox"/> Transgender Male/ Female-to Male <input type="checkbox"/> Other: _____		SEX ASSIGNED AT BIRTH <input type="checkbox"/> Male <input type="checkbox"/> Female	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW <input type="checkbox"/> SIGNIFICANT OTHER				

**ADDRESS**

CITY	STATE	ZIP CODE
Is it ok for a therapist to send mail to this address? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is there another address you would like mail sent to from us? <input type="checkbox"/> YES <input type="checkbox"/> NO
Preferred Mailing Address:		
CITY	STATE	ZIP CODE
HOME PHONE # IS THIS PRIMARY #? <input type="checkbox"/> YES <input type="checkbox"/> NO	CELL PHONE# IS THIS PRIMARY #? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is it ok for a therapist to leave a message at this number? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is it ok for a therapist to leave a message at this number? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**SECTION B PATIENT TRIBAL INFORMATION**

ARE YOU: <input type="checkbox"/> ENROLLED TRIBAL MEMBER <input type="checkbox"/> DESCENDENT OF ENROLLED MEMBER <input type="checkbox"/> SPOUSE OR PARENT OF ENROLLED MEMBER <input type="checkbox"/> NON-NATIVE	NAME OF TRIBE (IF APPLICABLE): _____ ENROLLMENT # (IF APPLICABLE): _____
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*Please provide Enrollment Card/Tribal Verification to be scanned*

**SECTION C EMPLOYMENT INFORMATION**

NAME OF EMPLOYER	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> On Call
OCCUPATION:	WORK PHONE#

**SECTION D ADDITIONAL PATIENT INFORMATION**

ETHNICITY: <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> UNKNOWN BY PATIENT <input type="checkbox"/> DECLINED TO ANSWER
RACE: <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> UNKNOWN BY PATIENT
PRIMARY LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____

**BEHAVIORAL HEALTH AND RECOVERY REQUEST FOR SERVICES (CONTINUED)**

PATIENTS EMAIL ADDRESS:

**SECTION E CONTACT INFORMATION**

PERSON WHO CAN BE CONTACTED IN THE EVENT OF AN EMERGENCY

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

**SECTION F ALTERNATE RESOURCE INFORMATION**

DO YOU CURRENTLY HAVE MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE NUMBER:	
ARE YOU CURRENTLY ENROLLED IN WA STATE MEDICAID PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE GIVE MEDICAID NUMBER:		
DO YOU HAVE AN EMPLOYER SPONSORED INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO PLAN NAME:	GROUP #	
POLICY #		
WHO IS THE PRIMARY INSURED (POLICY HOLDER)?	THEIR SOCIAL SECURITY #:	THEIR DATE OF BIRTH:

*Please provide insurance card to be scanned*

When this cover sheet is completed, return it to the front desk  
then continue with the remaining pages.

**CONTINUED ON NEXT PAGE** ►**FRONT DESK STAFF USE**

<input type="checkbox"/>	DATE RECEIVED
<input type="checkbox"/>	REGISTERED IN E.P.I.C.   INITIALS

**CLINICAL STAFF USE**

<input type="checkbox"/>	THERAPIST ASSIGNED:
<input type="checkbox"/>	APPOINTMENT SCHEDULED:
<input type="checkbox"/>	REFERRAL ENTERED INTO E.P.I.C.   INITIALS

BEHAVIORAL HEALTH AND RECOVERY REQUEST FOR SERVICES

In order to best meet your needs, please fill out the form below and return to the receptionist. A mental health counselor will contact you for an appointment.

REFERRED BY:

What stressors are you experiencing? (Please check all that apply)

- Family, relationship issues; Sad, anxious; Grief; Housing issues; Trauma; Anger; See medication provider

Notes:

What form of therapeutic service are you seeking? (Please check all that apply)

- Individual Therapy; Marriage/Couples or Family Therapy; Interested in a Group

Other (Please specify):

What therapeutic technique are you being requesting? (Please check all that apply)

- CBT or DBT; CBT-I; EMDR or other Somatic Therapy; Art Therapy; Gender Affirming Care; Other (notate below)

Notes:

Preferred Gender Presentation of Provider? (Please check all that apply)

- Male; Female; Other or Any

Notes:

Are there any scheduling limitations we should be aware of? (Please check all that apply)

- Not able to come in person; My availability is outside normal business hours

Notes:

## Court Involved *(Please check all that apply)*

Are you seeking a court ordered assessment or evaluation?  Yes  No

Which court is this for?  Tulalip  Snohomish County  King County  Other:

What type of case?  Criminal Court  Civil Court  Family Court  Wellness/Drug Court

Are your charges related to Domestic Violence (DV)?  Yes  No

*If an assessment is being requested, please provide documentation of the request.*

Additional information:

## Questions

Are you having thoughts of hurting yourself or suicide at this time?  Yes  No

Do you have a history of hurting yourself or attempted suicide in the past?  Yes  No

Are you having thoughts of hurting anyone else?  Yes  No

Have you ever assaulted anyone?  Yes  No

Do you use drugs?  Yes  No If so, what? Last use:

Do you use alcohol?  Yes  No If so, what? Last use:

## Relationships

SIGNIFICANT OTHER

WHO DO YOU LIVE WITH?

MOTHER

FATHER

EMERGENCY CONTACT

PHONE

SIBLINGS

CHILDREN

**TULALIP BEHAVIORAL HEALTH PRESCRIPTION CONTRACT**

To receive a prescription for the appropriate medication to treat persistent mental health conditions, you must:

- Be referred to the Tulalip Behavioral Health medication provider by one of our therapists.
- Commit to and participate in an ongoing treatment plan with your therapist.
- Make appointments to receive prescription refills through your therapist.
- Plan ahead for prescription refills.
- Tulalip Behavioral Health will not provide replacements or reauthorization for lost or stolen prescriptions.

Two ways to plan ahead for your medication refills:

- Call the pharmacy and ask for a refill at least one week before your medication runs out. Tell the pharmacy that our fax number is: 360-716-0758.
- If you have not seen your therapist or the medication provider for some time, call your therapist and make an appointment as soon as possible. It may be several days before you can be seen. All appointments with the medication provider are made through your therapist.

**IMPORTANT: Some medications require a urinalysis because the possibility of adverse drug interactions. If you are prescribed one of these medications, you must also be willing to submit to random urinalysis tests at the discretion of the Tulalip Behavioral Health medication provider.**

Please list the name and phone number of the pharmacy you wish to use below. Prescriptions and subsequent refills will only be sent to the pharmacy listed below:

NAME OF PHARMACY

PHONE

**Statement**

I, (my printed name):

- Am not currently taking Suboxone, methadone, benzodiazepine, gabapentin, or any other prescription narcotics for pain management.
- Am currently taking Suboxone, methadone, benzodiazepine, gabapentin or any other prescription narcotics for pain management. The narcotic medication that I am currently taking includes (please list and bring bottle to your appointment with our medication provider):

*I also agree to act in accordance with the conditions stated above in order to receive psychiatric services from Tulalip Behavioral Health.*

DATE OF BIRTH

DATE

YOUR SIGNATURE

## BEHAVIORAL HEALTH AND RECOVERY REQUEST FOR SERVICES

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Washington Administrative Code defines Consumer as “A person who has applied for, is eligible for, or who has received mental health services.” For a child, (thirteen to eighteen) whose parents or legal guardians are involved in a treatment plan, the definition includes “parents or legal guardians.”

### WAC CONSUMER RIGHTS (WAC 388-865-0410)

- (1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WAC 388-865-0260(3);
- (2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;
- (3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division:

#### You have the right to:

- (a) Be treated with respect, dignity and privacy;
- (b) Develop a plan of care and services which meets your unique needs;
- (c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
- (d) Refuse any proposed treatment, consistent with the requirements in chapters 71.05 and 71.34 RCW;
- (e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
- (f) Be free of any sexual exploitation or harassment;
- (g) Review your clinical record and be given an opportunity to make amendments or corrections;
- (h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;
- (i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;
- (j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;
- (k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
- (l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;
- (m) If you are Medicaid eligible, receive all services which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from:
  - (i) A provider within the regional support network about what services are medically necessary; or
  - (ii) For consumers not enrolled in a prepaid health plan, a provider under contract with the mental health division.
- (n) Lodge a complaint with the ombudsman, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombudsman may, at your request, assist you in filing a grievance. The ombudsman's phone number is 1-888-336-6164 (Ext. 0)
- (o) Ask for an administrative hearing if you believe that any rule in this chapter was incorrectly applied in your case.”

### Client Grievance Procedure

**Policy:** The Tulalip Tribes Mental Health Program recognizes the importance of settling client problems and grievances promptly and fairly. The agency also recognizes the desirability of settling problems in the most informal, appropriate way possible. It is the policy of The Tulalip Tribes Mental Health Program to inform clients of the following process for: 1) problem resolution (informal) and 2) grievance resolution (formal). Clients shall be free from agency interference, coercion or reprisal should they choose to file a grievance.

**Problem Resolution:** From time to time, clients of The Tulalip Tribes Tribal Mental Health Program have questions, concerns, complaints or problems that relate to their therapy, the handling of their case, appointment scheduling, policies and procedures, etc. Should such a problem arise, clients are encouraged to request an opportunity to discuss and resolve the concerns informally with the relevant staff or department.

**Grievance Resolution:** On some occasions, a client may feel the above process is inadequate, or they may have a concern or complaint of a more serious nature. Should a client wish to file formal grievance, the formal procedure should be followed.

## BEHAVIORAL HEALTH AND RECOVERY REQUEST FOR SERVICES

1. When the client tells any staff member of their desire to file a grievance, the grievance form will be given to the client to fill out, and the client will be instructed to give it to the grieved person's supervisor.
2. The grieved staff person will not participate in accepting, investigating or deciding any grievance of which they are the object. Clients stating that they want to make a grievance will be told how to reach the grieved person's supervisor and that the form should be turned in to the supervisor. The supervisor will assist the client in filling out the form if necessary.
3. The supervisor will notify and send copies of the form to the Manager of The Tulalip Tribes Mental Health Program and the Executive Director of Health Services.
4. The supervisor will make the client aware that he/she may choose a staff member, family member, friend or other advocate to represent him in a grievance procedure.
5. Staff who are not involved in the case will investigate. The supervisor will coordinate the investigative process.
6. A written report from the supervisor shall be made to the client in 15 days when possible or in any event within 30 days.
7. The client may appeal the decisions of the grievance staff to the Executive Director. A written report of the Director's decision shall be made to the consumer with 15 days when possible but, in all cases, within 30 days.
8. Grievances may also be filed with the state office of Human Rights and/or the DSHS office of Equal Opportunity.
9. There will be no retaliation.

### Mental Health Fee Agreement Disclosure Statement

*Each client shall be informed about the fees to be charged, the method of a payment agreed upon, and the collection consequences, with sensitivity toward the client's ability to pay.*

**Fee Policy:** Each patient is billed for services rendered; either to private insurance companies or to the state, if the patient is on Medical Coupons. If there is no insurance or medical coupon the policy is that you must apply for a medical coupon. Ultimately you are responsible for your portion of the cost of being seen at Tulalip Behavioral Health Family Services. Co-pays are due at time of service.

**Tribal Affiliation** (*provide tribal enrollment card*): • Tulalip • Other enrolled Native • Family of Tulalip • Family of other Native

**Enrolled Natives:** If you have no insurance all enrolled natives will be asked to apply for insurance. In the event that you are denied you will still be seen.

**Family Members of Natives:** Nonnative family members who have insurance other than HMA, will not be seen until we know what your insurance will cover and what you will need to pay at time of service. A sliding fee scale is provided for those who have no insurance.

**Sliding Fee Scale:** The only clients who are eligible for our sliding fee scale are family members of tribal members who are living in the tribal home, such as a spouse or a child. The sliding fee scale is based on family income. Our TFS Office Administrator will work up a fee agreement with you based on the sliding fee scale which must be set up before you can be seen.

**HMA Insurance:** (Current policy effective November 1, 2014) **Make a copy of insurance card, both sides.**

**Bronze Plan:** Your responsibility is a \$25 co pay **Gold/Platinum Plan:** Your responsibility is a \$15 co-pay *Tulalip Tribal Members & other Natives: HMA Co-pay is waived. All others will be responsible for Co-pay. Visits are unlimited, but after 8 sessions your therapist must request more sessions from Reliant Behavioral Health. Please see your HMA Employee Health Care Plan booklet for more information.*

**Other Insurance:** We are not currently on any other insurance boards, meaning that you will have to contact your insurance to see what your coverage is for 'out of network'. Once you have that information our Finance Coordinator can work up a fee agreement with you.

NAME OF INSURANCE

Make copy of insurance card, both sides

CO-PAY	NUMBER OF SESSIONS PER YEAR
IDENTIFICATION NUMBER	GROUP NUMBER

**Washington Apple Health (Medicaid)** • Yes, get copy of current Insurance Card

**Medicare:** Unfortunately at this time we do not bill Medicare

#### Fee Schedule for Mental Health Services

Assessment	\$185.00	Group Sessions (1 1/2 to 2 hours)	\$80.00 per group
Individual (45 to 50 minutes)	\$85.00	Family or Couples Sessions	\$85.00 per session
Brief Individual (20 to 30 min.)	\$40.00 per session		

ARNP Varies by the amount of time you are seeing our provider. Please see our Finance Coordinator.

*Your counselor or case manager is required to be registered or licensed with the Washington State Department of Licensing unless otherwise exempt. The Law requires counselors to provide a written disclosure statement for your signature.*

**TULALIP TRIBES FAMILY SERVICES THERAPIST DISCLOSURE STATEMENT**

**WELCOME!**

We appreciate the courage it takes to reach out for professional help when you are experiencing personal challenges in your life. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies.

**AIMS AND GOALS:**

Our major goal together is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals
3. Identifying personal treatment goals
4. Promoting wholeness through psychological/emotional healing and growth

*You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress.*

**Clear Form**

**Print Form**

## OFFICE POLICIES & CONSENT TO TREATMENT

Welcome! We are honored that you have chosen Adult Mental Wellness (AMW) to assist you in meeting your needs at this time in your life. We appreciate the courage it takes to reach out for professional help when you or your family are experiencing personal challenges in your life. This is an opportunity to acquaint you with information relevant to our services, confidentiality, and other office policies.

### ABOUT OUR SERVICES

Adult Mental Wellness (AMW) is a program within Behavioral Health in the Tulalip Tribes' Tulalip Health System. Our program provides quality mental health services for the Tulalip community (tribal members, spouses of, parents of), and Other Natives living within Snohomish County (must be enrolled in federally recognized tribes). We provide mental health assessments, counseling, and referrals for adults.

Our highly qualified and skilled clinicians are trained in accordance with the professional standards of psychology, mental health counseling, and marriage and family counseling. Each provider is certified or licensed in their discipline by the State of Washington.

We help with a wide range of emotional and mental health problems. We see adults age 18 and over. We value the involvement of family members, and significant others when clinically appropriate. We do not mediate custody disputes, evaluate parental fitness, or provide independent custody evaluations. We do not get involved in legal disputes between parents for a variety of reasons. If legal services are required, we will be happy to refer you to practitioners who are experts in these fields.

#### Assessment

To get a complete picture, we talk to you about symptoms, challenges, strengths and goals. We recommend that family and partners take part in the assessment. Usually, an assessment takes two or more visits. We provide court ordered assessments for adults, which includes recommendations for treatment. Provide a copy of your court document with orders for an assessment when requesting these services.

#### Individual Service Planning

Your clinician will collaborate with you in creating an individual service plan (ISP), or treatment plan. The ISP is designed to identify your goals for mental health services and includes steps that involved individuals (client, clinician, partner, etc.) can make to meet those goals. It may include a variety of psychotherapy approaches such as crisis intervention, homework, group therapy, family sessions, individual therapy, and more.

#### Other Associated Services

AMW works collaboratively with other divisions to offer therapeutic services at Child, Youth, and Family (CYF) Mental Wellness (for children and adolescents age 3 to 18), Chemical Dependency (CD), Psychiatric Services (prescribers), Psychological Services (testing), and more. We will provide you with further information about the programs offered when applicable.

### APPOINTMENTS

#### Types

Assessment Sessions: The initial appointment is 90 minutes to 120 minutes in length.

Therapy Sessions: The length of subsequent therapy sessions is roughly 50 minutes, but we may also see you for shorter or longer sessions when clinically indicated.

#### Cancelled Appointments

Please call your clinic location's reception desk or contact your assigned clinician if you need to cancel your appointment. Please understand that your appointment is held exclusively for you. If for some reason you are unable to keep your appointment, please give as much notice as possible; we prefer 24 hours' notice for cancellations.

#### No Show Policy

Due to high demand for services, we ask that you make every attempt to attend your scheduled appointments as outlined above. Three consecutively missed appointments within a six-month period will result in a discharge from services. We commit to notifying you after the second no show before sending you a letter of discontinuance. Please know you are always welcome

to return any time thereafter pursuant to the wait list or other considerations.

### **Clinic Location**

Adult Mental Wellness is located at Tulalip's Family Services Location:

2821 Mission Hill Road Tulalip WA 98271 Phone: 360-716-4400 Fax: 360-716-0758

## **RIGHTS AND RESPONSIBILITIES OF CLIENTS IN THERAPY**

This is a statement of your rights and responsibilities pertaining to the therapeutic relationship with your clinician. The Washington Administrative Code (WAC) 246-809-710 and RCW 18.225.100 requires therapists to provide written disclosure of the following information to clients before therapy begins. You have the right to refuse treatment, and the responsibility to choose the therapist and therapeutic approach, which best suits your needs. Additional client rights are outlined below.

### **Individual Rights - Clinical**

You have the right to:

1. Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
2. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
3. Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
4. Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
5. Be free of any sexual harassment;
6. Be free of exploitation, including physical and financial exploitation;
7. Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
8. Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
9. Receive a copy of agency grievance system procedures according to WAC 182-538D-0654 through 182-538D-0680 upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and
10. Submit a report to the department when you feel the agency has violated a WAC requirement regulating "behavior health agencies."

*Washington Administrative Code (WAC) 246-341-0600*

### **Your Responsibilities**

You are responsible for:

1. Providing necessary information to facilitate effective treatment services;
2. Playing an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress, and achieve your goals;
3. Regular attendance and engagement in your services is key;
4. Be aware that not following service recommendations may compromise your health and safety including leading to serious medical and/or psychological consequences;
5. Notify your clinician if your condition worsens or if you are having difficulty keeping yourself safe;
6. In a crisis situation, if you are unable to reach your clinician during regular working hours or if the program is closed, assistance is available by calling:
  - 24-hour Snohomish County Care Crisis Line at 1-800-584-3578.
  - 911 or going to the nearest emergency department

## **FEEDBACK & GRIEVANCES**

Feedback helps insure that we are meeting your needs appropriately. If you have any questions about any information that you have received or how AMW operates, do not hesitate to ask your clinician or the clinical supervisor

### **Concerns Regarding Clinicians**

If you have a concern with your clinician, you are encouraged to contact them to discuss the situation. When the clinician is aware of an issue, often something can be changed or worked out. If you believe that it is not possible to resolve an issue or a complaint with your clinician, you are encouraged to contact the clinical supervisor to discuss the complaint related to

professional or ethical issues can be made with the Washington State Department of Health at the address below. You may also obtain a list of acts of unprofessional conduct by contacting the Department of Health.

#### Health Systems Quality Assurance (HSQA) Complaint

PHONE: (360) 236-4700

WEBSITE:

EMAIL: [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

<https://fortress.wa.gov/doh/providercredentialsearch/>

### CLINICAL RECORDS AND CONFIDENTIALITY

#### Protected Health Information & Confidentiality

State and federal regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and professional standards, require AMW to keep records of the treatment and services provided. These records, and other information that AMW learns about you through the course of your treatment, is considered "protected health information" or PHI. Extensive measures are taken to ensure the privacy and security of your PHI pursuant to the state and federal regulations. The "Notice of Privacy Practices" document is universally followed by all Tulalip Health System programs that manage protected health information. To access a copy of the Notice of Privacy Practices, please see the reception desk or the Tulalip Health System website ([www.tulaliphealthsystem.com](http://www.tulaliphealthsystem.com)).

#### Limits to Confidentiality

Issues discussed in the course of therapy are strictly confidential including the fact that you or your family member is seeing a clinician. We will not disclose any information to others unless you tell us to do so, or unless compelled to do so by law.

Information about your mental health services may be released to other persons under the following circumstances only:

1. When a release of information is signed by you
2. To a parent or legal guardian, when the client is under the age of 13.
3. When abuse or neglect of a child or a vulnerable/dependent adult must be reported by law.
4. When you are a danger to yourself or someone else, or are gravely disabled
5. When your behavioral health provider deems it necessary or appropriate to disclose information to another physician or health provider, unless you specifically request them not to.
6. If you waive your right to confidentiality by bringing charges against your clinician.
7. If there is a subpoena or court order for records from the secretary of health. The subpoena may only be for records related to a complaint or report under RCW 18.130.050.
8. When your insurance company requests your record in order to process your insurance claim.
9. When your family member or significant other attends a therapy session with you we make every effort to maintain privacy, but their communication is not privileged or protected by law and can be released without their permission.
10. In the event of a client's death or disability, information will be released as authorized by the client's personal representative or beneficiary.
11. We may resist releasing info to others or to you if we believe that the release would cause imminent harm.

#### Electronic Health Records

The Tulalip Health System's Health Information Exchange (HIE) is an electronic system where healthcare providers share your information. Information about your visits will be stored securely in an Electronic Health Record (EHR) shared by other programs and providers in the Tulalip Health System (including Behavioral Health, Medical, Dental, and Community Health) to best coordinate your treatment through one health record. The Tulalip Health System policy prohibits all employees from accessing records except as needed for their job functions. *Your information may be accessed by, or shared with, Tulalip Health System staff outside of the AMW program only as needed for purposes of coordinating care, receiving consultation, or other reasons related to safety, treatment, payment, or healthcare operations.* If you have particular concerns about who can access your health record, you can discuss these concerns with your clinician or the clinical supervisor. You may also ask to examine and copy your record by making a written request. You may ask us to correct your record, if needed.

#### Audio or Video Recording

Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by your clinician.

## CONTACTING YOUR CLINICIAN

Your communication with your clinician is part of the clinical records. Please note that clinicians do not use social media sites and may be unable to use any form of texting. Adding clinicians as friends on these social media sites and/or communicating via such sites can compromise your privacy and confidentiality. Email is inherently unsecure unless it is fully encrypted. Below are secure, confidential ways to contact your clinician.

### Phones & Faxes

The phone and fax numbers for the AMW clinic location can be found in the “Appointments” section of this document. The direct phone numbers for the clinicians are listed in the “Clinicians’ Education, Training & Therapeutic Approaches” section. Clinicians may not be immediately available by phone. Confidential voicemail is available and clinicians make every effort to return calls as soon as possible.

### MyChart

The Tulalip Health System offers MyChart, a secure encrypted communications tool. Confidential patient information should ordinarily be exchanged through MyChart or other secure communication devices. **Zoom** Telebehavioral health sessions may be offered through Zoom. AMW’s Zoom licenses are both HIPAA and 42 CFR Part 2 compliant. For more information about communication via Zoom see the “Telebehavioral Information” document on the Tulalip Health System website ([www.tulaliphealthsystem.com](http://www.tulaliphealthsystem.com)).

## EMERGENCIES BETWEEN SESSIONS

In an immediate life or death situation, call 911. If you or your family needs help right away, are in an emergent crisis involving feeling suicidal, at risk of hospitalization, or need to talk to someone immediately, call the 24-hour Snohomish County Care Crisis Line at 1-800-584-3578. You may also go to the emergency room of any hospital if in crisis and/or having feelings of suicide. You can also text HOME to 741741 or call the National Suicide Prevention Lifeline, (800) 273-8255, from anywhere in the U.S. If your situation is not of an emergent state, but it is pressing, you may also call AMW reception desk by calling (360) 716-4400 and asking to speak with the clinical supervisor or by calling your clinician directly. Some calls may be returned between sessions or when the clinician’s daily caseload has been attended. Please do not use emails or faxes for emergencies.

## FINANCIAL AGREEMENT

Each client’s health insurance company is billed for services rendered. You will need to apply for health insurance coverage if you are not currently covered. Please contact Tulalip Health System’s Alternative Resources at 360-716-4511 if you need assistance in applying. You are not eligible for any fee or service prior to signing this disclosure statement. Please inform Tulalip Health System Behavioral Health of any changes in the financial information given.

## CLINICIANS' EDUCATION, TRAINING & THERAPEUTIC APPROACHES

### **Kelley Crane, MA, LMFT**

LICENSE #: LF 60445167 | PHONE: (360) 716-4321

#### **Credentials & Specialty**

- Licensed Mental Marriage and Family Therapist (LMFT)
- TF-CBT, EMDR, Art Therapy, and Gottman Couple's Trained Clinician
- Specialty: Trauma and Generational Trauma, Healthy Relationships, Domestic Violence (Survivors), Veterans, Young Adults, Life Transitions, and Parenting Support.

#### **Education & Training**

- Bachelor of Arts (BA), Sociology/ Criminology, Cal Poly Pomona
- Master of Arts (MA), Psychology, Couple's and Family Therapy/Art Therapy, Antioch University Seattle

#### **Experience**

- 15 years providing mental health therapy
- 13 years providing mental health therapy to Native Americans and Alaska Natives (at Tulalip, Muckleshoot, and Western Washington University)

#### **Theoretical Orientation and Approach to Counseling:**

Being human is messy and that's ok. I strive to provide non-judgmental, collaborative, person centered, and empowering therapy services, focusing on accessing and processing what is, while building the understanding, skills, and resources that will support you in creating the life you want. This is your healing journey, and I'm honored to walk it with you.

My therapeutic orientation is an eclectic mix of Systems Theory, Cognitive Behavioral Therapy, EMDR, and Dialectical Behavioral Therapy. I provide individual, couple's, and family therapy services to individuals across the lifespan. I specialize in trauma and generational trauma, healthy relationships, survivors of domestic violence, young adults, Veterans, parents, and life transitions.

### **Kourtney C. Soriano, MA, LMFTA**

License # MG 6149569 | PHONE: (360) 716-4339

#### **Credentials & Specialty**

- Licensed Mental Marriage and Family Therapist Associate (LMFTA)
- Strengths-Based Therapy Approaches

#### **Education & Training**

- Bachelor of Arts (BA), Medical Anthropology & Global Health, University of Washington
- Master of Arts (MA), Marriage and Family Therapy, Pacific Lutheran University
- Emotionally-Focused Therapy (EFT) Training, Narrative Therapy Training, Solution-Focused Therapy (SFT), Cognitive Behavioral Therapy (CBT) Training

#### **Experience**

- 2+ years of experience working with adults, families, youth, active duty members and veterans
- Settings: Military installations, Community Mental Health, Hospital Social Services Specialist, Adult and Child Inpatient/Outpatient Psychiatry Unit
- Experience with issues such as depression, anxiety, PTSD, relationship conflicts, grief and loss, and crisis interventions

#### **Theoretical Orientation and Approach to Counseling:**

I foster a respectful, trusting environment tailored to each person's needs, emphasizing safety and empowerment in counseling. My approach is client-centered, holistic, collaborative, focusing on building coping skills and understanding present experiences for meaningful change. In my practice, I firmly believe in creating a safe and welcoming space where clients feel empowered to explore their thoughts, feelings, and experiences without judgment. I understand that the journey towards healing is deeply personal and requires a client-centered approach that honors the individual's strengths and values. I honor the interconnectedness of mind, body, and spirit, adapting my approach to meet evolving needs. I'm here to listen, support and empower you, and I look forward to walking alongside you on your journey towards healing and wholeness.

### **Rachel Foster, MS, LMFT**

LICENSE #: LF 60803670 | PHONE: (360) 716-4318

#### **Credentials & Specialty**

- Licensed Marriage and Family Therapist (LMFT)
- Mental Health Professional (MHP)

- EMDR Trained Clinician

### **Education & Training**

- Master of Science (MS), Counseling: Marriage and Family Therapy, University of Phoenix
- Dialectical Behavioral Therapy Intensive Training – Seattle
- Gottman Methods Couples Therapy Level 1
- Internal Family Systems Therapy (IFS) Training

### **Experience**

- 12+ years of experience providing therapy with individuals, couples, and children
- Various Settings: schools, private practice, inpatient behavioral health unit
- Experience with issues such as: depression, anxiety, self-harm, suicidality, trauma, grief & loss, facilitating groups, crisis interventions

### **Theoretical Orientation and Approach to Counseling:**

My theoretical orientation can be described as eclectic, in that I merge together aspects of Family Systems, Cognitive Behavioral, Client Centered and Dialectical Behavioral Therapy. I work collaboratively with my clients, and strive to help them uncover their own personal strengths and achieve personal goals, through self-awareness and active participation in the therapeutic process. In counseling, you will be able to express your thoughts in a non-judgmental safe and nurturing environment. While we can't change the difficult situations of the past, we can work together to better understand and resolve challenges in the present and future.

**Raman Basanti, PhD, LMHC**

LICENSE #: LH 61085461 | PHONE: (360) 716-4311

### **Credentials & Specialty**

- Licensed Mental Health Counselor (LMFT)
- Mental Health Professional (MHP)
- Post-doctoral clinician
- EMDR, IFS, DBT Trained Clinician

### **Education & Training**

- Master of Science (MS), Counseling: Monash University
- Dialectical Behavioral Therapy Intensive Training – Seattle
- EMDR training- Spokane WA
- Internal Family Systems Therapy (IFS) Training

### **Experience**

- 12+ years of experience providing therapy with adults and children
  - Various settings: schools, private practice, inpatient behavioral unit, group practice
- Experience with issues such as: depression, anxiety, self-harm, suicidality, trauma, generational trauma, grief & loss, facilitating groups, crisis interventions

### **Theoretical Orientation and Approach to Counseling:**

I work with a wide range of clients across the life span with a specialty in trauma, generational trauma, generational healing, and identity. I use a person-centered and strengths-based approach in therapy. I have experience doing evaluations and therapy with neurodivergent individuals. I can support you with individual growth and wellness, self-discovery, trauma processing, and healing. I use a holistic approach in my work and believe that healing requires integrating mind, body, and spirit. I offer individual, family, and couple's therapy. I take a collaborative approach in therapy and focus on your values. I am trained in EMDR, IFS, TF-CBT, DBT, and ACT. I have experience providing assessment and therapy in English, Hindi, Punjabi and Urdu.

**S. Stevee Giba, MA, LMHC, MHP, ATR, C-DBT, Clinical Supervisor**

LICENSE #: LH 60506516 | ATCB #: 16-162 | PHONE: (360) 716-4347

### **Credentials & Specialty**

- Licensed Mental Health Counselor (LMHC)
- Mental Health Professional (MHP), specialization in Developmental Disabilities and Native Americans
- Registered Art Therapist (ATR)
- Certified DBT Provider (C-DBT)
- Developmental Disabilities Mental Health Specialist (MHP)
- Specialty: LGBTQ (issues, rights, advocacy), Grief and Loss, Somatic Trauma Processing, Art Therapy

### **Education & Training**

- Associate's Degree (AA), Liberal Arts, Spokane Falls Community College

- Bachelor of Arts (BA), Psychology, University of Washington
- Bachelor of Arts (BA), English/Creative Writing, University of Washington
- Master of Arts (MA), Psychology, Mental Health Counseling/Art Therapy, Antioch University Seattle

**Experience**

- 15 years providing mental health counseling to Native Americans and Alaskan Natives
- 8.5 years in supportive role with independently living persons with Developmental Disabilities
- 5 years private practice

**Theoretical Orientation and Approach to Counseling:**

I work from a transpersonal, humanistic, intersectionality and mindfulness approach with tools such as Art Therapy, DBT and bilateral somatic integration. I am proficient in working with trauma-focused care, grief and loss, spiritual challenges, disabilities, couples, betrayal trauma and gender and sexuality issues, to name a few. I promise to always treat you with respect and dignity and ask that you do so for me as well. I believe in open communication and am here to listen to you.

\*\*\*\*\*

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to persons outside Family Services, and only then with a release signed, by the client. Exceptions to this rule: state law mandates that there is no confidentiality where child abuse, elder abuse or abuse of a developmentally disabled adult has occurred. The counselor may also be required to break confidentiality in life-threatening situations where the client poses a clear and present danger to self or others or is unable to provide minimum life-sustaining self-care. Here, the counselor would take steps necessary to secure the safety of the client or others.

**The Rights of Clients in Counseling**

It is appropriate for clients to raise questions about the counselor, the therapeutic approach and the progress of the therapy. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

## INFORMED CONSENT FOR SERVICES

CLIENTS NAME:

DATE OF BIRTH:

### LEGAL INVOLVEMENT & RELATED DOCUMENTS

**Do any of the following apply to you? If yes, please provide a copy of the document.**

YES NO

- Powers of Attorney?  YES  NO

- Do you have Psychiatric Advance Directives?  YES  NO

If Yes, a copy of your Psychiatric Advance Directives are on file at \_\_\_\_\_

- Under department of corrections (DOC) supervision?  YES  NO

- Under civil or criminal court ordered mental health or substance use disorder treatment?  YES  NO

- On a Less Restrictive Alternative or Conditional Release court order?  YES  NO

- If you answered yes to any of the above questions, is there a court order exempting you from reporting requirements? *If so, a copy of the court order must be included in the record – please provide a copy.*  YES  NO

### OUR SAFETY AND EMERGENCY PLAN

You will need to provide permission for your clinician to communicate with this person about your care during emergencies.

PRINTED NAME OF EMERGENCY CONTACT

RELATIONSHIP TO CLIENT

( ) - PHONE NUMBER FOR EMERGENCY CONTACT

### Authorization for SERVICES

I have read the information provided above, received a copy, and understand the office policies including the following:

- Tele-behavioral Health
- Rights and Responsibilities of Clients in Therapy
- Feedback & Grievances
- Clinical Records & Confidentiality
- Emergencies Between Sessions
- Financial Agreement
- Clinician's Education, Training & Therapeutic Approaches

I am consenting to mental health services at Tulalip Tribes' Adult Mental Wellness, and I agree to participate in therapy.

### SIGNATURE

SIGNATURE OF CLIENT

PRINTED NAME

DATE

### LEGAL GUARDIAN SIGNATURE (if required)

SIGNATURE OF LEGAL GUARDIAN      RELATIONSHIP TO CLIENT

DATE      PHONE NUMBER FOR LEGAL GUARDIAN

LEGAL GUARDIAN

### CLINICIAN SIGNATURE

SIGNATURE OF CLINICIAN

DATE

PRINTED NAME OF CLINICIAN



# Tele-mental Health Informed Consent

CLIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

## Nature of Telemental Health

“Telemental health” means, in short, “provision of mental health services with the provider and recipient of services being in separate locations and the services being delivered over electronic media.” Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, virtual environments, specialized mobile health (“mHealth”) apps, and others.

Telemental health allows your clinician to diagnose, consult, treat and educate using interactive audio, video or data communication regarding your behavioral health services. The telemental health appointment will be similar to a therapy appointment in the office, except interactive video technology will allow you to communicate with a clinician at a distance. *Tulalip Tribes’ Behavioral Health & Recovery (BH&R)* may not provide telemental health services to you if you are outside of Washington state.

## Technology

You will need to have a broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. In case of technology failure, you may contact *Tulalip Tribes’ BH&R* by phone to coordinate alternative methods of treatment.

## Your Telemental Health Environment

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your clinician during the session. If you are unsure of how to do this, please ask your clinician for assistance.

## Healthcare Records and Confidentiality

All existing laws regarding your access to healthcare information and copies of your healthcare records apply to telemental health services. As a general practice, *Tulalip Tribes’ BH&R* DOES NOT record telemental health sessions without prior permission. Please do not record video or audio sessions without your clinician’s consent. Making recordings can quickly and easily compromise your privacy, and should be done so with great care.

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telemental health. All existing confidentiality protections under federal and Washington state law apply to information disclosed during telemental health services. *Tulalip Tribes’ BH&R* platform is HIPAA compliant to protect your privacy and confidentiality.

## Our Communication Plan

At our first session, we will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises.

Scheduling is conducted through *Tulalip Tribes’ BH&R* and is based on your clinician’s normal clinic hours. Telemental health appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the Snohomish County Crisis Line (1-800-584-3578) or by dialing 911.

## Our Safety and Emergency Plan

As a recipient of telemental health-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your clinician. Your clinician will require you to designate an emergency contact. You will need to provide permission for your clinician to communicate with this person about your care during emergencies.

\_\_\_\_\_  
PRINTED NAME OF EMERGENCY CONTACT

\_\_\_\_\_  
RELATIONSHIP TO CLIENT

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
PHONE NUMBER FOR EMERGENCY CONTACT

Your clinician will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. It is important that you engage with your clinician in the creation of these plans and that you follow them when you need to.

### Risks and Consequences

There are risks unique and specific to telemental health, including but not limited to, the following:

- At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct client to clinician contact.
- There is a possibility that therapy sessions could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
- There are potential risks and benefits associated with any form of behavioral health services, and that despite your efforts and efforts of your clinician, your condition may not improve, or may have the potential to get worse. While psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of behavioral health disorders and personal and relational issues, there is no guarantee that all treatment of all clients will be effective. While you may benefit from telemental health, results cannot be guaranteed or assured.

### Authorization

I have read and understand the information provided above. I understand that:

- I have the right to discuss any of this information with my clinician and to have any questions I may have regarding my behavioral health services answered to my satisfaction.
- I may withhold or withdraw my consent to telemental health at any time without affecting my right of future care or services.

I hereby consent to participating in psychotherapy via telemental health (i.e., telephone or the internet).

### Minor Client Signature

\_\_\_\_\_  
SIGNATURE OF CLIENT (if 13 yrs of age or older)

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

### Adult Client and/or Guardian Signature

\_\_\_\_\_  
SIGNATURE OF CLIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF CLIENT/LEGAL GUARDIAN

\_\_\_\_\_  
RELATIONSHIP TO CLIENT

(\_\_\_\_\_)\_\_\_\_\_  
PHONE NUMBER FOR CLIENT/GUARDIAN