1010 Harris Ave, Suite 202, Bellingham, WA 98225

Kellie Furlan, M.S.

Licensed Marriage and Family Therapist

**Formal Education and Training:**  I hold a Master’s Degree in Marriage and Family Therapy from Seattle Pacific University (2001).  I am a Licensed Marriage and Family Therapist in Washington State (MG 60584956), I completed an intensive in Narrative Therapy the fall of 2013 and again the fall of 2016 in Vancouver, BC at the Vancouver School of Narrative Therapy and I am increasing my knowledge and interest in somatic modalities, which address the nervous system distress that is often the result of prolonged stress and traumatic experiences. I work with Individuals Adults, Couples, Families and Teens ages 14+ toward the resolution of difficulties in relationships, anxiety, grief, trauma and premarital education. I do not specialize in treating personality disorders or have the resources required to properly support Clients who are actively suicidal.

**Philosophy and Approach:**  I am honored to accompany you at this juncture as you look to address things in your life that may have been concerning to you for quite some time.  In counseling I will be actively involved in working with you, providing information, guidance, and support.  I use a combination of approaches in treatment including Narrative, Cognitive Behavioral and Somatic awareness as informed by the Hakomi Method all applied through the lens of Family Systems and the importance of what Murray Bowen described as the “differentiation of the self” towards decreasing both internal and relationship distress. These approaches help to dis-entangle you from Problems that are leading to patterns of living that you want to leave behind while strengthening a positive sense of who you are and where you are headed.   You can expect us to explore relationship patterns, how to improve boundaries and how to undermine Problems while using everyday language.

Counseling can have risks *and* benefits. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness.  On the other hand, over time there is evidence that counseling can have many benefits to one’s own wellbeing and the wellbeing of one’s relationships.

Some Clients need only a few sessions to achieve their goals, while others may benefit from longer term counseling. It is difficult to provide a clear picture of a timeline for your treatment until after we meet a few times and we get a clearer picture of your needs and goals. This is something that you have a right to know and we will discuss it together.

All sessions will be conducted according to the Code of Ethics for Counselors and Therapists adopted by the State of Washington Department of Health and the American Association of Marriage and Family Therapists.  My code of ethics demands that our relationship remain professional therapeutic one, and never a personal one.  Furthermore, I am a clinician, and not an Expert Witness.  This means that I do not provide evaluations or opinions for the court of law related to mental health, custody, parenting fitness or otherwise.

It is important that you know that if you have a concern that some form of our work together has been unethical or unlawful, please express your concerns with me openly.  Otherwise, consumers who believe a health care provider acted unprofessionally are encouraged to call the Washington State Department of Health with my License # MG 60584956 at 360-236-4700, to report their complaint.

**Session Length and Fees:**  Sessions last between 55-60 minutes as we attempt to close our time together in graceful fashion.  Unless we have made other arrangements each individual and family counseling session is $150.00.  A discount of 30% at a rate of $105.00 is offered for private pay individuals and couples not utilizing insurance benefits regardless of income or household dependents and a Sliding Scale Application is not required.

A limited number of weekly sessions will be designated at a discounted rate for those clients qualifying for a discount of up to 50% of the private pay rate of $105.00.  Please do not hesitate to inquire regarding your qualification for a reduced fee based upon Bellingham Family Counseling’s sliding scale. All requests and supporting financial documentation will be handled with dignity and remain a confidential portion of your record  For consideration please request a copy or download from the website.

Client portion of payment is required at the time of service for in person sessions. Sessions rendered via telehealth require provision of credit card or HSA card to be charged as appropriate. If you pay by check, please be aware that in the normal course of business my bank may see your name and thus it could be argued that your confidentiality as a client may be compromised in this small way. If you are utilizing insurance, your insurer will also have access to your Protected Health Information.

**If you will be unable to attend a scheduled session, you will be charged 52.50, which is 50% of my out of pocket rate, for the missed session unless you provide 48  hours notice or your cancellation is the result of an emergency because I cannot bill insurance for missed sessions. If you would like to be provided with an autotext or voice reminder call of your appointment time two days prior to your appointment please initial here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please also be aware that if your insurance company denies payment, you will be responsible for the remaining charges incurred. If more than three sessions remain unpaid, future sessions will not be scheduled.

If you are experiencing thoughts of harming yourself or someone else at any point in our work together it is important that you are honest with me so that I can support you by developing a care and safety plan. In an emergency situation, before you are in danger of harming yourself or are a threat to the safety of others immediately contact 911 or the Whatcom County Crisis line at (360) 715-1563. You may also contact the national suicide prevention lifeline at (800) 273-8255

Completion of Treatment:  You have a right to terminate counseling at any time.  We will evaluate together whether you believe you have satisfactorily met your goals and I will offer any recommendations regarding additional support that I may believe would be helpful in a closing session.  If on the other hand it becomes apparent to me that your needs are beyond my scope of practice and therefore you would best be served with a referral to another professional for appropriate care, I will discuss this with you and support you to the best of my ability to locate an appropriate provider. If a formal closing session is not completed and I do not have contact or communication from you for a period of 6 months, I will assume you no longer intend to remain active in this therapeutic relationship, your course of therapy will be terminated. You are always welcome to reach out for support in obtaining resources or referrals to support your ongoing mental health or to inquire about reinstating treatment at a future date.

**Mandatory Reporting:**

I will make every reasonable effort to safeguard the personal information that you share with me.  However, the laws of this state mandate licensed counselors to report to governmental authorities’ specific actions or intentions.  Failure to do so may result in civil and/or criminal prosecution of the counselor.  Confidentiality will be broken in these specific situations:

Any known or reasonably suspected cases of ***child abuse or neglect.***

Any known or suspected ***intentions of harming yourself (suicide****).*

Any known or suspected ***intentions of harming others.***

When written ***consent is given by the client*** to release information.

If you file a complaint against me or your records are ***subpoenaed by a* *court of law or administrative agency.***

In an effort to provide you with the best ongoing care I may at times reach out for consultation with colleagues. This is considered best practice in the field of counseling and demonstrates my commitment to ‘thinking outside the box of my own head’ when necessary to support you on your journey. In these situations I commit to protecting your confidentiality by omitting any identifying information.

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| I acknowledge that counseling is provided *on the condition* that clients recognize this policy of confidentiality and agree that all licensed/certified or registered counselors will and are free to break confidentiality under any of these specific circumstances.   |

\_\_\_\_\_\_\_\_\_\_(Initials)

**Online Communication:**

Please understand that E-mail transmission and cell phone communication cannot be guaranteed to be secured or error-free. Information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses.  By signing below, you acknowledge that if you communicate with me via E-mail and or cell phone that I do not accept liability for any errors or omissions in the contents of the documents which arise as a result of e-mail transmission.  Secure telehealth videoconferencing and written communication are provided through my secure client portal.  Sign up is completed at JITUZU.COM after receiving my invitation to join.

By signing below, each of us confirms this disclosure document to represent the agreement between us. Also, you confirm receiving a copy and you confirm that you understand the information in this document.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Client1)**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Client2)**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Kellie Furlan, LMFT**

**NOTICE OF PRIVACY PRACTICES**

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.**

We collect and create personal information about you and your health. State and federal law protects your privacy by limiting how we may use and disclose such information. Protected health information (“PHI”) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

**Your Rights Regarding Your PHI.** The following are rights you have regarding PHI that we maintain about you:

**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in certain limited circumstances, to inspect and receive a copy of the PHI that we maintain. We may charge a reasonable, cost-based fee for the copying process. As to your PHI that we maintain in electronic form and format, you may request a copy to which you are otherwise entitled in that electronic form and format if it is readily producible, but if not, then in any readable form and format as we may agree upon (e.g., PDF). Your copy request may also include transmittal directions to a third party.

**Right to Amend.** If you feel the PHI we have about you is incorrect or incomplete, you may ask us in writing to amend the information, although we are not required to agree to the amendment. You may write a statement of disagreement if your request is denied. The statement will be maintained as part of your PHI and will be included with any disclosure.

**Right to an Accounting of Disclosures.** We are required to create and maintain a prescribed accounting of certain disclosures we may have made of your PHI. You have the right to request a copy of such an accounting.

**Right to Request Restrictions.** You have the right to request in writing a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are generally not required to agree to such a request.If we have been paid in full for all of the services covered by such a request, then we will honor a request to restrict disclosure to your insurance.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you in a certain way or at a certain location. We will accommodate reasonable requests and will not ask why you are making the request.

**Right to a Copy of this Notice.** You have the right to obtain a paper copy of this notice upon request.

**Right of Complaint.** You have the right to file a complaint in writing with us or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. ***We will not retaliate against you for filing a complaint.***

**Our Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations**

**Treatment**. We may use your PHI for the purpose of providing you with health care treatment, including management, coordination and continuity of your care with other of your current providers.

**Payment.** We may use your PHI in connection with billing statements we send you. We may use your PHI for the purpose of tracking charges and credits to your account. Unless you have requested and we have specifically agreed to restrict disclosure of your PHI to your health plan, we may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability as well as to submit claims for payment.

**Health Care Operations.**  We may use and disclose your PHI for the health care operations of our professional practice in support of the functions of treatment and payment. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist us in our delivery of your health care.

**Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object**

**Required by Law.** We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. We also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Health Oversight.** Wemay disclose your PHI to a health oversight agency for activities authorized by law, such as our professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to us, such as third-party payers.

**Threat to Health or Safety**. We may disclose your PHI when necessary to minimize an imminent danger to the health or safety of you or any other individual.

**Business Associates.** We may disclose your PHI to the extent minimally necessary to Business Associates that are contracted by us to perform health care operations or payment activities on our behalf, which may involve their collection, use, or disclosure of your PHI. To safeguard the privacy of your PHI, such contracts are regulated by the Department of Health and Human Services and must contain provisions designed to limit the use and re-disclosure of your PHI, to require compliance by the Business Associate with your individual rights, to subject the Business Associate to specified security obligations, and to require the Business Associate to require such obligations of a subcontractor.

**Compulsory Process.** We will disclose your PHI if a court issues an appropriate order. We will also disclose your PHI if (1) you and we have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) we have received satisfactory assurances that you received notice of your right to seek a protective order, and (4) the time for your doing so has elapsed.

**Uses and Disclosures Requiring Your Opportunity to Agree or Object**

**Prior Providers.** We may disclose your PHI to your prior health care providers, unless we have given you the opportunity to agree or object, and you have objected in writing.

**Close Personal Relationships.** In accordance with good professional practice, we may disclose your PHI to person(s) who are close to you that are involved with your care, unless we have given you the opportunity to agree or object, and you have objected. When you are not present or in situations of your incapacity or in an emergency, and where disclosure, in our clinical judgment would be in your best interests, we will disclose your PHI as minimally necessary.

**Disaster Relief Purposes.** In situations of your absence, incapacity or emergency and in accordance with good professional practice, we may disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, which are directly relevant to your identification and care.

**Uses and Disclosures of PHI with Your Written Authorization**

We will make other uses and disclosures of your PHI only with your written authorization. One example is our psychotherapy notes from our sessions (unless we are otherwise required by law). Unless we have taken a substantial action in reliance on the authorization such as providing you with health care services for which we must submit subsequent claim(s) for payment, you may revoke an authorization in writing at anytime.

**Certain Uses and Disclosures of PHI I do not make**

We do not engage in academic or commercial research involving patient PHI. We do not engage in marketing activities using patient PHI. We do not engage in the sale of patient PHI. We do no fundraising using patient PHI. We do not maintain directory information for public disclosure. We do not receive compensation for recommending any health care product or service.

**This Notice**

This Notice of Privacy Practices informs you how we may use and disclose your PHI and your rights regarding your PHI. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI related to you. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at anytime. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by providing you a copy upon your request or by providing you a copy at your next appointment.

**Complaints**

Our Privacy/Security Official is Kellie Furlan, MS. If you have any questions about this Notice of Privacy Practices or complaints about how your PHI has been utilized, please contact our Privacy/Security Official. The contact information for help is: (360) 325-1717.

We will not retaliate against you for filing a complaint.

You may also file a complaint with the Secretary of the Department of Health and Human Services:

**Office for Civil Rights**

U.S. Department of Health and Human Services

Customer Response Center: (800) 368-1019

Email: ocrmail@hhs.gov

Washington State Department of Health

<https://fortress.wa.gov/doh/opinio/s?s=ComplaintFormHPF>

**The effective date of this Notice is February 18,2022**

**ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES AND HEALTH CARE PROVIDER DISCLOSURE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have reviewed the following documents:

\_\_\_\_\_\_\_\_(initial) Notice of Privacy Practices

\_\_\_\_\_\_\_\_(Initial) Health Care Provider Disclosure Form.

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Signature of Client (or Parent or Legal Guardian) Date