Kimberle J. Ykema, MSW, LICSW
Kim Ykema Counseling PLLC
908 Georgiana Street
Port Angeles, WA 98362
360-504-3784 ext. 1

Printed Name of Client _____

Date of Birth _____ Last 4 digits SSN _____

Signatures

Consent for Treatment

I agree to treatment with Kimberle J. Ykema, MSW, LICSW. I certify I have been offered copies, read, and understand the following information:

1. Clinician Disclosure statement
2. Washington State codes for counselors and social workers
3. Fee schedule and payment policy
4. Cancellation policy
5. A list of unprofessional conduct and where to report unprofessional conduct.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

Telemental Health Informed Consent (if applicable)

I agree to participate in telemental health services with Kimberle J. Ykema, MSW, LICSW. I certify I have been offered a copy, read, and understand the Telemental Health Informed Consent form.

Email address for invitations and handouts: _____

Emergency contact if telehealth session ends due to crisis concerns:

_____

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

Professional Executor Informed Consent

I authorize my provider's Professional Executor, and any persons required by him or her to carry out the duties necessary upon my provider's incapacity or death, to access my health care records. I understand this authorization may not be required by law but that it is intended to facilitate my provider's Professional Executor in administering his or her duties.

It is my wish that I be notified of my service provider's incapacity or death by the following means:

_____

_____

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

Privacy Consent

I hereby acknowledge that I have been offered and been given an opportunity to read a copy of Kim Ykema Counseling PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Privacy Officer Kim Ykema.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

□ Client refuses to acknowledge receipt:

_____

Signature of Staff Member Date

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Authorization Contact by Telephone/Email in Event of Breach of PHI

I authorize Kim Ykema Counseling PLLC to provide notice to me by telephone or email in the event of a breach of my protected health information (PHI) by Kim Ykema Counseling PLLC. Such conversation shall be documented by Kim Ykema Counseling PLLC. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the telephonic or electronic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Kim Ykema Counseling PLCC.

Email address: _____

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

Electronic Communication Consent

I agree that Kim Ykema Counseling PLLC may communicate with me electronically unless and until I revoke this authorization by submitting notice to Kim Ykema Counseling PLLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described in the Clinician Disclosure.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

_____

***If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)**