Joshua@envisioncounseling.net | P: 206.858.1177 | envisioncounseling.net

Dear New Client,

Thank you for choosing Envision Counseling. This packet includes the information you will need to begin counseling services.

My ***Disclosure Statement*** describes: (a) how I conduct therapy; (b) my education and training; (c) billing and insurance policies; (d) fees for therapy services; (e) appointment scheduling guidelines; (f) your client rights and responsibilities; (g) my responsibilities as your therapist and a mandated reporter; (h) confidentiality in therapy; and (i) how therapy is initiated and terminated.

The ***Intake Form*** provides me your contact and billing information, and your reasons for seeking therapy. Also included in the ***Intake Form*** packet is my ***Professional Disclosure***, ***Washington State Clients Rights Statement,*** and ***Notice of Privacy Practices.*** Please read, sign, initial and date all the forms where indicated.

Feel free to contact me with any questions.

I look forward to meeting you.

Regards,
Joshua Horvath, MA, LMHC

PROFESSIONAL DISCLOSURE STATEMENT

Julie's Landing on Lake Union
2100 Westlake Ave N, Suite 201
Seattle, WA 98109

Canyon Park Business Center
22125 17th Ave SE, Bldg. F, Suite 101
Bothell, WA 98021

Cabrini Medical Towers
901 Boren Ave, Suite 1020
Seattle, WA 98104

Philosophy and Approach

I was drawn to the mental health profession for two reasons, my desire to help people, and my passion for psychology and understanding the human experience. My most effective work with clients comes from my ability to help someone gain new perspectives, and teaching coping skills for some of the most troubling inner experiences—such as our feelings of isolation, disconnectedness, abandonment, helplessness, and trauma. My therapeutic techniques are varied, and depending on the presenting challenge I will work from one or a combination of modalities, particularly: Existential, CBT, DBT, or a Mindfulness based approach. I believe in holding an unconditional positive regard, a not judging stance, towards all my clients, and I work towards being focused on solutions and my client's strengths. Sometimes in life we cannot solve all our challenges alone, and I consider it an honor to share the therapy experience with another person—as they grow and create a life they want to live.

Education

- M.A. Counseling Psychology Northwest University 2012
- B.A. Pastoral Ministries Northwest University 2004

Continuing Education:

- CBT + Certified through UW Medicine/Harborview

Experience

Much of my experience has been working within a diverse population dealing with issues of grief and loss, PTSD, existential crisis, developmental crisis, anxiety and depression. I am CBT+ certified counselor and have extra training in using DBT skills and motivational interviewing. I am a Child Mental Health Specialist and also have experience working as a Mental Health Evaluator at Seattle Children's Hospital. I have done extensive work dealing with parenting issues, parental education and providing family therapy between children and parents. I have also worked with clients who identify within the LGBTQ community working through issues surrounding gender identity and societal stigmatization.

Informed Consent

Counseling is understood to be a choice you have made among available options such as (a) other counselors; (b) other therapies; (c) support groups; (d) self-help resources; and (e) other modes of treatment. Counseling can have benefits and risks. Counseling sometimes involves discussing unpleasant aspects of your life, and you may experience uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has been shown to have many benefits. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of emotional distress. Some clients require only a few sessions to achieve their goals, while others benefit from long-term counseling. You have the right to terminate counseling at any time; however, it is understood that premature termination may result in the return or worsening of the initial problems and symptoms.

I encourage you to talk with me directly if you are dissatisfied with my services, want a second opinion or referral, or if you are intending to discontinue appointments. If I am not able to resolve your concerns, you have the right to file a complaint with the Department of Health.

_____, _____ (Initial and Date Here)

Confidentiality

I am providing you with a copy of my *Notice of Privacy Practices* which describes how I may use and disclose your health information. In this document I will highlight some of those disclosures: (1) to report suspected abuse of a child, of a developmentally disabled person, or of a dependent adult; (2) to interrupt potential suicidal behavior; (3) to intervene against threatened harm to another (which may include knowledge that a client is HIV positive but is unwilling to inform others with whom he/she is intimately involved); and (4) when required by court order or other compulsory process.

Confidentiality extends to all members involved in therapy. This means I will not release to any third party any information prior to obtaining a signed ***Release of Information*** from each member. Additionally, I am not bound by confidentiality in joint sessions with information I have obtained in individual sessions. Thus, I reserve the right to discuss in joint sessions the information you share in the individual sessions, if I believe doing so will facilitate the identified outcomes and goals of therapy.

Disclosures may also be made if (a) you sign a written authorization permitting disclosure; (b) you file a complaint against me; (c) you make payment by check, which permits bank employees to view names of my clients; (d) you have caller identification on your phone and my name appears on the monitor; and if (d) a contracted third-party agent contacts you by mail or phone to receive payment for a balance due that exceeds 90 days.

As a licensed mental health counselor, I engage in ongoing mutual consultation and peer review with other professional therapists. I consult with other therapists regarding my cases because I believe our collective knowledge may help me provide you the best counseling services possible. I do not disclose names or details that would allow identification of my clients during these processes.

Professional Boundaries

I refrain from entering into a dual relationship with any of my clients. This means the therapeutic relationship is a professional one, not a social or business relationship. Once a therapeutic relationship is established, any other relationship would potentially compromise the efficacy and the outcome plan for therapy. Therefore, I will not acknowledge the existence of a relationship with my clients outside of the therapy session.

Appointments Times and Fees

Daytime and evening appointments are available. The initial session requires 90 minutes, followed typically with 50-minute sessions once per week. You will be provided with the recommended course of therapy and number of required sessions at the conclusion of your first appointment.

My fee for an initial visit is $165 and $140 for subsequent visits. 24 hours' notice is required when rescheduling appointments to avoid a $100 charge. Missed appointments are also charged at $100. If you miss two consecutive sessions without prior notification, I will assume you no longer wish to obtain therapeutic services, and will mail you my notice of termination.

How Insurance Works

It is your responsibility to provide current and accurate insurance coverage information to ensure your insurance company properly processes your claims. Once received, the Envision client care coordinator will verify your insurance benefits and submit insurance claims on your behalf. If prior to your first appointment you have not authorized verification of your insurance eligibility, payment in full is required. Verification of your insurance determines your session payment amounts as follows:

_____,_ _____ (Initial and Date Here)

- If I am an out-of-network provider: You are responsible for the dollar amount remaining after subtracting the insurance estimated portion, plus any co-pays and deductible amounts.
- If I am an in-network provider: Your insurance reimburses me their contracted allowable amount, and you pay any co-payments and deductible amounts.

Your insurance company and I are required by law to protect your healthcare information (see the attached *Notice of Privacy Practice*) including systems and policies in place to insure your private information is protected. To this end, all insurance verification transferred electronically by Envision Counseling is encrypted. At a minimum I am required to provide to your insurance company a diagnosis. Your insurance company may require of me additional information i.e., your treatment plan, progress/session notes, or copies of your entire clinical record. In any case, I will submit to your insurance company the minimum information necessary to conduct business on your behalf, and only in so far as your release of information authorizes.

Scheduling Appointments and After-Hours Contact

Please call 206.858.1177 to schedule an appointment. I see clients on Wednesdays from 9:00AM to 5:00PM, and on Fridays from 9:00 AM to 6:00 PM. If you wish to speak to me between appointments, please leave a message at 206.858.1177**.** I check my voicemail regularly during normal business hours. If you are experiencing a clinical emergency, contact 911 or the Crisis Clinic at 206.461.3222.

I will do my best to keep all communications private. However, I cannot guarantee that the contents of electronic communication will remain confidential as email usage can be monitored and others may read the content of personal messages. If you are concerned about the content of your email being read by someone other than me, you should contact me by phone. While I check my email often during regular office hours, I may not receive your message immediately. Therefore, please do not send email you consider urgent and expect an immediate reply. I do not offer online therapy nor do I engage in communication via social media with clients or families of clients.

Vacations

I will give you reasonable notice before taking vacation leave. When I am unavailable, a colleague will be on call for emergencies. The name and phone number of this individual will be on my office phone. If you anticipate continuing treatment during this time, I will help you make arrangements with another therapist in advance. If you are experiencing an emergency and are unable to contact my on-call therapists, please contact 911 or King County Mental Health Services, 206.461.3222.

Record Keeping

I keep very brief records for each therapy session including:

1. Date of service;
2. Client's name;
3. Fee arrangement and record of payment;
4. Disclosure form, signed by the client and me;
5. Presenting problem(s), purpose or diagnosis;
6. Notation and results of formal consults, including information obtained from other persons or agencies through a release of information;
7. Progress notes sufficient to support responsible clinical practice for the type of theoretical orientation/therapy I use.

If you prefer that I keep no treatment records, you must submit a written request to that effect. Once received, I will place your request in your file and retain only the following records: Your name and signed disclosure statement, the session date and fee for service.

_____, _____ (Initial and Date Here)

Client Rights

As a client in therapy, you have specific rights in addition to the right of confidentiality. These rights include:

- The right to ask me questions about my qualifications and experience;
- The right to ask questions about any procedures I use in therapy with you;
- The right to refuse a particular treatment method or testing;
- The right to discuss your therapeutic progress and treatment goals;
- The right to refuse any psychological testing I recommend;
- The right to request referral to another therapist;
- The right to terminate or suspend therapy at any time without my permission or agreement;
- The right to file a complaint with the Washington State Department of Health if you believe I have behaved in an unprofessional or unethical manner and decide that a resolution to the problem cannot be reached.

Please see the attached Department of Health Brochure, *Counseling or Hypnotherapy Clients* for information regarding how to file a complaint. You also have specific rights pertaining to how I maintain personal information about you and your health (please review the Notice *of Privacy Practices).*

Terminating Treatment

My goal is to assist you in obtaining your desired therapeutic outcomes. If you have any questions or concerns about any aspect of your therapy, please discuss them with me. If you elect to terminate or suspend treatment, please discuss your decision with me so that we can bring sufficient closure to our work together. In our final session we can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge you have gained through your therapy. We can also discuss any referrals that you may require at that time.

Independent Group Practice

I conduct my counseling as an independent practitioner in a group practice. Given this, I share a common waiting room with other independent practitioners.

By signing below, each of us confirms this document to represent the agreement between us, and that you have read, understood and received copies of this disclosure along with a copy of *Notice of Privacy Practices* and the Department of Health Brochure, *Counseling or Hypnotherapy Clients*.

Client _____ Date _____

Client _____ Date _____

Therapist _____ Date _____

_____,_ _____ (Initial and Date Here)

NEW CLIENT INFORMATION

Name _____ DOB ___/___/____ Age _____

Preferred Phone _____ _ □CellPh □HmPh □WkPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? Yes No

Email _____May I use email to confirm appointments? Yes No

Employer _____ Type of Work _____

Relationship Status (required by insurance companies)

Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact _____Relationship_____Phone_____

Financial Responsibility—*If you will be using insurance benefits, please complete this section:*

Name of Insured _____

Preferred Phone _____ _ □CellPh □HmPh □WkPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier. I further authorize payment of insurance benefits for services rendered to Joshua Horvath MA, LMHC.

Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

Client _____ Date _____

Therapist _____ Date _____

_____, _____ (Initial and Date Here)

What prompted you to seek therapy?

_____

_____

_____

_____

Who is impacted by the issue?

_____

_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____

_____

_____

Have you had any prior counseling or psychiatric treatment? ____ No ___Yes If yes:

When? _____ Where? _____

Reason for and length of counseling_____

Check one: Therapy was ____ helpful ___ not helpful. Please explain:

_____

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:

_____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

_____

_____

_____,_ _____ (Initial and Date Here)

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse? __Yes __No
Have you ever felt like you should cut down on alcohol or other drug use? __Yes __No
Has a friend or relative ever discussed concerns about your drug use? __Yes __ No
Is there a history of problem with alcohol or drug use in your family? __Yes __ No

Have you received help for drug or alcohol dependency? ____ No ___Yes If yes:

1. When? _____ Where?_____

Check one: Treatment was ____ helpful ___ not helpful. Please explain:

_____

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____, _____ (Initial and Date Here)

NOTICE OF PRIVACY PRACTICES

Joshua Horvath MA, LMHC

Purpose: Recognizing the trust you place in me as your counselor, I am committed to protecting the privacy of your personal information[1]. I am also required by law to maintain this privacy, and to provide you with this detailed Notice of my legal responsibilities and privacy practices relating to your personal healthcare information. This is a legal document required by new federal regulations and therefore contains specific legal terms specified in federal law.

Record Keeping Practices: Standard practice requires me to keep an official record of your therapy process, including a general description of your emotional or psychological functioning, a diagnosis if required for insurance purposes, agreed-upon treatment goals, a list of symptoms, any medications, and some description of your progress throughout the time we work together.

Your Rights Relating to Your Personal Healthcare Information: You have specific legal rights relating to your personal healthcare information. First, I am required by law to maintain the privacy of your information and to provide you with this document describing my legal duties and privacy practices with respect to the information I maintain about you. You also have the following rights:

- To inspect and receive a copy of your personal healthcare information for as long as I maintain it. I am permitted to charge a reasonable, cost-based fee for copies. Only in certain limited circumstances may this right be restricted.
- To request that I amend your personal healthcare information if you believe that it is incorrect or incomplete. I am not required to agree to the amendment, but you have the right to file a statement of disagreement with me and I am allowed to prepare a rebuttal to your statement—all of which will go into your official record.
- To request restrictions on certain uses and disclosures of your healthcare information for purposes of treatment, payment or operations of my practice. You may also request that any part of your personal healthcare information not be disclosed to your family members or friends who may be involved in your care. Please be advised that I am not required to agree to such a request. If I believe it is in your best interest to make such disclosures, I will not honor your restriction request.
- To request confidential communications from me by alternative means or at an alternative address. I will accommodate reasonable requests and will not require an explanation of your request. I may condition an accommodation on your providing information as to how payment will be handled, and/or for an alternative address or other method of contact.

---

[1] This specific legal term refers to any information either I create (whether electronically or on paper) as a result of providing services to you, or receive about you that relates to your past, present, or future health, or payment for your healthcare, and that identifies you or which could conceivably be used to identify you.

- To receive a copy of the required accounting of disclosures that I make of your personal healthcare information. This accounting documents non-routine disclosures or those made for purposes other than treatment, payment or operations of my practice. It also excludes disclosures I may have made to you or disclosures made at your request and accompanied by a specific written authorization of disclosure.
- To file a written complaint with me and/or with the Secretary of Health & Human Services. I will not retaliate against you for filing such a complaint.

Sign_____

Date_____

_____, _____ (Initial and Date Here)

Uses and Disclosures of Your Healthcare Information

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully.

I may use your personal healthcare information for the purpose of providing you treatment. To coordinate and manage your care, I may disclose your information to others of your current providers, and to the extent you have not raised an objection in writing, to your prior providers, or to other persons (including family members), involved in your care.

I may use your personal healthcare information in connection with billing statements I send you and in my system for tracking charges and credits to your account. With your authorization, I may disclose your information to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and disclose your healthcare information for medical necessity and quality assurance reviews. I may use and disclose your personal healthcare information for the healthcare operations of my practice in support of the functions of treatment and/or payment. Such disclosures would include those for administrative, legal, or financial services to assist me in providing your healthcare treatment.

Other Uses and Disclosures that Do NOT Require Your Authorization or an Opportunity to Object: I may use or disclose your personal healthcare information 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. I must also make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

I may also disclose your personal healthcare information to a health oversight agency for activities authorized by law such as my professional licensure. Oversight agencies also include government agencies and organizations that audit the provision of financial reimbursement to me, such as third party payers. I may disclose your healthcare information when necessary to minimize an imminent danger to the health or safety of you or any other individual.

I may use your personal information to contact you to remind you of your appointments with me. I may disclose your personal healthcare information to Business Associates that are contracted by me to perform professional services on my behalf which may involve their collection, use or disclosure of your personal information. My contract with these entities requires them to safeguard the privacy of your information.

I may disclose your personal healthcare information if a court of competent jurisdiction issues an appropriate order. I will also disclose your personal healthcare information if:

1) You and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the personal healthcare information sought, and the date by which a

_____,_ _____ (Initial and Date Here)

protective order must

2) No qualified judicial or administrative protective order has been obtained;

3) I have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand;

4) Such time has elapsed.

Uses and Disclosures of Your Personal Healthcare Information Made With Your Authorization: I will make other uses and disclosures of your personal healthcare information only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claim(s) for payment.

Changes to this Notice of Privacy Practices: I am required to abide by the terms of this Notice of Privacy Practices, but I am also permitted to change the terms of this Notice at any time. Once a revision is in effect, it applies to all of your personal healthcare information that I maintain whether or not you are still in treatment with me. You may request a copy of my revised Notice of Privacy Practices at any of your appointments, ask that one be mailed to you by leaving me a message on my answering machine, or by accessing the current contact information.

I am my own Privacy Officer, so if you have any questions about this Notice of Privacy Practices, please contact me: Josh Horvath, 22125 17th Ave SE Bothell, WA 98021, 206.858.1177.

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing with me. I 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.

Sign_____ Date_____

_____, _____ (Initial and Date Here)

COUNSELING OR HYPNOTHERAPY CLIENTS

Client and Counselor Responsibilities and Rights

Counselors must provide disclosure information to each client in accordance with chapter 18.19 RCW prior to implementation of a treatment plan. The disclosure information must be specific to the type of counseling service offered; in language that can be easily understood by the client; and contain sufficient detail to enable the client to make an informed decision whether or not to accept treatment from the disclosing counselor.

If you have concerns about being dependent upon your counselor or hypnotherapist, talk to him or her about it. Remember, you are going to that person to seek assistance that helps you learn how to control your own life. You can and should ask questions if you don't fully understand what your counselor or hypnotherapist is doing or plans to do.

Requirement for Registration or Licensure

Your counselor or hypnotherapist must be either registered under chapter 18.19 RCW or certified under chapter 18.25 through the Washington State Department of Health unless otherwise exempt. To be registered, a person fills out an application and pays a fee. To become licensed, a person fills out an application form and pays a fee, but he or she must also show proof of appropriate education and training. There are some people who do not need to be either registered or certified because they are exempt from the law. You should ask your counselor or hypnotherapist if he or she is registered or licensed and discuss his or her qualifications to be your counselor or hypnotherapist.

Definitions

Counseling means using therapeutic techniques to help another person deal with mental, emotional and behavioral problems or to develop human awareness and potential. A registered or certified counselor is a person who gets paid for providing counseling services.

Confidentiality

Your counselor or hypnotherapist cannot disclose any information you've told them during a counseling session except as authorized by RCW 18.19.180:

1. With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary or an insurance policy on the person's life, health, or physical condition;
2. That a person registered or certified under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;
3. If the person is a minor, and the information acquired by the person registered or certified under this chapter indicates that the minor was the victim or subject of a crime, the person registered or certified may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
4. If the person waives the privilege by bringing charges against the person registered or certified under this chapter;
5. In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or
6. As required under chapter 26.44 RCW.

Assurance of Professional Conduct

Thousands of people in the counseling or hypnotherapy professions practice their skills with competence and treat their clients in a professional manner. If you and the counselor agree to the course of treatment and the counselor deviates from the agreed treatment, you have the right to question the change and to end the counseling if that seems appropriate to you.

We want you to know that there are acts that would be considered unprofessional conduct. If any of the

following situations occur during your course of treatment, you are encouraged to contact the Department of Health at the address or phone number in this publication to find out how to file a complaint against the offending counselor or hypnotherapist. The following situations are not identified to alarm you, but are identified so you can be an informed consumer of counseling or hypnotherapy services. The conduct, acts or conditions listed below give you a general idea of the kinds of behavior that could be considered a violation of law as defined in RCW 18. t130.180.

1. The commission of any ac involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilty of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purpose of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
2. Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
3. All advertising which is false, fraudulent or misleading;
4. Incompetence, negligence, or malpractice which results in injury to a patient, or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
5. Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
6. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
7. Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
8. Failure to cooperate with the disciplining authority by:
   (a) Not furnishing any papers or documents;
   (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
   (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceedings;
   (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
9. Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
10. Aiding or abetting an unlicensed person to practice when a license is required;
11. Violations of rules established by any health agency;
12. Practice beyond the scope of practice as defined by law or rule;
13. Misrepresentation or fraud in any aspect of the conduct of the business or profession;
14. Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
15. Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;
16. Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
17. Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended.

_____, _____ (Initial and Date Here)

Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

18. The procuring, or aiding or abetting in procuring, a criminal abortion;
19. The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means or procedure which the licensee refuses to divulge upon demand of the disciplining authority;
20. The willful betrayal of a practitioner-patient privilege as recognized by law;
21. Violation of chapter 19.68 RCW;
22. Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
23. Current misuse of:
    (a) Alcohol;
    (b) Controlled substances; or
    (c) Legend drugs
24. Abuse of a client or patient or sexual contact with a client or patient;
25. Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

This publication should not be considered as the final source of information. If you want more information about the law regulating counselors and hypnotherapists or want to file a complaint, please write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington 98405-7869.

If you want to contact someone by phone to discuss the law or talk about a possible complaint, call 360.236.4700, Monday through Friday, 8:00 a.m. to 5:00 p.m.

_____,_ _____ (Initial and Date Here)