Intake Form

Please fill out this form and bring it to your first session.

Please provide the following information and answer the questions below.
Please note: The information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle initial)

Address:
_____
(Street and number)

_____
(City) (State) (Zip code)

Birth Date: _____/_____/_____ Age: _____ Gender identification: _____
Sexual orientation: _____
Marital Status:

- ○ Never Married
- ○ Domestic Partnership
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Committed Relationship

Number of marriages: _____

Number of divorces: _____

How long have you been married/divorced/separated/in a relationship? _____

Please list any children/age:
_____

_____

With whom do the child(ren) reside?: _____

Where do the child(ren) reside?: _____

Home phone: ( ) _____-_____ May we leave a message?: ○ Yes ○ No

Work phone: ( ) _____-_____ May we leave a message?: ○ Yes ○ No

Email: _____ May we email you?: ○ Yes ○ No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Referred by (if any):_____

May we contact the referral source to say Thank You? ○ Yes ○ No

Emergency Contact_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
○ No
○ Yes. Previous therapist/practitioner: _____

From: _____ to _____ Location: _____

Are you currently taking any prescription medication?
○ Yes
○ No
Please List: _____

_____

Have you ever been prescribed any psychiatric medication?
○ Yes
○ No
Please list and provide dates: _____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

How would you ate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Are you currently experiencing chronic pain?
○ No
○ Yes
If yes, please describe:

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?
○ No
○ Yes
If yes, for approximately how long? _____

Have you *ever* had thoughts of harming yourself in any way (including self-injury and suicide)?
○ No
○ Yes
If yes, when was the *last* time you felt that way? _____

Have you *ever* had thoughts of harming others in any way?
○ No
○ Yes
If yes, when was the *last* time you felt that way? _____

Have you ever attempted suicide?
○ No
○ Yes
If yes, when and what method was used?

_____

_____

Have you ever self-injured?
○ No
○ Yes
If yes, when was the last time you self-harmed and what method was used?

_____

_____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

○ No
○ Yes
If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once per week? ○ No ○ Yes ○ Sometimes

How often do you engage in recreational drug use?

○ Daily ○ Weekly ○ Monthly ○ Occasionally ○ Never

How many caffeinated products do you consume daily? _____
Do you use tobacco? ○ No ○ Yes
If yes, how much do you smoke per week? _____
Has anyone ever asked you to stop/cut back on using any substance? ○ No ○ Yes
Have you ever had any legal issues related to drug use (including alcohol/marijuana)? ○ No ○ Yes
Have you ever felt guilty about using any substances? ○ No ○ Yes

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship (including self) in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List of Family Member(s)
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Bipolar Disorder	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts/Completion	yes/no	
Physical abuse	yes/no	
Sexual abuse	yes/no	

Further Information: _____

ADDITIONAL INFORMATION

Are you currently employed? ○ No ○ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself spiritual or religious? ○ No ○ Yes

If yes, describe your faith or belief: _____

Do you currently have any legal proceedings occurring? ○ No ○ Yes
If yes, please describe:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

Who are your primary supports (family/friends/community organizations)? How supportive are these people?

What are some of the ways you typically cope with or try to reduce stress in your life?

What would you like to accomplish out of your time in therapy?

Agreement Regarding Services, Fees, and Client's Rights and Responsibilities

Purpose of this agreement:

This agreement provides you the client with an outline of what you can expect from your provider and what we will expect of you as we work together. In order to provide the highest quality of care, we want to give you as much information as you need to answer all of your questions.

Our Mission:

To serve our patient and our community in a spirit of total caring, to provide quality service to each patient, to treat each patient with kindness, respect and consideration while presenting multiple paths to wellness, and to commit to relief of suffering, promoting wellness and restoring health. We believe that life is far more fulfilling when the mind and body are in balance and strive to create a space where that journey becomes possible.

We are a group of skilled Mental Health Professionals collaborating in an innovative way reaching multiple mental health diagnoses and issues. Each provider has their own unique interests and specialties, including but not limited to-- psychiatric evaluations, medication evaluation and management, acute and complex mental illness, adolescents, eating disorders, trauma, sexual abuse and domestic violence, chemical dependency and dual diagnosis, child life and developmental therapy, parenting assessments and coaching. Our goal is to partner with our clients in their journey towards improved mental health and symptom management. Therapy and medication can be helpful tools for your journey, but in no way will they be a quick fix. We ask for a shared commitment in this process, including regular and ongoing therapy until your therapist and you feel that you are better equipped to handle what brought you here initially. It may be painful, and it definitely won't be easy, so be prepared to put in some work and sit in some discomfort with us in this process.

Professional Standards and Ethics:

All of the providers at Counseling Services for Wellbeing are licensed by the State of Washington Department of Health (DOH) and have fulfilled all of the requirements required to provide your psychiatric and mental health services. You may search our individual credentials on the DOH website at www.doh.wa.gov, or call (800) 525-0127.

Appointments:

Psychotherapy: Most therapy appointments are scheduled for 53 minutes each. If you are late to your appointment the lost time will be part of your scheduled time, it will not be added to the end of your scheduled time.

Family Doctor Initial evaluation: New patients and initial intakes can take between 60 - 90 minutes. These appointments will be used to evaluate the health and needs of the individual patient. Our Medical Doctor will then determine the course of treatment based on the evaluation and findings. Subsequent appointment times can vary and will be based on the patients needs and presenting issues.

Medication Management and Psychiatric Evaluation: New Patients-- you will have two initial visits to establish a proper diagnosis and thorough evaluation. We generally do not prescribe medication on the first visit. The first appointment is 60 minutes, and subsequent appointments will likely be 30 - 60 minutes. These appointments will be used to evaluate, educate and determine a mental health diagnosis, as well as discuss side effects and efficacy of your prescribed medication. Our Medical Doctor and/or Psychiatric Nurse Practitioners will see you weekly until either your symptoms are alleviated or your condition is stabilized. You will then be seen either monthly or quarterly, depending on your health and stability of your condition.

Refills: You will be given refills for your prescriptions during your medication management appointments. If you cancel this appointment, but need a refill, you will be responsible to provide us with 7 days notice prior to you running out of your current prescription, and will need to be seen by your provider for further refills. If we notice a pattern of repeated cancellations and refill requests over the phone, this will be addressed, and a service charge of $50 for phone refill requests will be charged for each occurrence.

Cancellation Policy:

In order to provide you with optimal care, your appointment time is reserved specifically for you. Our providers do not double book. In return, we ask that you provide us with **48-hours notice if you are unable to make it to your appointment**. If you are unable to provide us with this 48-hour notice, you will incur a charge of $100 for therapy appointments, $100.00 for routine medical exams, and $200 for psychiatric medication management appointments--irrespective of the reason for the cancellation/no show.

Insurance does ***NOT*** cover this fee**.**

We will make every effort to provide you with adequate notice if your provider will be unavailable for a scheduled appointment and be more than happy to reschedule as needed.

Fees and Financial Responsibility:

Psychotherapy: Fees are set by the individual practitioner based on their qualifications, experience and degree.

There is a limited number of sliding scale session sessions available for those clients who qualify. The fee for service in these cases is based on a sliding scale that is determined by the client's ability to pay, and is set by individual providers.

Medical Doctor/Family Physician: We accept Premera/ Lifewise, Regence, Blue Cross Blue Shield, Group Health PPO, Medicare and First Choice Health Plans for these services, or out-of-network and private pay. A schedule of the private pay fees for these services is available through our front desk.

Psychiatric Nurse Practitioner Services: We accept Premera/ Lifewise, Regence, Blue Cross Blue Shield, Group Health, Medicare and First Choice Health Plans for these services, or out-of-network and private pay. A schedule of the private pay fees for these services is available through our front desk.

As of 2013 the visit types, visit lengths, reimbursement for psychiatric visits have changed nationwide.

If you see a non-prescribing therapist (i.e. social worker) the co-pay or coinsurance is usually the same for each visit. It is important to note that visits with medical specialists and psychiatric nurse practitioner are billed based on many factors including, but not limited to time, complexity, amount of therapy etc. *As a result, your copay/coinsurance and the length of the appointment CAN BE DIFFERENT for each visit.*

Since you cost-share with your insurance company, we do our best to estimate your portion at the time that you check in. Despite our best efforts, it is possible that once we get the claim back (usually 3-6 weeks after it is submitted), your cost-share may be higher than originally anticipated. We will notify you about any balance due with a monthly statement. If we overestimated the cost-share, the credit will be applied towards your future visits unless you specify otherwise.

Financial Responsibility and Insurance Billing Practices:

Payment in full is due at the time of each session including private pay amounts, copays, coinsurance and deductibles. You will be billed for any remaining balance. If an unpaid balance remains after 60 days, we will require a payment plan be initiated to continue to provide services. Unpaid balances that exceed 90 days will initiate a collection effort by our administrative team, and after 120 days will be sent to an outside collections agency for recovery and some identifying confidential information will be released in this process. This may negatively impact your credit.

We reserve the right to bill our standard fees for case coordination, clinical and legal write-ups, and phone consultations exceeding 5 minutes per week. Our time is valuable and is best served providing high quality therapy to you while

you are here in session. There is no charge for routine telephone calls to our administrative staff regarding scheduling, appointments, or billing.

Insurance:

We are currently accepting all forms of insurance** and can bill out-of-network if we are not covered by your plan. We will make every effort to match you with providers who are contracted with your insurance, but may ask that you see an out-of-network provider in special needs situations and on a case by case basis. Please provide full insurance information and your insurance card upon your initial visit to determine eligibility of benefits, and obtain authorization from your insurance provider when necessary prior to your first visit.

If your insurance plan requires pre-authorization for services, it is ultimately the responsibility of the client to obtain this authorization *prior* to being seen by your provider. If you fail to obtain authorization, any and all charges incurred and not reimbursed, will be your financial responsibility.

As noted previously, since you cost-share with your insurance company, we do our best to estimate your portion at the time that you check in. Despite our best efforts, it is possible that once we get the claim back (usually 3-6 weeks after it is submitted), your cost-share may be higher than originally anticipated. We will notify you about any balance due with a monthly statement. If we overestimated the cost-share, the credit will be applied towards your future visits unless you specify otherwise. At the start of the each new calendar year in January, with new insurance plans taking effect along with new deductibles to be met, we will be re-verifying benefits and collecting your full visit fee that will be applied to your deductible, at the time of service.

****** Premera/ Lifewise, Regence, Blue Cross Blue Shield, Group Health PPO, Medicare and First Choice Health Plans only for psychiatric mental health services with the Nurse Practitioners.

Confidentiality:

Information discussed during the course of therapy is confidential. By law, information concerning treatment may be released only with the written consent of the person treated (or the person's guardian if applicable). In the event where there is suspected child or elder abuse or an imminent danger of harm to one's self or others, the law requires the release of confidential information. In these instances we are required to make a report to the appropriate authorities. In addition, the courts may subpoena treatment records in certain circumstances. Any type of release of confidential information will be discussed with you.

We are compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights with regard to personal health care information. HIPAA requires that I provide you with a Notice of Privacy Practices. This Notice, which is attached to this agreement, explains HIPAA in detail and its application to your personal health care information.

We may ask you to allow an intern social worker to sit in on your sessions or participate in your care. Any use of your information for teaching purposes will not be transferred outside of our practice, and your PHI will be protected in accordance with our Privacy Practices as described below. You may opt out of this at any time.

Since maintaining confidentiality between family members may reduce the ability to work effectively on behalf of the clients, the practitioner requests that domestic or intimate partners and/or married persons or divorced parents (when working on issues related to their children), and members of the same nuclear family waive their right to confidentiality among themselves or among each other. This does not mean that the therapist will necessarily disclose to one or more family members what another family member(s) discussed in a counseling session. It does mean that the practitioner may do so, if they deem it necessary for the success of the work in progress. The client's(s') waiver(s) of the privilege of confidentiality in this regard is (are) thereby given by the signature(s) below.

The client's(s') waiver of the privilege of confidentiality as regards any release of information to a designated insurance company and/or to professional collection agencies and/or to other relevant professionals utilized by Counseling Servicers For Wellbeing, Inc. as consultants on any issue that may arise in conjunction with services provided to the clients(s) is (are) also give by the signature(s) below.

The client also acknowledges and accepts that other than the occasional use of designated questionnaires, the occasional notation, notes taken during therapy, and occasional email correspondence (see below), it is not the usual practice of Counseling Services For Wellbeing, Inc. to provide such notes to third parties.

Risks associated with the use of email, internet means of communication, telephone and texting.

I (we) understand and accept that confidentiality, otherwise provided by the practitioners of Counseling Services For Wellbeing, Inc., according to the terms above, may be at risk by using and/or our using email and/or Skype and/or texting and/or other internet means of communication and/or telephone for the transmission of information related to our healthcare and treatment. For instance, I (we) realize that unknown or third parties may electronically intercept our personal information. I (we), hereby, accept all such risks and authorize practitioners of Counseling Services For Wellbeing, Inc. to communicate electronically by using Skype and/or the telephone (text) and/or the email address(es) provided below as well as any email addresses provided by my (our) insurance carrier.

Age of Consent:

In accordance with RCW 71.34.530: Any minor thirteen years or older may request and receive outpatient mental health treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

Notice of Privacy Practices

01.1.1

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice of privacy practices is effective as of January 1st, 2016, and applies to:
Counseling Services For Health and Wellbeing, Inc.
15811 Ambaum Blvd SW
Suite 110
Burien, WA 98166

Privacy Contact: Deanna Hoyt, Director of Operations, phone: 206-242-8211

*We never market or sell personal information

Printed Name:_____

Agreement

I hereby authorize Counseling Services For Wellbeing, Inc. to render mental health services to me. I have read and understand this agreement and have received a copy for myself.

*I am aware of the **48-hour cancellation policy** and have discussed this with my provider:*

_____*client initials* _____*provider initials*

Signed: _____ *Signed*: _____

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

Responsible Party for minors under the age of 13:

Signature:_____ Date: _____

Printed Name: _____ Relationship: _____

HIPAA

I acknowledge that I have received the Notice of Privacy Practices explaining HIPAA.

Signed: _____ *Signed*: _____

Printed Name:_____ Printed Name:_____

Date: _____ Date: _____

Financial Responsibility

I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including: ***copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees****.*

If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature:_____Date:_____

Counseling Services for Wellbeing
15811 Ambaum Way SW,
Burien, WA 98166
(206) 242-8211
FAX (206) 242-0162

Provider name: _____

Client Name:_____ Diag. Code: (1)_____(2)_____

Address:_____Apt #:_____

City:_____**State**:_____**Zip**:_____

Client's Date of Birth: _____Age:_____ Gender: Male ☐ Female ☐

Home Phone: _(_____)_____**Cell Phone**:_(_____)_____

Email address: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Child ☐ Other:_____

Primary Insurance Co. Name:_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

Insurance ID#:_____**Group #**:_____

Subscriber's Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Co.Name:_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

Insurance ID#:_____**Group #**:_____

Subscriber's Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments. If it becomes necessary to effect collections of any amount owned, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature: _____**Date:**_____