La Perla Counseling and Trauma Response Services, Inc.
Steve Sandvik, MA, LMHC

1611-116th Ave N.E. Suite 215, Bellevue, WA, 98004
425-449-8171

Client Registration
(Please Print)

Name (including prefix):_____ Today's Date: __/__/____
Address: _____

_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____
Email:_____
Birthdate: __/__/____ Age:____ Marital Status: __Single __Married __Separated __Divorced
Spouse's name (if married): _____
Social Security Number: _____ Driver's License Number: _____
Emergency Contact:_____ Relationship to Client:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Client's Employer: _____
Occupation: _____ Date Hired: ____/__/____
Referred By (if applicable): _____

Person Responsible For Bill, If Not Client

Name (including prefix):_____ Today's Date: __/__/____
Relationship to client: __Spouse __Child __Dependent __Other:_____
Address: _____

_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

PLEASE NOTE: Claims submitted to Insurance are subject to individual plan provisions and are not a guarantee of payment. **The provider is not responsible for any unpaid claims; please check with your Insurance Company to receive full benefits*

PRIOR TO CLAIMS BEING PAID YOUR INSURANCE POLICY MAY REQUIRE ONE OR MORE OF THE FOLLOWING FROM YOU:

- **Obtain preauthorization prior to your first appointment**
- **See a contracted plan provider**
- **A written referral through your primary care physician**

Full fees charged for sessions cancelled with less than 48-hour notice.

By signing below I fully understand the above stated information, and I am responsible for my total fees at the time of service and I may seek insurance coverage with this provider on my own.

Signed: _____**Today's Date**: __/__/____

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Personal Data

Name: _____ Birthdate: ___/___/____ Age:_____
Parents' Names:_____
Siblings' Names:_____
Spouse (or Significant Other):_____
Children:_____
Support Person:_____
Hobbies/Interests:_____
_____
Losses:_____

Reason For Visit: (please circle) Addiction Depression Traumatic Event Co Dependency Life Changes
Other:_____
Are you involved in a 12-step program or Support Group of some kind? Yes No
What kind of Counseling do you prefer? (please circle) Traditional Christ Centered
Do you have a religious preference? _____
Place of Worship: _____

Current Medications (including dosage): _____
_____

Pertinent Medical History: _____
_____
_____

Do you use any of the following? If so, how often? (please circle)
Coffee: Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: _____
Tea: Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: _____
Alcohol: Yes No *Frequency: Daily Weekly Monthly Yearly Never*
Number of drinks at each sitting: _____
Marijuana: Yes No *Frequency:*_____ **Tobacco**: Yes No *Frequency:*_____
Other:_____

Person Referred By:_____

Goals for Treatment/Visit Today: _____
_____
_____

Why Now?_____

_____

Current or Past Treatment Information: _____

_____

_____

Have you ever received Psychological Counseling or Psychiatric Counseling before? Yes No

Counselor or Doctor's Name(s) and Place(s) of Practice: _____

_____

Please describe the main difficulty that has brought you to see me:_____

_____

_____

Indicate the severity of your problems on the scale below: (please circle)

Mild Moderate Severe Extremely Severe Incapacitating

Please indicate the major stressors in your life in the last twelve months: (please circle)

Serious Injury/Illness Death of a close friend or Relative Major Illness in Family

Divorce/Separation Job Change Gain of New Family Member

Other (please describe):_____

_____

Please describe what you would like to be different in our life when you are done with therapy: _____

_____

_____

Have you ever thought about suicide? Yes No

Have you ever attempted suicide? Yes No If Yes, when?_____

Have you ever had a traumatic brain injury? Yes No If Yes, when?_____

Have you ever been involved in an accident where your head was hit? Yes No

(For example: Diving into a pool, car accident where your head hits the windshield, falling off a horse)

If Yes, when?_____

Are you required by a court, the police, or a probation officer to have this appointment? Yes No

If yes, please explain:_____

_____

Is there anything else that is important for me, as your therapist, to know about that you have not written on any of these forms? If yes, please explain here or on another sheet of paper:_____

_____

_____

Client Signature:_____ **Date:**___/___/_____

Steve Sandvik, MA, LMHC

La Perla Counseling & Trauma Response Services, Inc.

Provider Credentials: LH 60443136 EIN#: 201049804 NPI#: 1023485968

Campus Office Park, 1611 116th Ave. N.E., STE 216 Bellevue, WA 98004

Cell phone/Voicemail/Scheduling of Appointments: (206) 669-3456

stevensandvikma@me.com

DISCLOSURE STATEMENT AND CLIENT CONTRACT

We are about to begin a counselor/client relationship that I believe will be a helpful, rewarding, and healing process. I also believe that choosing a mental health counselor or marriage and family therapist must be made from an attentive and conscientious course of action. I expect our first 1 – 3 sessions together will be a time to evaluate whether or not we will be able to work effectively together. However, before we do, we should have a mutual understanding of what each of us should expect from our session.

The State of Washington requires specific information be provided to you regarding services rendered by a mental healthcare provider. The purpose of this STATEMENT OF DISCLOSURE (RCW 18.19.060) is to inform you of your rights, responsibilities, and the provisions of state law. The STATEMENT OF DISCLOSURE is also designed to share with you my background, philosophy of treatment, and expectations.

You should read it carefully to make certain you understand what I am saying and to be sure our philosophies fit. If you do not believe I am the appropriate counselor for you, either after reading this document or at any time during treatment, you are free to terminate our professional relationship and seek counseling from someone else.

Education and Training

At Antioch University Seattle, I completed the graduate school coursework in The Center for Programs in Psychology in the Child, Couple, and Family Therapy (CCFT) combined with Mental Health Counseling (MHC) Program. By design, both the CCFT and MHC programs are grounded in a curriculum that is intended to provide the basic competencies needed for effective clinical practice. The focus of the Combined Program prepared me for the practice of child, couple, and family therapy and mental health counseling and to meet Washington State licensure requirements.

I am capable to offer you "mental health counseling" as defined under RCW 18.225.010. I have the provider credential "Mental Health Counselor License" (LMHC) after the successful completion of the supervised experience requirement under RCW 18.225.090; I was officially with two certified supervisors, Robert Hossack, PhD, and Rob Baker, MA, LMHC, LMFT and CSAT-S in a process to maximize my licensed mental health counselor opportunity in Washington State. The licensure hours for Washington are complete; and the National Clinical Mental Health Counselor Examination (NCMHCE) for Washington is passed. I have received comprehensive trainings in problematic sexual behavior. I have also completed work (Mod 1) toward Patrick Carnes' certified sex addiction therapist (CSAT) candidate certification. I have received comprehensive client trainings and in vivo hours leading group counseling.

In fall 2006, I exclusively advanced in a graduate student MHC Internship. MHC students at Antioch University Seattle must complete their internships during a minimum 600 on-site hours. At least 300 of the internship hours must involve direct face-to-face client contact. I have concluded therapy with clients directly related to my MHC Internship at CoHear, and engaged for more than the required 600/300 internship hours leading to a Master's Degree in Psychology. I also gained additional group experience and internship hours as a co-therapist under Myrna Pinedo, PhD, treating sex offenders under court order residing in the community as a graduate student.

Leading up to my MHC Internship and to help me learn a range of counseling business perspectives and practices, I was independently contracted with CoHear as an office staff member; I provided contract therapy services in my role as a LMHCA ("Mental Health Counselor Associate License" provider credential) for CoHear from 2007-2012.

I was also an employee for the Washington State's Department of Corrections (DOC). Within the DOC, I had the provider credential "Counselor Agency Affiliated Registration" who treated incarcerated sex offenders (June 2008 – April 2012).

Therapeutic Orientation

I believe it is essential to establish a safe space to look at one's presenting problems. I also believe the past experiences of a client strongly influence whom they become later in life, and affect patterns of thought, emotions, and behavior. I focus not only on the whole person (biological, cognitive, emotional, and social/spiritual components of health), but also on their family system. Furthermore, I carefully think and listen by way of a broadminded perspective, and notice one's personal choice, opinion, conformity, and belief concerning their life or family.

Individuals seek mental health counseling or marriage and family therapy for many reasons and with a variety of expectations and/or fears. One of the first things we will do together is to explore your reasons for being here, and what you hope to accomplish. The evaluation of your goals will be an ongoing process that we will return to throughout our time together.

I practice a wide-ranging therapeutic orientation with clients and use methods and interventions that are mostly based in Attachment-Focused EMDR (Eye Movement Desensitization Reprocessing), Cognitive-Behavioral, Humanistic, Group, and Solution-focused brief therapies. These theoretical perspectives are more *intrapersonal and individual-oriented.*

I also work in Family Systems oriented theory. Family therapy uses methods and interventions from theoretical perspectives that are more *interpersonal and system-oriented.* In this sense, I will concentrate more on your relational, social, and cultural experiences of your family while taking into account the context of your inner world.

Predominately, I am paying attention to various clinical issues where the client and/or family suffer from behavior in an *addiction cycle, a sexual compulsivity, and risk-taking behaviors* (e.g. pornography, prostitution, drug and alcohol use/abuse); *women* and *men's issues* (i.e. restoring couples intimacy and trust, dating, career, fatherliness); *codependence*; *family dynamics* (i.e. origin, the past) and *trauma resolution and healing.*

In order for you to gain the most from our sessions together, I would like to comment on three areas of concern.

First, I would like to comment on my role as a counselor.

I will provide counseling treatment to an individual, couples, and the family. When you request treatment for yourself or for person for whom you are responsible, be assured that I shall do my best to perform all services in a professional manner. You should expect from me the best and most thoughtful counseling I can offer. You should expect me to be open and honest with you and to respect your confidentiality. I will work with you to the best of my abilities consistent with my philosophy of treatment to give you the guidance and counseling you and your family require.

I shall endeavor to explain the nature of the treatment I recommend for you and the length and course of treatment as well as other options that may be available to you in treating the kinds of issues or problems discussed. In this view, it is always appropriate, and I encourage you, to raise questions about the nature and course of your treatment. You also have a right to request a review of your records.

As a counselor, I would like you to know that my perspective is influenced by Christian spiritual principles. I will endeavor to simultaneously honor the sacredness of each client's chosen spiritual orientation and welcome a diversity of clients. I will work to the best of my abilities to provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

Second, I would like to comment on your role and responsibility as the client.

Our relationship will be a joint undertaking (i.e. firstly rapport-building, leading to a therapeutic alliance) where we will work together to solve the problems you are experiencing and with a goal of healing you and your family's wounds. The course of treatment will be openly discussed with you and/or with your family at whatever time is necessary and appropriate. You should remember that our relationship is entirely voluntary, and that you have the absolute right to end it at any time you wish and for whatever reasons you desire.

I, too, may end our relationship if I believe it is not producing productive results. Therefore, if we are to work together, we must clearly understand what we should expect from each other. For your part, I expect you to be open and honest with me, to show up for your appointments on time, and to meet your financial obligations pertaining to the counselor/client relationship. Any veiled threats of acting out violence or violent outbursts in the office by you will result in immediate termination of therapy and a referral to another counselor.

There are no guarantees that the results of therapy will conform to your every expectation. I promise no particular outcome from treatment. In fact, effective therapy every now and then confuses, and is from time to time emotionally painful. Effective treatment depends to a significant degree on your openness, your commitment to change, collaboration, and a therapeutic alliance in place.

Third, I would like to comment on my standards about confidential information.

In order for me to counsel you effectively, I believe we must be as open and honest as possible with each other. I will preserve private or confidential information you disclose to me as long as this privacy is legal and ethical. I will share no information that could be personally identifying to anyone (including your name) unless I have written permission to do so from you.

Standard #1: If you are seeking counseling with your entire family. If you are seeking counseling with your entire family I will share with all family members what you share with me. I believe in the free flow of information within families to facilitate the breaking of barriers and stimulate the healing process better if I a free to discuss all family matter with all family members. If, on the other hand, you are seeking counseling as an individual, I will not share the fact you are seeking counseling from me, or anything that is said in our sessions with anyone else without your prior written permission.

Standard #2: If the law or ethical rules require me to release information. There are certain circumstances when the law or the ethical rules that apply to counselors require me to release information I have learned during our sessions without your written permission to do so. Clients are to informed of the extent of confidentiality provided by chapter 18.19.180 RCW. The exceptions are:

(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 of an insurance policy on the person's life, health, or physical condition;
(2) That a person registered under this chapter is not required to treat as confidential a communications 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 under this chapter indicates that the minor was the victim or subject of a crime, the person registered 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 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) If I learn a child is being subject to abuse or neglect. I am also required to report such incidents to authorities. "Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child by any person under circumstances that indicate that the child's health, welfare, and safety is harmed, as required under chapter 26.44 RCW. I am also required to report such incidents to authorities if I learn an adult dependent or developmentally disabled person has suffered abuse or neglect.

I may release information I have learned during our sessions without your written permission when:

(1) An involuntary commitment for mental health assessment seems necessary.
(2) You are unable to pay my fees on time or in full, hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. I have the option of using legal means to secure payment.

Duty to Warn or Report

Washington State Law requires counselors to report instances of abuse and we may be required to report harmful, dangerous or criminal action intended against oneself or another human being. In these cases, it is the counselor's legal duty to warn specific individuals of such intentions. For example:

(1) A family member of the client who is likely to suffer grave personal harm.
(2) A family member of the client who intends to harm oneself or others.
(3) Law enforcement officials, hospitals, or child protective services (CPS).

I will first take steps to share that intention with you, if you are the client, before informing anyone and/or making a report to anyone who may need to be warned.

No child under the age of twelve (12) can be left unattended in the waiting area due to the need for child protection and safety. If you have a child under this age, appropriate childcare must be provided for them while you are occupied in a counseling session with me.

Adolescents in the State of Washington who are age thirteen (13) or older may have specific rights to confidentiality with their counselor. Parents who request treatment for an adolescent for whom they are responsible please notice and be knowledgeable of your adolescent's legal rights to confidentiality. Please feel free to direct your questions or concerns regarding these specific teenage rights to confidentiality to me.

Disclosure or Release of Information

If you are a minor (under 18-years old) and the victim of a crime, I may be required by law to testify at an inquiry concerning that crime. Also some of the information you give me may be discussed with your parent or guardian.

Under certain circumstances, which you are a minor or an adult, information that you reveal may be subpoenaed. A court of law would determine any information that would be revealed. If you choose certain information to be disclosed or released to a third party (e.g. another counselor, physician, social worker), you will need to sign a written consent for me to disclose or release it.

Client Consultations

There are times when I may determine it is your best interest for me to seek consultation about your case from other professionals in my field or in other physical or mental health areas. If I do, I will always do so without identifying you. This way, I can seek the best course of treatment for you while maintaining confidentiality in our therapeutic

relationship. Your case may be discussed with a certified mental health professional, a physician, or a licensed supervisory consultant whose services have been contracted solely for professional consultation.

The following licensed healthcare practitioners provide me consultation for the counseling work I do:

Brian L. Whitney, MA, LMHC, LMFT

Rob Baker, MA, LMHC, LMFT, CSAT-S

Sonja Rudie, MA, LMHC, EMDR-S, CSAT

Information Practices

Healthcare providers are required to provide you with the following information:

> Records of services provided to you are safely kept and you may ask for a copy of that record. Also, you may ask for the records to be corrected. You may see your record or get more information about it from me. The record will not be disclosed to others unless you direct me to do so, or unless the law authorizes and compels me to do so. Your records will be kept for seven (7) years. After seven years, they may be destroyed through a disposal service that maintains a confidentiality practice.

Scheduling & Statement of Treatment

All appointments are scheduled by me and are occasionally offered during off peak business hours (e.g. after 7:00 pm).

Please call (206) 669-3456 to leave a confidential message or schedule an appointment M – F.

Office hours are Monday, Tuesday, Thursday, and Friday (7:00 a.m. – 7:00 p.m.) and Wednesday (7:00 a.m. – 12 p.m.).

I may make return calls during/after these normal business hours. In the event of an emergency, when I am not available to speak with you, my cell phone is answered by voicemail and monitored frequently during office hours

If you cannot wait for me to return your call,

(1) Contact your family physician or the nearest emergency medical center
(2) Contact the Crisis Line at (206) 461-3222
(3) Dial 911

The duration of therapy will be based upon a treatment schedule designed by the client and me that will address his or her needs.

Group therapy is provided by verbal contract for a minimum 12-week commitment and this signed DISCLOSURE STATEMENT acknowledges a 12-week financial commitment in spite of your attendance.

Fees

Intake, Standard, and Group Fees

Our initial counseling session is called an *intake.* An intake is a significant session to obtain past and present information from you; so your first session will take 60 minutes.

The one-time fee for an *initial intake* counseling session is $165 (REV: 1/7/2016)

If you require a longer initial session to meet your needs, please talk about it with me; and you can make a second appointment or extend this *intake* session.

A following *standard* counseling session is $140 and will take 50 minutes in my office (REV: 1/7/2016).

If you prefer more standard session time, it can be prearranged ahead of a scheduled appointment. I apply the remaining 10 minutes of a scheduled counseling session for your case management, phone calls, file updates, progress notes, treatment planning, and obtaining suitable releases of information.

A weekly *group* counseling session is $50.

If you are unable to pay my fees on time or in full, and arrangement for payment have not been agreed upon, after 60 days I have the option of using legal means to secure the payment.

If the arrangements have not been made, I may need to discontinue our relationship if you fail to pay for services rendered by me.

Cell phone Conversations/Email Correspondence

There is a fee for cell phone discussion that lasts 15 minutes or longer. The dialogue will be prorated at my *standard* fee ($140) during regular business hours. For example, if we consult on the telephone for 20 minutes, the fee for this discussion is $56 (i.e. $140/50 min. x 20 minutes).

Telephone discussion that you initiate outside regular business hours will be considered emergency hours.

The fee for emergency dialogue will be prorated at my *initial* fee ($165).

Confidentiality cannot be protected via Internet for counseling services. However, the Internet may be used to answer a request for information or questions you may have.

Additional Services

File and case reviews ($200/hr)

Report writing ($200/hr)

Transportation to Court ($200/hr)

Waiting for Court to testify ($300/hr)

Court testimony or deposition ($400/hr)

Parking reimbursement (100% of parking cost)

Payment and Insurance

Clients or their responsible guardian are responsible in full for their accounts.

Payment in full is due at the time services are rendered. Important therapy time is protected if your check is completed prior to the beginning of you counseling session. I also accept cash, credit cards and money orders as a method of payment.

Counselors practicing counseling for a fee must be credentialed with the department of health for the protection of the public health and safety.

Again, my provider credential is the "Mental Health Counselor License" from the Washington State Department of Health. I am credentialed to diagnose mental disorders or to conduct psychotherapy as defined in WAC 246-810-010 (14). I am able to screen a client's level of functional impairment as described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

It is not my best practice for me to "bill" your insurance coverage at this time. I will provide you a receipt with a CPT & DX Code (when appropriate) for services rendered to you by me; it is up to you to submit receipts to your insurance provider to cover (or not) any monetary reimbursements for services rendered.

Missed Appointments/Improper Cancellation/Collections

All scheduled appointments are charged; and a 2-day notice is required to cancel a scheduled appointment with me. If you have an emergency, you may call to inquire about the availability of a change. Your call will be returned as soon as an available opening occurs, or to inform you that there is no opening.

The client's cost per counseling session will be charged for a scheduled appointment that is missed, or where notification is not received two (2) days in advance of the recognized appointment. Let's work together to make certain it doesn't happen to you. You are responsible for last-minute sick calls (i.e. less than a 2-day notice to cancel a scheduled appointment) will render at half-rate (50%) as a consideration to you. Group meetings are the exception. All group meetings are held within a 12-week "Session" schedule (and can be less or more), and your seat is held by your verbal and monetary commitment during a group's weekly schedule.

Furthermore, dropped cell phone calls or missed messages due to cell phone practice are not the responsibility of this counselor. Please consider using a landline for doubtful contact or else you will be responsible for the appropriate fee if I have not received timely conversation in/or a message from you.

I do, a times, accept advance payments (i.e. outside the time services are rendered) for individual, family or group counseling sessions. There are times when this practice is unavoidable (e.g. correct change for the fee for service rendered is unavailable in my office).

Refunds will be a collaborative responsibility between the client and/or family and me.

Termination of Treatment

The following language must appear on every client's DISCLOSURE STATEMENT:

> "Credentialing of an individual with the department of health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment."

I am required to inform clients about the purpose of the Counselor Credentialing Act chapter 18.19 RCW is to:

(A) Provide protection for public health and safety, and
(B) Empower the citizens of the state of Washington by providing a complaint process by those counselors who would commit acts of unprofessional conduct.

Concerns about your counselor may be made to:

Washington State Department of Health

Health Professions Quality Assurance

P.O. Box 47860

Tumwater, WA 98504-7865

An Internet hyperlink of the acts of unprofessional conduct in RCW 18.130.180 is provided to you in this disclosure in this DISCLOSURE STATEMENT.

Your signature below indicates you have been given a copy of the required disclosure information

Your signature also indicates that you read the information provided and understand and accept the general conditions described in this document; and your signature also indicates that you received and understand the department of health's education and assistance brochure, *Counseling or Hypnotherapy Clients*.

Furthermore, your signature below indicates you have received a copy of the following:

(1) Disclosure Statement (this document)
(2) Statement of Treatment (included in this disclosure)
(3) Limits of Confidentiality (included in this disclosure)
(4) Financial Requirements (included in this disclosure)
(5) Washington State brochure titled, *Counseling of Hypnotherapy Clients* (I do not offer Hypnotherapy)
(6) Authorization of Healthcare Release
(7) Accounting Disclosures

Signature of client/guardian: _____ Date: _____

Steven E. Sandvik, Therapist: _____ Date: _____

My signature indicates the accuracy of the information and my declaration to uphold my responsibilities described in this document.

I am a *Mental Health Counselor* (WA Dept. of Health Provider Credential: LH 60443136), Steve Sandvik, MA, LMHC. I remain a division in the business and legal entity of La Perla Counseling & Trauma Response Services, Inc. If my name appears in context with other practitioners or professionals it is not intended to specify or imply any mutual liability.

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Therapy Contract/Informed Consent

Client: _____ Date: _____

Home Phone: _____ Work/Cell Phone: _____

Date First Seen: _____ Referred By: _____

Check this area if you do not wish to have progress notes kept on your case:____

Steve Sandvik, MA, LMHC, has agreed to provide an outpatient treatment in the following manner:

Frequency:	**Fee**
Individual therapy:	**$**
Conjoint/Family therapy:	**$**
Group therapy:	**$**
Estimated Length of Treatment:	
Goal of Treatment:	
Travel time:	**same as hourly fee door to door**

I have read the treatment plan indicated above. This treatment plan reflects Mr. Sandvik's professional opinion and my stated personal preference. I understand this treatment plan can be modified by me, in consultation with Mr. Sandvik, at a later date. I understand that Mr. Sandvik is a Licensed Mental Health counselor and that Mr. Sandvik's fee is $140 for a 45 minute session and $165 for a 60 minute session. I understand Mr. Sandvik consults with a professional case consultation group where my case may be discussed from time to time to ensure the best application of treatment planning is made available for my care.

Please ask for clarification in you are unsure how the work we are doing pertains to your reason for seeking therapy. This meets the disclosure requirements as set by the Health Department for the State of Washington.

Client: _____ **Date:** _____

Therapist: _____ **Date:** _____

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Communication Agreement

Name: _____ Birthdate: ___/___/_____

Your Healthcare Provider may need to contact you to discuss your health, review results of testing, or to coordinate your care. Please review and answer the questions below outlining your preferences regarding this communication. *Additional phone numbers can be listed below.*

1. May we leave messages regarding your health information on your answering machine or voicemail at home?
   _____NO ____YES ____N/A

2. May we discuss your medical care with anyone that answers the telephone at your home?
   _____NO ____YES ____N/A

3. May we leave messages regarding your health information on your answering machine or voicemail at work?
   _____NO ____YES ____N/A

4. May we leave messages regarding your health information on your cell phone voicemail?
   _____NO ____YES ____N/A

5. Are there members of your family, household, or those coming with you to this appointment with which we should not discuss any of your health care issues?
   _____NO ____YES ____N/A

   If yes, please explain:_____
   _____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be canceled or modified. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship

Home Phone:_____ Cell Phone: _____ Work Phone: _____

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Insurance Benefits

Most Health insurance companies now include some form of mental health care coverage. If you have mental health insurance, there are certain issues I believe are important for you to consider.

Medical Necessity

Most people with health insurance assume they can just use their mental health benefits on the basis of their desire to participate in counseling or psychotherapy, or with a letter of referral from their doctor. The reality is that insurance companies require that mental health care treatment be considered "medically necessary". To be considered medically necessary, the treatment must address a mental disorder. Counseling or psychotherapy intended solely for self-improvement or normal life stress reactions is not considered medically necessary by insurance companies, and therefore, not covered by insurance mental health benefits.

A Mental Health Diagnosis

Medical necessity can be established when an individual describes certain psychiatric symptoms and/or behavior that affects their ability to function on the job, school, or relationships. For example, someone might begin therapy because they are feeling depressed and are having trouble feeling motivated to complete tasks, visit with friends, and/or are having trouble sleeping.

When someone begins therapy and describes such symptoms, their insurance company requires that the therapist assign them a mental health diagnosis. You should know that all diagnoses have certain actuarial ramifications, as do smoking, age, weight, sex, and other past medical conditions. You should also realize that if you are ever asked whether you have been treated for a psychiatric problem you will have to answer "yes" because your permanent medical records will contain this information.

Confidentiality and Privacy

When you submit a claim to your insurance company for reimbursements for treatment, you are required to sign a release form in which you are giving your insurance company the right to ask for whatever documentation and information it deems necessary to determine the legitimacy of the claim.

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425-449-8171 | Office@laperlacounseling.com

Authorization for Use and Disclosure of Protected Health Information

For Purposes Requested by ☐ Provider or ☐ Patient

Name of Client:_____ **Date:**_____

Name of Provider/Recipient of Information: _____

Address: _____

_____

Phone:_____ Fax:_____ Email:_____

Age:_____ D.O.B: _____ Attorney: _____

Check one: ☐ Insurance ☐ Other:_____ Deliver copies by: ☐ Mail ☐ Phone ☐ In Person

For the following purposes:_____

_____

Types of Information to be Disclosed:

☐ Entire Medical Record ☐ Office Chart Notes ☐ Discharge Summary ☐ All Hospital Records
☐ Emergency and Urgent Care Records ☐ Medical Records for Continuity of Care ☐ Police Reports
☐ Substance Abuse Treatment Reports ☐ Teacher Reports ☐ Guardian Ad Lietem Reports

Extent of Information: I am aware that these records may contain information concerning the testing, diagnosis, and treatment for HIV/AIDS, other sexually transmitted diseases, and/or substance abuse services governed by 43 CFR Part 2, and/or mental health services governed by RCW 71.

Revocation: It is my understanding that this authorization can be revoked at any time, except to the extent that use and/or disclosure made in good faith may have already occurred in reliance on this authorization.
Revocation Date:_____ *Re-disclosure Date*:_____

Expiration:
If not previously revoked, this authorization will expire 180 days from the date of signing or (date):
(*Specific limitation:* Except as to third-party payers, this authorization does not include disclosure for health care services received more than ninety (90) days from the date of last signature.)

Signature:
My signature below authorizes use and/or disclosure of protected information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment, or eligibility for benefits.

Initial Signature:_____ **Date:**_____
Printed Name of Patient's Representative (If applicable):_____
Witness:_____ **Date:**_____

Renewal Signature:_____ **Date:**_____
Printed Name of Patient's Representative (If applicable):_____

☐ **Sonja Rudie, MA, LMHC, CSAT, C-EMDR** ☐ **Danielle Melton, MA, LMHC, NCC**
☐ **Kristine Zimmerman, LMHC, CSAT, CMAT** ☐ **Blair Schmautz, MA, LMHC, CSAT**
☐ **Kerry Fitzgibbons, MA, LMFT, CEAP**