Client Intake Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Is it ok to leave a detailed voicemail message on these phone numbers? _____ by text message? _____

Email: _____

Do you give your permission to be contacted by email, including for billing purposes? _____

SSN : _____

Birth Date: _____ Marital Status: _____

Spouse/Partner: _____

How did you hear about us? _____ Do we have permission to thank them for their referral? _____

Reason for Seeking Counseling

Family member about whom you have concern (IP): _____ Relationship to you: _____

IP's age: _____ Does this person live with you? _____

Primary drug of use: _____ Are they in treatment? _____

Other concerns: _____ Are you currently in counseling? _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

This information is given in compliance with the Washington State Licensing requirement, according to RCW 18.19.225.

DISCLOSURE FORM

The following information is provided to establish a clear understanding of the professional and business aspects of our relationship. You have the right and responsibility to choose a provider and treatment modality that will best suit your needs. Please read this information carefully and feel free to ask about anything that is unclear to you, to ask for additional information, or share any concerns about anything in this disclosure.

THERAPY PRACTICE

About Lara Okoloko:
I am a Washington Licensed Independent Clinical Social Worker Associate, SC60108119. My education includes a Master's degree from the University of Washington, School of Social Work (2005). My experience includes working in agency and medical settings providing social work services and individual and family counseling. My work has included working with troubled youth, people with substance use disorders, pregnant and parenting mothers, adult individuals and parenting families.

Psychotherapy has benefits and risks. Risks may include: experiencing unpleasant emotions, failure to relieve emotional distress, and the possibility of changed relationships. Benefits may include: a significant reduction of distress, better relationships, and the resolution of specific problems. There are numerous other forms of psychotherapy based on different theories and techniques as well as medications which may also relieve emotional distress. Sometimes talking about negative emotions and situations can temporarily make you feel worse. Please keep me informed about your feelings and your symptoms. All psychotherapy requires collaboration between the patient and the therapist to effect change.

Clinical practice at Center for Advanced Recovery Solutions (CARES) provides psychotherapy (talk therapy) and skills based group therapy. Therapy at CARES uses approaches based in Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Community Reinforcement and Family Therapy (CRAFT). The length and type of treatment (individual, family or group counseling) is determined by the specific nature of the problem a patient is facing and the wishes of the patient.

You have the right to ask questions about your therapist's experience and philosophy of therapy. If you believe that you are not being helped, please discuss this me so that we can try to work through this difficulty together. You also have the right to request that your therapist refer you to another therapist if you decide he or she is not the best fit for you. If I determine that I am not able to adequately help you, I will refer you to a therapist who may better meet your needs. You also have the right to refuse treatment, and to end therapy at any time without any obligation beyond payment due for completed sessions.

I have a confidential voicemail, which is checked regularly at (530) 436-5272. Most phone calls are returned within 24 and text messages are returned promptly. If you need assistance immediately, please call The Crisis Clinic 24-hour hotline at (206) 461.3222 or the Washington Recovery Help Line (866) 789-1511. In life threatening emergencies please dial 911 or go to your closest hospital emergency room.

RECORDS AND FEES

I keep minimal notes of my work with patients. Health insurance plans require a mental health diagnosis to pay claims. I am happy to talk to you about your diagnosis and to provide you with information about it, should I assign a diagnosis to your records. I do not disclose information about my work with patients, except when required by state or federal law. I will not disclose any information without the written consent of the patient. I accept limited insurance reimbursement at this time, but can provide a record of sessions to assist in the patient's effort to collect reimbursement from their insurance company for out of network benefits. Should I contract with insurance companies in the future, I may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, I may contact your health insurer to certify that you are eligible for benefits and may provide your insurer with details regarding your treatment to determine if your insurer will pay for your treatment. I also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members, with your consent.

My fees are $125.00 per clinical hour for individual, couples or family sessions. For those who would benefit from longer sessions, $175 per 85 minute session. The fee for group series and workshops are $400 if paid in full before the first session. This one-time payment reflects a discount from the $75 per-session cost and thus reimbursement is not provided for missed sessions. Care management is provided at the rate of $100 per clock hour and includes services such as treatment coordination, facilitation and advocacy; billed weekly in 1/10th of an hour increments and not reimbursable by insurance.

Session payment is expected at time of service, unless otherwise arranged. If you fail to pay a debt, I reserve the right to give your contact information, and the amount due, to a collection agency. A sliding scale is available for those for whom my fees are not accessible.

Your appointment is held exclusively for you. If you arrive late your appointment, I will happily meet with you for the remaining portion of your appointment time. If you need to cancel an appointment, you must give 24 hours notice to avoid being charged the full appointment fee.

CONFIDENTIALITY

With the exception of the specific exceptions described below, you have the right to confidentiality within psychotherapy. I cannot, and will not, tell anyone the content of our sessions, nor the fact that you are in therapy, without your written permission. Ethical and legal exceptions to this are:

- if I become aware of the abuse or neglect of a child under 18, or of an adult over 65,
- if I feel that you are a danger to yourself or others,
- if I were to receive a court-ordered subpoena,
- if you were to file a complaint against me with the WA Dept of Health.

If you are being seen with another person/s present, I request that each person respect the privacy of the others', but there is no guarantee that each will do so. Although every safeguard possible is in place when using electronic communication such as email, computer, cell phone, or fax, I cannot guarantee there will be no interception.

You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). I am required by law to maintain the privacy and security of your protected health information. I can use and share your personal health information to run my practice, improve your care, and contact you when necessary. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I must follow the duties and privacy practices described in this notice and give you a copy of it, which you have received by email and is available on my website. I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.

In order to provide the best service possible, I may seek consultation from other licensed clinicians, as part of a peer consultation group. During consultation, your name and identifying information is not shared.

Anyone wishing to review licensing requirements or unprofessional conduct for therapists may do so at the Department of Health website, www.doh.wa.gov. If you believe that your therapist has behaved unethically, you have the right to speak to the Department of Health, Health Professionals Quality Assurance, PO Box 47868, in Olympia WA 98504.

CONSENT TO PSYCHOTHERAPY

I have read this disclosure statement, have had time to consider it carefully and to have any questions adequately answered.

I consent to participate in therapy at CARES. No promises have been made as to the results of my therapy. I understand that I may stop my therapy at any time.

I have been informed that I must give 24 hours notice to cancel an appointment and that I will be charged the full session fee if I do not cancel or show up for a scheduled appointment as noted above.

I have been notified and understand the limits to confidentiality. If my therapist is billing my health insurance plan, I consent to the use of a diagnosis listed in my patient record and to the release of that information and other information necessary to complete the billing process.

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. Along with this disclosure, I also received a copy of Privacy Practices.

My signature signifies my understanding and agreement:

_____ _____

Client Date

_____ _____

Client Date

(Optional): I authorize CARES to thank the person (name: _____) who referred me:

_____ _____

Client Date

Billing Information and Financial Agreement

Please complete as fully as possible

Personal Information

Your Name: _____

If another person is responsible for payment:

Name _____ ____ _____ Phone at home (____) _____

Address _____ Cell Phone (____) _____

_____

If you plan to use your insurance or seek out-of-network reimbursement:

Primary Insurance _____ Subscriber _____

Group number _____ Subscriber ID _____

Patient's relationship to subscriber is (circle one): self spouse child other

Employer _____

Consent

Consent for treatment, statement of financial responsibility, and release of information:

- I hereby give my consent for mental health consultation and treatment.
- I agree to be financially responsible for all charges that accrue from consultation and treatment, including those not covered or reimbursed by my health insurance.
- I agree to be financially responsible for cancelled appointments in accord with CARES cancellation policy.
- I understand that CARES does not direct bill insurance companies and has made no promises of reimbursement. Any efforts to be reimbursed out of network for the cost of treatment is my own responsibility.
- In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
- This authorization will remain in effect indefinitely.

Signature of client _____ Date _____

If signed by another responsible person, specify relationship.

Credit Card Information

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

Card Type (circle one): Visa MasterCard

Card #:_____ Expiration Date:_____

Name as Printed on Card:_____

Verification/Security Code (3 digit code on back of card by signature line):_____

Billing Address:_____

City:_____ State: _____Zip:_____

Signature:_____ Date:_____

Credit Card Authorization

By signing below I acknowledge my understanding of the policies outlined in the Therapist Disclosure Statement and Billing Information and Financial Agreement Forms, including full fee for late cancellations (less than 24 hours) and no-shows for scheduled sessions. An additional $25 is assessed for returned checks.

Signature:_____ Date:_____

**** Please sign in the space above <u>and one of the options below</u>**
to indicate your preferred method of payment **

By signing below I am authorizing Center for Advanced Recovery Solutions (CARES) to automatically charge my credit card for all scheduled appointments ***as my preferred method of payment.*** Charges will appear within 24 hours after each appointment. I also authorize my credit card to be charged in the case of late cancellations, no-shows for scheduled sessions, returned checks or unpaid balances beyond 60 days of services rendered, as agreed to in the Therapist Disclosure Statement and Billing Information and Financial Agreement Form.

Signature:_____ Date:_____

By signing below I am indicating my preference for paying for services by cash or check, ***at the time of service***, unless otherwise arranged with CARES. Please come prepared with payment for your first session.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

This notice describes how your health information may be used and disclosed by your therapist, your rights pertaining to that information, and how you can gain access to that information. Please review it carefully.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you attend a session, a record is made of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. Your record is the physical property of the therapist while the information within the record belongs to you. In using and disclosing your protected health information, it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required. The contents of a counseling, intake, or assessment session are considered to be confidential as required (and except as limited) by law. Our discussions, as well as your record and testing material, are kept confidential. **Any information you provide in therapy is never released to anyone**, including your spouse/partner or family, without your written consent, **except** as required by law or ethical guidelines as described below:

Duty to Warn and Protect

Consistent with legal statutes and ethical guidelines, your therapist will disclose your health information as necessary to avert a serious threat to the health or safety of you or others, although disclosures are limited if information is obtained through counseling or therapy.

Abuse of Children and Elderly or Developmentally Disabled Adults

As allowed by law, your therapist will disclose your health information to social service or other government agencies if you report that you are abusing a child or vulnerable adult, that you have recently abused a child or vulnerable adult, or that a child or vulnerable adult is in danger of abuse.

Law Enforcement and Court Orders

Your therapist may disclose health information to law enforcement in the following circumstances:
1) information required by law, 2) limited information for identification and location purposes, 3) information regarding suspected victims of crime, though your therapist will usually attempt to first obtain your agreement to release the information, 4) information about a deceased client if your therapist has a suspicion that the death resulted from criminal conduct, and 5) information that your therapist believes in good faith establishes that a crime has been committed on the premises. Your therapist may also disclose health information to others as required by court or administrative order, or in response to a valid summons or subpoena.

OTHER PROVISIONS OF HIPAA

Your therapist may use or disclose your protected health information for treatment, payment, operations, and purposes described below:
Health information may be used for treatment: e.g., your therapist will use information obtained to determine your best course of treatment. The information obtained from you or from other providers will become part of your mental health records. To provide the best possible treatment, your therapist will regularly consult with other professionals about clients; no identifying information will be given in these consultations.
Health information may be used for payment: e.g., your therapist may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used as necessary to obtain payment.
Health information may be used for regular health care operations: e.g., your therapist may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service you receive or for educational purposes.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- Request a restriction on certain uses and disclosures of protected health information as described in this notice, though your therapist is not required to agree to the restriction you request. You will be notified within 30 days if your therapist cannot agree to the restriction.
- Obtain a paper copy of this notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage. You are not entitled to access to, or to obtain a copy of, information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to your therapist. In most cases, you will receive a response within 30 days. Your therapist is not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that your therapist is not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to your therapist that communication with you be done with a specific method at a specific location. Your therapist will typically communicate with you in person or by letter, telephone, and/or email.
- Revoke an authorization to use or disclose health information at any time except to the extent that action has already been taken.

RESPONSIBILITIES OF YOUR THERAPIST

Your therapist is required to:

- Maintain the privacy of your protected health information and provide you with notice of his or her legal duties and privacy practices with respect to your protected health information.
- Abide by the terms of the notice currently in effect. Your therapist has the right to change the notice of privacy practices in which case a new copy will be given to you. These changes will apply to all of your protected health information, including information obtained prior to the change.
- Accommodate reasonable requests to communicate with you about your protected health information by alternative means or locations.
- Use or disclose your health information only with your authorization except as described in this notice.

In some circumstances, state or federal law may prohibit or further restrict the disclosure of your health information. If that is the case, your therapist is required to follow the more stringent law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

For more information or to report a problem, you may contact your therapist directly. If you feel your rights have been violated, you may file a complaint in writing. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services or with the State Licensing Board. You will not be retaliated against for filing a complaint.

DISCLOSURES REQUIRING AUTHORIZATION

All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent your therapist has already relied upon the authorization.

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that your therapist seek your acknowledgment of receipt of this Notice of Privacy Practices. The signature line is located on the next page.

Please sign and date below:

I acknowledge that I have received this Notice of Privacy Practices with an effective date of:

Signature: _____ _____ Date:____/____/_____

Printed Name: _____

FOR OFFICE USE ONLY

Patient Refused or Failed to Acknowledge Receipt on _____. Initials _____

Reason for refusal or failure to acknowledge receipt: