



Freedman & Associates

Mental Health Services for Children & Families

1513 E Street, Bellingham, WA 98225

phone: 360-734-2664

fax: 360-671-8006

Authorization for Disclosure of Healthcare Information

Client Name: _____ Birth date: ____/____/____ SS#: _____

Previous Name(s): _____ Address: _____

Freedman & Associates Treating Provider: _____

Information is to be disclosed to and/or received from :

Name of Person/Agency: _____

Address: _____ Phone: (____) _____ Fax: (____) _____

For purposes of: ____ evaluation ____ treatment ____ forensic assistance ____ other: _____

I authorize Freedman and Associates to release my:

____ General Mental Health Record

____ Information related to chemical dependency/substance abuse

____ Psychotherapy Notes (the private content of your conversations with your therapist)

____ Information related to HIV/AIDS and/or sexually transmitted diseases

____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 90 days after the last dated signature.

Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

Signature of Parent/Guardian Date

Signature of Witness Date

[90-Day Signature Updates]

Signature of Client/Parent/Guardian or Authorized Representative Date

Signature of Client/Parent/Guardian or Authorized Representative Date



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CLIENT INTAKE FORM

Please complete both sides of form.

Name: _____ Social Security#: _____

Address: _____

Home Phone: _____ day evening OK to leave msg? YES NO

Work Phone: _____ day evening OK to leave msg? YES NO

Cell Phone: _____ day evening OK to leave msg? YES NO

Date of Birth: _____ Gender: MALE FEMALE

Referred by: _____ Primary Care Physician: _____

PRIMARY INSURANCE INFORMATION (on card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to you: _____

ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION (on card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to you: _____

ID#: _____ Group/Plan #: _____

PERSONAL INFORMATION

Where were you born/raised? _____

Religion: _____

Important in up-bringing? _____ Now? _____

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Emergency Contact: _____ Relation: _____

Phone #(s): (1) _____ (2) _____

COUNSELOR'S NOTES (for office use only)

| Date | dx code | dx | Counselor Signature |
|------|---------|----|---------------------|
| | | | |
| | | | |

MEDICAL HISTORY
(All current medications-including herbal and over-the-counter)

Medication: _____ Dosage: _____ Date Started: _____
 Medication: _____ Dosage: _____ Date Started: _____
 Medication: _____ Dosage: _____ Date Started: _____

Significant Medical Problems-
 Past: _____
 Present: _____
 Allergies: _____
 Alcohol Use-
 Past: _____
 Present: _____
 Drug Use-
 Past: _____
 Present: _____
 Tobacco Use-
 Past: _____
 Present: _____
 Caffeine Use-
 Past: _____
 Present: _____

Have you had previous counseling? Yes No
 If yes, with whom? _____ When? _____
 Would it help to contact your previous counselor (s)? Yes No

FAMILY SITUATION

Relationship/Marital Status: Single Involved Engaged
 Cohabiting Married Separated
 Divorced Widowed

Marriages, Significant relationships, and children:

| Partner/Spouse | From (Year) | To (Year) | Names & ages of children from relationship | Where/with whom do they live? |
|----------------|-------------|-----------|--------------------------------------------|-------------------------------|
| | | | | |
| | | | | |
| | | | | |

GOALS FOR THERAPY

What would you like to see happen as a result of your work here?

Leslie A. Clawson, LICSW
1101 Harris Avenue #27
Bellingham, WA 98225
Registered Counselor # RCO0055312

| |
|--------------------------------------------------------|
| Terms of Service/Counselor Disclosure Statement |
|--------------------------------------------------------|

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions at our next meeting. When you sign this document, it will represent an agreement between us.

Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

Education:

Masters of Social Work, CSUS, Phi Alpha, Epsilon Chapter, May 2003
Postgraduate course work in Education and Educational Research, CSUS, 1985.
Masters of Arts (Candidacy) in Education. College of Notre Dame, June 1979.
Montessori Teaching Credential, American Montessori Society, June 1978.
Bachelor of Arts Degree, U.C. Davis, Modern European History, March 1977.

Approach to Therapy:

Psychotherapy is not easily described in general statements. It varies depending on the personality of the client, and the particular issue or problems you bring forward. There are many different methods I may use to deal with issues or problems you hope to address. However, effective therapy calls for a very active effort on your part. In our work together, we will identify your goals for counseling, develop an appreciation for your particular life patterns, and then work toward supporting you in attaining new skills, new ways of evaluating your situation, or different ways of relating to yourself and others.

Confidentiality and Privacy:

I will keep confidential anything you say to me, with a few exceptions as required by law.

Freedman and Associates is a consultative group of experienced therapists. Good clinical practice requires occasional peer review and consultation within this group. Please be aware that your case may be clinically reviewed in this or other consult settings.

I have been provided a copy of the required disclosure information the brochure "Counseling or Hypnotherapy Clients" and the "Notice of Practices Regarding Protected Health Information" and read and understand the information provided.

Initial here to acknowledge receipt_____

Appointments:

Your appointment times are reserved for you alone. I try very hard to begin and end on time, out of respect to both of our schedules. If you need to cancel your appointment for any reason, appointments must be cancelled 24 hours in advanced. Otherwise you, not your insurance company, will be charged a cancellation/no show fee equal to the full fee for the session missed. Telephone therapy time is prorated at the same rate as in-office therapy.

Billing practices:

Payment for services will be due at the end of each session. My basic rate is \$100.00 per 50-minute session, or \$135.00 per 75-minute session. In some cases, your insurance company may pay a percentage of the cost of your therapy per session. In this case, your co-pay becomes your fee, while I collect the remainder of your fee from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company. In addition I hold a certain number of spaces for Adjusted Fee situations on a "space available" basis. The adjusted fee will be determined between the two of us at the intake session. My sliding fee

scale ranges from \$25 to \$85 dollars. Costs per session will be determined at the first session and will remain at that level for six months, when it will be renegotiated. If you can not make it to a session, please phone 24 hours in advanced. Cancellations on the same day will result in a charge of half of the negotiated fee. No shows for appointments will be charged at full fee.

Emergencies: If there is an emergency between sessions, I can be reached by phone at 360/734-2664, ext 13. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If you are unable to reach me when you feel the need for some emergency help, Volunteers of America have a 24 hour on call crisis line at 1-800-584-3578 or please call 911.

Treatment consent:

I have been informed of the type of counseling I will receive from Leslie Clawson, the methods and techniques used, her education, training and experience and the cost of counseling services. Furthermore, I have received this information in writing.

Counselors practicing for a fee must be registered or certified with the Department of Health for protection of the public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

Client's Signature

Leslie Clawson, LICSW

Date

Date

Please read the attached Notice of Privacy Practices for more information about your privacy rights, and initial here to acknowledge that you received a copy of the Notice: _____

Leslie A. Clawson, LICSW
Freedman and Associates
1101 Harris Avenue #27 Bellingham, WA 98225
360.734.2664 ext.15

Notice of Privacy Practices Regarding Protected Health Information
effective April 14, 2003

To our clients: We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your **Protected Health Information (PHI)** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By initialing on the “Terms of Service” agreement, you are indicating that you received and reviewed this form, and you are giving consent for us to “use” your PHI within our practice group, or “disclose” your PHI to an outside entity for the following purposes:

- **Treatment:** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.
- **Payment:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.
- **Health Care Operations:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an **Authorization Form** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your “**Psychotherapy Notes**”—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has suffered abuse or neglect, she/he is required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, she/he must immediately report it to the appropriate authorities.
- **Health Oversight:** If the State Department of Health subpoenas your therapist as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)
- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.
- **Worker's Compensation:** If you file a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- **Right to Request Restrictions:** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).
- **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.
- **Right to an Accounting of Disclosures:** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

V. Therapist's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way we have handled your privacy rights, you may contact please contact me at the above address or you may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. Our office can provide you with the appropriate address upon request.