



Freedman  
& Associates

## Mental Health Services for Children & Families

2110 Iron Street  
Bellingham, WA 98225  
phone: 360.734.2664  
fax: 360.671.8006  
www.freedman-associates.com

### 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 12 months 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

#### [12 Month Signature Updates]

\_\_\_\_\_  
Signature of Client/Parent/Guardian or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client/Parent/Guardian or Authorized Representative

\_\_\_\_\_  
Date



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# Mental Health Services for Children & Families

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## CHILD AND FAMILY INTAKE FORM

Please complete all pages of form.

Today's Date: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  MALE  FEMALE

Referred by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Child lives with:  Both  Mother  Father  Other: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Child's 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

### PRIMARY INSURANCE INFORMATION (information found on insurance card)

Insurance Company: \_\_\_\_\_

Phone#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

ID#: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION (information found on insurance card)

Insurance Company: \_\_\_\_\_

Phone#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

ID#: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_

### COUNSELOR'S NOTES (for office use only)

Date	Dx code	Dx	Provider Signature

## CHILD'S MEDICAL HISTORY

How is your child's general health?      Excellent      Good      Fair      Poor

Briefly describe your primary concerns and why you have brought your child to the office:

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When was your child's last comprehensive medical evaluation? \_\_\_\_\_

Has your child ever been hospitalized for psychological reasons?      Yes      No  
 If yes, when and where? \_\_\_\_\_

Please check whether your child currently has, or has ever had any of the following:

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> drug/alcohol abuse                                    | <input type="checkbox"/> sleeping problems          | <input type="checkbox"/> changes in appetite        | <input type="checkbox"/> flashbacks   |
| <input type="checkbox"/> running away  | <input type="checkbox"/> frequent headaches         | <input type="checkbox"/> epilepsy or seizures       | <input type="checkbox"/> ulcers       |
| <input type="checkbox"/> disturbing thoughts                                   | <input type="checkbox"/> lack of interest           | <input type="checkbox"/> sexual abuse               | <input type="checkbox"/> depression   |
| <input type="checkbox"/> memory problems                                       | <input type="checkbox"/> low self-esteem            | <input type="checkbox"/> speech problems            | <input type="checkbox"/> confusion    |
| <input type="checkbox"/> irritability  | <input type="checkbox"/> emotional abuse            | <input type="checkbox"/> hearing problems           | <input type="checkbox"/> stress       |
| <input type="checkbox"/> bowel problems  | <input type="checkbox"/> irregular heartbeat        | <input type="checkbox"/> visual problems            | <input type="checkbox"/> bedwetting   |
| <input type="checkbox"/> suicidal ideations/ attempts                          | <input type="checkbox"/> feelings of hopelessness   | <input type="checkbox"/> homicidal thoughts         | <input type="checkbox"/> weight loss  |
| <input type="checkbox"/> sexual concerns                                       | <input type="checkbox"/> difficulty managing anger  | <input type="checkbox"/> asthma                     | <input type="checkbox"/> head trauma  |
| <input type="checkbox"/> chronic illnesses                                     | <input type="checkbox"/> family/relationship issues | <input type="checkbox"/> communication problems     | <input type="checkbox"/> mood swings  |
| <input type="checkbox"/> phobias: _____  | <input type="checkbox"/> hormone disorder           | <input type="checkbox"/> difficulty concentrating   | <input type="checkbox"/> anxiety      |
| <input type="checkbox"/> physical abuse or neglect                             | <input type="checkbox"/> panic attacks              | <input type="checkbox"/> serious infection          | <input type="checkbox"/> allergies    |
| <input type="checkbox"/> racing thoughts                                       | <input type="checkbox"/> frequent stomachaches      | <input type="checkbox"/> feelings or paranoia       | <input type="checkbox"/> broken bones |
| <input type="checkbox"/> school/work difficulties                              | <input type="checkbox"/> blood pressure concerns    | <input type="checkbox"/> problems with coordination |                                       |
| <input type="checkbox"/> frequent or self-destructive or uncontrolled crying   |   | <input type="checkbox"/> self-injurious behavior    |                                       |
| <input type="checkbox"/> Other physical or emotional issues (please describe): |   |   |                                       |
- 
- 

Is your child currently taking medication?      Yes      No

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

List any serious illnesses for which the child required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has your child ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

## FAMILY SITUATION

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

Names and ages of other adults & children residing in the home:

Name	Age	Relationship to Client

**Mother's-**

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

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

**Father's-**

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

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

Are there any family members experiencing significant medical problems or substance abuse?

**(Please indicate relationship to child):**

Medical Problems-

Past: \_\_\_\_\_

Present: \_\_\_\_\_

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

**GOALS FOR THERAPY**

What are the goals and outcomes you would like to achieve for your self/child with therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Elizabeth A. Snyder, MS, LMHC**  
2110 Iron Street, Bellingham, WA 98225  
360.734.2664 ext.12  
**Registered Counselor # RC37547**  
Licensed Mental Health Counselor # LH7502

**Terms of Service / Counselor Disclosure Statement**

Welcome to my practice. 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:**

2000 M.S. Psychology, Mental Health Counseling, Western Washington University  
1997 B.S. Psychology, University of Washington  
1993 B.A. Business Administration-H.R., Western Washington University

**Approach to Therapy:**

In my practice I work with clients from a strength-based perspective of the individual in context, including an awareness of the contributions of their history, gender, environment and culture. I believe that individuals have the knowledge and ability to help themselves with the collaboration and understanding of another individual. I use a variety of integrated therapeutic approaches for treatment including, but not limited to the following: Testing and assessment, existential-phenomenological, cognitive-behavioral, and dialectical behavioral therapy. I have also participated in training regarding the areas of self-harm behaviors and eating disorders. Therapy may be offered in either an individual, couples, family or group format. I will also collaborate with any medical providers involved in a client's treatment as seen necessary, and with a client's consent. We will evaluate our progress towards treatment goals to allow for adjustments to the therapy process and/or individual goals. My intent is to provide a respectful, holistic and relationship-based approach to therapy, rather than one that is narrowly focused and/or impersonal.

You have the right to choose a counselor who best suits your needs and purposes and if ever you or I feel that our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area. You also have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6).

**Confidentiality and Privacy:**

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\_\_\_\_\_

## Office Policies, Procedures and Fees

### Appointments:

Appointments are 50 minutes and 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. Cancellations on the same day will result in a charge of half the negotiated fee.

### 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 \$150.00 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 75 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. In the case of court involvement, (including letters or court evaluations), my fee is \$100.00 per half hour. If you can not make it to a session, please phone 24 hours in advanced.

**Emergencies:** If there is an emergency between sessions, I can be reached by phone at 360-927-7372. 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 Elizabeth Snyder, 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

\_\_\_\_\_  
Elizabeth A Snyder, MS, LMHC

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Elizabeth A. Snyder, MS, LMHC  
2110 Iron Street, Bellingham, WA 98225  
360.734.2664 ext.12  
Registered Counselor # RC37547  
Licensed Mental Health Counselor # LH7502

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

**Freedman & Associates**

Directions to:  
2110 Iron Street  
Bellingham, WA 98225  
360.734.2664

Directions from I-5 South

- Take exit #254 (State Street/Ohio Street) onto Ohio Street towards State Street
- Turn **RIGHT** onto Iron Street
- Drive approximately three blocks
- After crossing Kentucky Street, we are the second house on right (sage colored home with white picket fence).

Directions from I-5 North

- Take exit #254 (State Street/Iowa Street)
- Turn **LEFT** onto Iowa Street
- Turn **RIGHT** onto Iron Street
- Drive approximately two blocks
- After crossing Kentucky Street, we are second house on right (sage colored home with white picket fence).

Parking:

- There is parking in the parking lot or anywhere along the street.