



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 & 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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CLIENT INTAKE FORM Please complete both sides of form.

Today's Date: _____

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?

CARA ANDERSON, MA

Intern

Freedman & Associates

2110 Iron Street, Bellingham, WA 98225

360-734-2664

Terms of Service / Disclosure Statement

Introduction

This document is intended to provide important information regarding your treatment and our professional relationship. Please read the entire document carefully and be sure to ask any questions that you may have regarding its content.

Confidentiality

All communications between you and I will be held in strict confidence, with a few exceptions as required by law. These limitations are outlined in the “Notice of Practices Regarding Protected Health Information” form you have received.

Experience and Training

I am currently a doctoral candidate in clinical psychology at Fuller Graduate School of Psychology. I am in my sixth, and final, year of studies and will complete my Doctorate of Psychology in June 2011. I have previously received an MA in psychology and a BA in Honors psychology. I will be working at Freedman & Associates through May 2011.

Supervision

As I am in the process of completing my psychological training, my clinical work at Freedman & Associates is supervised by Dr. Jason Prinster and Dr. Evan Freedman, both licensed psychologists. I will consult with Dr. Prinster and/or Dr. Freedman along with other professionals at Freedman & Associates in order to provide you with the best treatment possible.

Therapy Appointments

Therapy sessions are normally 50 minutes in length, scheduled at the same time each week. Consistent attendance greatly contributes to successful therapeutic outcomes, and is much appreciated.

Cancellations

Your appointment times are reserved for you alone. I respect your time, and try very hard to begin and end on time. In the event that you need to cancel or reschedule an appointment, you are expected to contact me at 360-734-2664, ext. 23 **at least 24 hours in advance** of your scheduled appointment. Otherwise you will be charged the **full fee** for the session missed.

Billing Practices

Payment for services will be due at each session. Payment for services will be \$30. If you cannot make it to a session, please phone 24 hours in advance. Cancellations without 24 hours of notice, and no-shows will be charged at the full fee. In the event that payment has not been received, your personal information may be given to a collections agency in order to acquire payment.

Emergencies

If you have an emergency between sessions, I can be reached by phone at 360-734-2664, ext. 23. While I am not always available by phone, I will return your call within 48 hours. If you are unable to reach me when you feel the need for emergency help, Freedman & Associates also has a 24-hour on-call therapist who may be contacted by calling (360) 325-3999. Alternately, you may call one of the following hotlines:

- Volunteers of America: **1-800-584-3578**.
- Crisis hotline: **1-800-273-TALK** (1-800-273-8255)
- Suicide hotline: **1-800-SUICIDE** (1-800-784-2433)

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call **911**.

Therapeutic Process

I believe the relationship between therapist and client is vital to the therapeutic process. Often, change occurs through relationship, as relationship allows for an increase in self-understanding as well as an experience of being fully known and accepted by another.

Privacy Practices

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:

Consent for Therapeutic Services

Your signature below indicates that you have read and understand this contract for therapeutic services. Your signature below indicates your understanding and agreement with its contents.

Signature of Client

Date

Cara Anderson, MA, Intern

Date

Supervisor

Date

CARA ANDERSON, MA
Intern
Freedman & Associates
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Consent for Therapeutic Services

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Signature of Client

Date

Cara Anderson, MA, Intern

Date

Supervisor

Date

Cara Anderson, MA

2110 Iron Street, Bellingham, WA 98225

360.734.2664 ext.23

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.