



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?

Jayne D. Fergoda, LICSW

2110 Iron Street, Bellingham, WA 98225

360.734.2664 ext. 18

Licensed Independent Clinical Social Worker # LW5652

TERMS OF SERVICE / DISCLOSURE STATEMENT

I am pleased that you have selected me as your therapist. This document is designed to ensure that you understand our professional relationship.

CONFIDENTIALITY AND PRIVACY:

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

PEER REVIEW:

Freedman & 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 setting.

OUR RELATIONSHIP:

Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

FEES AND PAYMENT:

Unless otherwise arranged with me, my fees are as follows:

Initial Interview	\$150
Individual Therapy	\$100/hr
Couple/Family Therapy	\$125/hr

While this fee is usually collected in full at the beginning of each session, Freedman & Associates has agreements with Regence, Group Health Cooperative, and some other insurance companies to collect co-payments and co-insurance, if any, at the time of service and submit billings for the insurance company portion directly to them. They will pay Freedman & Associates directly for covered services. This billing procedure is a service to you provided through our arrangements with your insurer.

With other insurance carriers, we will decide together whether you will pay me the co-pay or co-insurance only or the full fee at the time of service. You are responsible for determining the specifics of your insurance coverage, as well as procuring relevant paperwork (such as primary care physician referrals) as your insurer may require. I will assist you by providing any necessary information.

Please note that as the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time the insurance company notifies us any unpaid portion.

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit it to your insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or a behavioral health care manager. If you have any questions about the details of your plan, please refer to your benefits booklet or contact your insurer.

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 advance. Otherwise **you, not your insurance company**, will be charged a cancellation/no show fee equal to **half of the fee** for the session missed. Telephone therapy time is prorated at the same rate as in-office therapy. Please initial in the box provided to acknowledge you have read and understand the Appointment and Cancellation/No Show Fee Policy.

ATTENDANCE:

Attending scheduled appointments is critical to the success of counseling. If missed appointments become a concern, I will initiate a conversation about how to remain engaged in services. I may request that an attendance contract be discussed and signed. Please initial in the box provided to acknowledge that you have read and understand the Attendance Policy.

CANCELLATIONS:

In the event that you are unable to keep an appointment, you must notify me 48 hours in advance. If I do not receive such advanced notice, you will be responsible for paying for the full fee for the session you missed. We cannot bill your insurance for missed sessions, and insurance will not pay for missed sessions.

If you need to cancel or reschedule, you can leave a message on my voice mail at **(360) 734-2664, ext 18**. Also, please remember to leave your home and work phone numbers with every message as I am not always in the office when retrieving messages and may not be able to get back to you otherwise.

EMERGENCIES:

If you are unable to reach me when you feel the need for some emergency help, Freedman & Associates also has a 24-hour on-call therapist who can be reached by calling **(360) 325-3999**. There is no charge for on-call contacts less than 10 minutes. If a contact of more than 10 minutes is necessary, a fee will be charged at my usual hourly rate. In the case of a life-threatening emergency please call **911**, go to the **Emergency Room**, or call the 24-hour Crisis Line at **1-800-584-3578**.

COMPLAINTS:

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to The Department of Health, Health Professionals Quality Assurance Division, P.O. Box 47869, Olympia WA 98504-7869, or call them at (360) 236-4700.

By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure statement. I also give Freedman & Associates my permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

Client's Signature

Jayme D. Fergoda, 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: _____

Jayme D. Fergoda, LICSW
2110 Iron Street, Bellingham, WA 98225
360-734-2664 ext. 18
Licensed Independent Clinical Social Worker #LW5652

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.