Mental Health Services for Children & Families

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

Freedman & Associates

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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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:
____
____

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:

__drug/alcohol abuse
__running away
__disturbing thoughts
__memory problems
__irritability
__bowel problems
__suicidal ideations/attempts
__sexual concerns
__chronic illnesses
__phobias:_______________
__physical abuse or neglect
__racing thoughts
__broken bones
__problems with coordination
__sleeping problems
__frequent headaches
__lack of interest
__low self-esteem
__emotional abuse
__irregular heartbeat
__feelings of hopelessness
__difficulty managing anger
__family/relationship issues
__hormone disorder
__panic attacks
__frequent stomachaches
__school/work difficulties
__frequent or uncontrolled crying
__changes in appetite
__epilepsy or seizures
__sexual abuse
__speech problems
__hearing problems
__visual problems
__homicidal thoughts
__asthma
__communication problems
__difficulty concentrating
__serious infection
__feelings or paranoia
__blood pressure concerns
__self-destructive or self-injurious behavior
__flashbacks
__ulcers
__depression
__confusion
__stress
__bedwetting
__weight loss
__head trauma
__mood swings
__anxiety
__allergies

__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 ☐ Cohabitating
☐ 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: ______________________________

Has your child had previous counseling? ☐ Yes ☐ No

If yes, with whom? ______________________ When? ______________________

Would it help to contact the 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?

____

____

____

____

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
2110 Iron Street, Bellingham, WA 98225
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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.