



Mental Health Services for Children, Adolescents & Adults

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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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:

- | | | | |
|--|--|--|--------------------------------------|
| <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 uncontrolled crying | <input type="checkbox"/> self-destructive or 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: _____

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?

Jennifer M. Gronholt, Psy.D.
2110 Iron Street, Bellingham, WA 98225
(360) 734-2664 ext.14
Licensed Clinical Psychologist # PY60118572

TERMS OF SERVICE / DISCLOSURE STATEMENT

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

CONFIDENTIALITY AND PRIVACY:

Your privacy is important to me and I will keep everything you say and all information about you confidential including the fact that you are my client except in specific circumstances as required by law. These limitations are outline in the “Notice of Practices Regarding Protected Health Information” form you have received.

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	\$190
Individual Therapy	\$135/hr
Couple/Family Therapy	\$160/hr
Psychological Testing	\$150/hr

While this fee is usually collected in full at the beginning of each session, Freedman & Associates has agreements with Regence, Premera, 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/CANCELLATIONS:

Appointments:

Appointments are 50 minutes and reserved for you alone. I try very hard to begin and end on schedule, out of respect to both our schedules. **In the event that you are unable to keep an appointment, you must notify me at least 24 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 14**. 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.

Please initial the box provided to acknowledge that 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 the box provided to acknowledge that you have read and understand the Attendance Policy.

EMERGENCIES:

If there is an emergency I can be reached by phone at **(360) 734-2664, ext 14**. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If a contact of more than 10 minutes is necessary, a fee will be charged at my usual hourly rate.

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; over 10 minutes will be charged at the 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 Examining Board of Psychology, Dept. of Health, P.O. Box 47869, Olympia WA 98504, or call them at (360) 236-4928.

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

Dr. Gronholt's Signature

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: _____

Jennifer M. Gronholt, Psy.D.
2110 Iron Street, Bellingham, WA 98225
(360) 734-2664 ext.14
Licensed Clinical Psychologist # PY60118572

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360.734.2664 ext. 14
Licensed Clinical Psychologist # PY60118572

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.