



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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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 |
|---------|------|--------|---------------|
| | | | |
| | | | |

Krista DeRoche, MA, LMHC
2110 Iron Street, Bellingham, WA 98225
360.734.2664 ext.16
Licensed Mental Health Counselor # LH00009713

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, as well as 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 you do not 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:

2003 M.A. Psychology, Mental Health Counseling, Antioch University
1998 Chemical Dependency Certification Program, Edmonds Community College
1994 B.S. Human Development; Minor in Psychology, California Polytechnic State University (SLO)

Approach to Therapy:

My approach focuses on supporting and empowering the youth, adults, and families I serve to successfully face and overcome the many challenges life may bring in ways that promote enhanced communication skills, improved relationships, improved functioning, and a positive well being. I believe therapy is a collaborative process. I will work with you to develop a service plan tailored to meet your specific goals and objectives as I believe individuals have the knowledge and ability to help themselves with the support and understanding of another individual. Therapy may be offered in an individual, family, or group format. In my practice I work with clients from a client centered, strength based perspective. I also work primarily with the present and deal with the past as the need arises. I use several therapeutic approaches in my treatment depending upon your personality and needs. These approaches include, but are not limited to the following: humanistic, solution focused, strength based, systemic, gestalt and cognitive-behavioral; I often employ more than one method at a time. My intent is to use my experience and training in your therapy to promote a relationship in which you feel respected, safe and comfortable so you are able to bring up and resolve any issues that block your well being or the achievement of your goals.

You have the right to choose a counselor who best suits your needs and purposes; if at any time you or I feel our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area.

Confidentiality and Privacy:

Your privacy is important to me; I will keep everything you say completely confidential except in specific circumstances as required or authorized by law-RCW 18.19.180 (1) through (6):

RCW 18.19.180 Confidential Communications.

An individual registered under this chapter shall not disclose the written acknowledgment of the disclosure statement pursuant to RCW [18.19.060](#) nor any information acquired from persons consulting the individual in a professional capacity when that information was necessary to enable the individual to render professional services to those persons except:

(1) With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;

(2) That a person registered under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;

- (3) If the person is a minor, and the information acquired by the person registered under this chapter indicates that the minor was the victim or subject of a crime, the person registered may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
- (4) If the person waives the privilege by bringing charges against the person registered under this chapter;
- (5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter [18.130](#) RCW; or
- (6) As required under chapter [26.44](#) RCW.

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 or other consult settings.

I have been provided a copy of Krista DeRoche’s professional profile, the “Terms of Service / Counselor Disclosure Statement” 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 reschedule or cancel your appointment for any reason, appointments must be cancelled a minimum of 24 hours in advance. If I do not receive this advance notice, **you, not your insurance company**, will be charged a cancellation/no show fee equal to **the full fee** for the session missed (Insurance does not pay for missed appointments). Telephone therapy time is prorated at the same rate as in-office therapy. Please initial in 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 in the box provided to acknowledge that you have read and understand the Attendance Policy.

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 35 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. Reminder: If you can not make it to a session, please phone 24 hours in advance; failure to provide 24-hour notification will result in a full-session charge.

Emergencies:

If you have an emergency between sessions, I can be reached by office telephone at: 360-734-2664 ext.16. I will keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting therapy. 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 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 addition, Volunteers of America has a 24-hour on call crisis line at: **1-800-584-3578**. In the case of a life threatening emergency, please call **911**.

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 concern, you may report your complaint to: Washington State Department of Health, Health Professions Quality Assurance, P.O. Box 47869, Olympia, WA 98504.

Treatment consent:

I have been informed of the type of counseling I will receive from Krista DeRoche, 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

Krista DeRoche, MA, LMHC

Date

Date

Krista DeRoche, MA, LMHC
2110 Iron Street, Bellingham, WA 98225
360.734.2664 ext. 16
Licensed Mental Health Counselor # LH00009713

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|--|
| 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.