



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 and 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



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

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?

Elizabeth A. Snyder, MS, LMHC

2110 Iron Street, Bellingham, WA 98225

360.734.2664 ext 12

Registered Counselor # RC37547

Licensed Mental Health Counselor # LH7502

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, and 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 that you don't 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:

2000 M.S. Psychology, Mental Health Counseling, Western Washington University

1997 B.S. Psychology, University of Washington

1993 B.A. Business Administration-H.R., Western Washington University

MY APPROACH TO COUNSELING:

I believe that individuals have the knowledge and ability to help themselves with the collaboration and understanding of another individual. In my practice I work with clients from a strength-based perspective of the individual in context, including an awareness of the contributions of their history, gender, environment and culture. I use a variety of integrated therapeutic approaches for treatment including, but not limited to the following: Testing and assessment, existential-phenomenological, cognitive-behavioral, and dialectical behavior therapy. I have completed the Intensive Training in Dialectical Behavior Therapy (DBT), as well as many other training offerings in the area of DBT. I have also participated in training regarding the areas of grief/loss, attachment, trauma and eating disorders.

Therapy may be offered in either an individual, couples, family or group format. I will also collaborate with any medical providers involved in a client's treatment as seen necessary, and with a client's consent. We will evaluate our progress towards treatment goals to allow for adjustments to the therapy process and/or individual goals. My intent is to provide a respectful, holistic and relationship-based approach to therapy, rather than one that is narrowly focused and/or impersonal.

CONFIDENTIALITY:

You have the right to choose a counselor who best suits your needs and purposes and if ever you or I feel that our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area. You also have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6).

I will keep all information about you confidential, including the fact that you are my client.

With teens age 13 and over: I will keep your individual information confidential, even from your parents/guardians. I may need to communicate with your parents regarding appointment scheduling and payment, or if I am worried that your life is in danger.

When I am required to release information:

If I suspect that a child or dependent person is being abused; if you intend to seriously harm yourself or someone else; to consult with my confidential clinical team regarding my counseling work; or if a judge subpoenas my records.

I have been provided a copy of the required disclosure information the “Notice of Practices Regarding Protected Health Information” and read and understand the information provided.

Initial here to acknowledge receipt_____

BILLING PRACTICES:

Payment for services will be due at the beginning of each session. My basic individual counseling rate is \$100.00 per 50-minute session and family rate is \$125.00 per 50-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 the case of court involvement, (including letters or court evaluations), my fee is \$200.00 per half hour.

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 25 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.

(If using sliding fee, the rate we have agreed on is: _____ per hour.)

APPOINTMENTS:

Your appointment times 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 an appointment, please notify me by voice mail at least **24 hours in advance**. If you do not show for an appointment, you will be charged a “**No Show Fee**” at your full regular session rate. If you cancel with less than 24 hours notice, you will only be charged a “**Late Cancellation Fee**” at half your regular rate. (There will be no fee if you have to cancel due to an emergency.) I will adhere to the same policy if I need to change your appointment.

PHONE CONTACT:

If there is an emergency between sessions, I can be reached by phone at 360-972-7372. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If you are a client of mine, getting coaching from me over the phone is an important way for you to learn to apply skills during the stressful times in your life. The best time to call me is when you are feeling stressed or emotional and *BEFORE* you do an impulsive action (i.e.: hurt yourself, get drunk, yell at someone). We will not have a whole therapy session on the phone, but a brief conversation to help you use skills to get through the moment.

**If a phone contact of more than 10 minutes is necessary, a fee will be charged at our usual hourly rate.

**If you are unable to reach me when you feel the need for urgent help, you can call:

Your skills group leader or co-leader for coaching (their numbers are in your skills binder)

Care Crisis Line at 1-800-584-3578 (24 hours a day, 365 days a year, toll free)

If life-threatening, call **911** or go to the nearest **Emergency Room**.

CLIENT RIGHTS:

As a client, you have the right to refuse treatment, and the responsibility to choose the provider and type of treatment which best suits your needs.

If you are ever dissatisfied with my services, I encourage you to talk to me about your concerns. Your thoughts provide very important feedback for me, and maybe growth for you as well. If I am not able to resolve your concerns, you may write to the WA Department of Health, Health Professions Quality Assurance Division.

I have read and understood these policies, and have received my own copy of this Disclosure:

Client Signature(s)

Date

Parent/Guardian Signature

Date

Counselor Signature

Date

Elizabeth A. Snyder, MS, LMHC

2110 Iron Street, Bellingham, WA 98225

360.734.2664 ext.12

Registered Counselor # RC37547

Licensed Mental Health Counselor # LH7502

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.