



Name: _____ Date: _____

Address:

May I leave a message? Yes No

Home Phone: _____ Cell Phone: _____

E-Mail _____

How did you learn of my services (check all that apply)?

Friend/Family Member

Workshop/Presentation

Web Site

Other (specify)

Date of Birth: _____ Gender: F M

Ethnicity: _____

Employed? Yes No If yes, what is your job-

Are you married or partnered? Yes No

What brings you here?

Please check the number that tells us how urgent your concern(s) are:

1 2 3 4 5 6 7

Not at all urgent

Extremely urgent



Treatment and Medical History

Are you currently receiving or have you previously received services from a counselor/mental health professional?

If yes, please list provider name, dates and type of treatment.

Did you find this helpful? Yes No

Have you ever been hospitalized for emotional or drug/alcohol treatment? If yes, please describe the circumstances.

Please list any medical conditions that you have or believe you might have.

List any medications you are currently taking:

Name of Health Care Provider/Treating Physician-

Do you have health insurance? Yes No

Name of Insurance Company:

Name of Insured _____

Policy# _____

Group# _____

Phone# _____



CLIENT RIGHTS

You have the right to be treated with dignity and respect without regard to your race, color, religion, national origin, gender, age, sexual orientation, or disability. You have the right to have explained the way in which your confidential mental health information will be handled and the limitations of confidentiality.

You have the right to receive an appropriate referral for community mental health services if you request one or if your needs exceed what I able to provide you.

You have the right to work collaboratively in establishing treatment goals.

You have the right to ask questions about qualifications, credentials, and theoretical orientation, as well as any counseling and testing techniques/procedures utilized.

You have the right to refuse or terminate treatment.

You have the right to review with me, the records in your personal file maintained by In Touch Counseling Services inc. including diagnosis and test results.

You have a right to a copy of records generated by my office. Typically, you will be asked to meet with me to review the records before they are released to you.

CLIENT RESPONSIBILITIES

You should make every effort to arrive on time for appointments.

You should notify In Touch Counseling Services Inc. if you are unable to keep a scheduled appointment. *Appointments need to be cancelled with a 24 hour notice. Failure will result in a full session cancellation fee.* Notification allows me to make appointment time available to other clients. Clients who consistently miss appointments without notification may have those services terminated or restricted.

You are expected to arrive for appointments without being under the influence of drugs or alcohol.

I have read and understand these rights and responsibilities.

Signature _____

Date: _____



Behavioral Health Questionnaire - Please answer these questions as they relate to the past two weeks.

1. How distressed have you been?

- Extremely distressed (0)
- Very Distressed (1)
- Moderately Distressed (3)
- A little bit distressed (4)
- Not at all distressed (5)

2. How satisfied have you been with your life?

- Not satisfied at all (1)
- Mildly satisfied (2)
- Somewhat satisfied (3)
- Satisfied (4)
- Very satisfied (5)

3. How energetic and motivated have you been feeling?

- Not at all energetic and motivated (0)
- A little bit energetic and motivated (1)
- Somewhat energetic and motivated (2)
- Energetic and motivated (3)
- Very energetic and motivated (4)

In the past two weeks how much have you been distressed by:

4. Feeling fearful, scared:

Never A Little Bit Sometimes Often Almost Always

5. Alcohol/drug use interfering with your performance at school or work:

Never A Little Bit Sometimes Often Almost Always

6. Wanting to harm someone:

Never A Little Bit Sometimes Often Almost Always

7. Not liking yourself:

Never A Little Bit Sometimes Often Almost Always



8. Difficulty concentrating:

Never A Little Bit Sometimes Often Almost Always

9. Alcohol/Drug use causing problems with your physical health:

Never A Little Bit Sometimes Often Almost Always

10. Thoughts of ending your life:

Never A Little Bit Sometimes Often Almost Always

11. Feeling sad most of the time:

Never A Little Bit Sometimes Often Almost Always

12. Feeling hopeless about the future:

Never A Little Bit Sometimes Often Almost Always

13. Powerful, intense mood swings (highs and lows):

Never A Little Bit Sometimes Often Almost Always

14. Alcohol/drug use interfering with your relationships with family and/or friends:

Never A Little Bit Sometimes Often Almost Always

15. Feeling nervous:

Never A Little Bit Sometimes Often Almost Always

16. Heart pounding or racing:

Never A Little Bit Sometimes Often Almost Always



How have you been getting along in the following areas of your life over the past two weeks? *Leave blank if the item does not apply.*

17. Work/school (for example, performance, and attendance)

Terribly Poorly Fair Well Very Well

18. Intimate relationships, (for example, support, communication, closeness)

Terribly Poorly Fair Well Very Well

19. Nonfamily social relationships/friends (for example, communication, closeness, level of activity)

Terribly Poorly Fair Well Very Well

20. Life enjoyment (for example, recreation, life appreciation, leisure activities)

Terribly Poorly Fair Well Very Well

Behavioral Health History

21. Did you ever experience physical, sexual or emotional abuse when you were a child (less than 18 years of age)?

Yes No

22. Have you experienced sexual or relationship violence as an adult (18 years or older)?

Yes No

23. When you drink alcohol do you drink more than three per occasion?

Never Once a month Once a week more often than once a week

24. Have you ever had problems with illicit drugs or the misuse of prescription drugs?

Yes No



Gabriele M. Smith, MA,LPC,NCC

In Touch Counseling Services, Inc. 108 SE 124th Ave, Vancouver, WA 98684

As a Licensed Professional Therapist in the State of Washington (LH#60078778), I am providing the following disclosure of information, policies, and procedures so you are able to be fully informed about me and offer your consent to treatment. **Education, Training, and Experience.** I received my Master of Arts in Counseling Psychology from Lewis & Clark College in 2006. I received my Bachelor of Psychology from San Jose State University in 1998. Yearly, I participate in continuing education in specialized areas to be able to provide quality treatment for my clients and as a condition of my license in the state of Washington. Throughout both my undergraduate and graduate work, I had the opportunity to apply my knowledge and skills to counseling children, adolescents, and families at a community mental health agency and in a specialized private practice. My work there focused on providing comprehensive support services in the areas of social thinking deficits, mental illness and recovery from trauma . I have focused on advancing my clinical skills in my private practice by working with children, adolescents, individual women with a variety of issues. **Therapeutic Orientation.** As a Jungian, Cognitive Behavioral and solution-oriented therapist, I focus on your natural resources and resilience to help you make powerful and positive changes in your life. I believe that people have an innate need to move toward growth and healing. My goal is to provide an accepting and understanding climate that helps facilitate your growth and healing. As you teach me about yourself, we will consider your emotional, behavioral and spiritual life as well as the environment that surrounds you daily. I will help you to look at your past, present, and future to identify problems and solutions. I truly love the process of collaborating together to help you and your family discover and live a more meaningful, satisfying and authentic life. **Confidentiality.** All information you disclose in treatment is confidential unless you specifically request a release of this information in writing. It is important however, that you are aware that the law provides certain exclusions from confidentiality that include, but are not limited to: reported child, elder and dependent adult abuse; when a client makes a serious threat of violence towards a reasonably identifiable victim; when a client is dangerous to him/herself or the person or property of another; or when there is a court order. For my own professional growth and development and to ensure quality service to you, I participate in small consultation groups with other therapists. I may discuss your situation but will do so without revealing your name or other identifying information so as to maintain confidentiality. **Fee Information and Cancellation Policy.** If you would prefer that I bill your insurance company directly, my non-discounted rate is \$110/session. Longer sessions are offered at a prorated fee. Credit cards, cash and personal checks made payable to "In Touch

Counseling Services" are accepted. When we schedule an appointment, I set aside that time exclusively for you. I would like a 24-hour advance notice if you must cancel or reschedule any appointment. It is my policy to charge the full fee for any missed appointments or one that is canceled without the 24-hour notice.

Insurance Reimbursement. If you have a health insurance policy, it will often offer some coverage for mental health treatment. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you**, and not your insurance company, **are responsible for full payment of my fees.** You should be aware that submitting claims to your insurance company requires a mental health diagnosis and carries a certain amount of risk to confidentiality, privacy, and to future capability to obtain health or life insurance. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. **Emergencies.** I attempt to respond to my messages

within 24 hours. If you need help sooner or if there is a life-threatening emergency, call Clark County Crisis Line (360.696.9560), call 911, or go to the nearest hospital emergency room. **Laws and Client Rights. WAC 308-109-040:** (WA Registration #RC 39893) Counselor practicing for a fee must be registered or certified within the department of health for protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

Health Insurance Portability and Accountability Act (HIPAA): My Notice of Privacy Practices provided at intake informs you of HIPAA, a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This notice carries more detailed information regarding your rights. *Washington State Department of Health's brochure for counseling clients* is provided at intake. It contains information about client and counselor rights and responsibilities, confidentiality, and an assurance of professional conduct. If you wish to complain about any improper conduct you can call the state Department of Health, Health Professions Quality Assurance Division, PO Box 47869, Olympia, WA 98504. **Consent.** I have read and understand all the information provided in this disclosure statement. I hereby give my consent for treatment. I have been provided a copy of this Client Consent and Disclosure Form, In Touch Counseling Services Notice of Privacy Practices, and Washington State Department of Health's brochure for counseling clients.

Client's Signature Date _____

Client's Printed Name If a client is under 13 years of age: _____

Child's Name Date of Birth _____

Parent/Legal Guardian's Signature Date _____

Parent/Legal Guardian's Printed Name _____



CREDIT CARD AUTHORIZATION FORM

Please complete the following information.

This form will be securely stored in your clinical file and may be updated upon request at any time. I,

_____, authorize Gabriele M Smith, MA, LPC, NCC to charge my credit card for professional services as follows:

Please Initial:

_____ Recurring charges for services in the amount of \$_____ per visit.

_____ I understand and agree that my card will be charged In Touch Counseling Services Inc. full fee of \$_____ for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Consent and Disclosure Form I signed.

_____ **I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and co-pays).**

_____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charges (“charge back”) for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as “In Touch Counseling Services.”

Visa MasterCard Debit Card

Card #:

Expiration Date:

Name as Printed on Card:

Verification/Security Code (the 3-digit code on back of card by signature line):

Billing Address (Street, City, State & Zip):

Email Address:

Signature _____

**In Touch Counseling Services inc.
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights. If you have any questions about this Notice please contact me at (360) 356 8756

I am committed to protecting the confidentiality of your medical information, and am required by law to do so. This Notice describes my legal duties and privacy practices with respect to your medical information. I must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF MEDICAL INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

In certain situations, which I describe in Section C below, I must obtain your written authorization in order to use and/or disclose your medical information. However, I do not need any type of authorization from you for the following uses and disclosures (the examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law):

1. Treatment: I may use and disclose your medical information in order to provide treatment to you. For example, I may use medical information to diagnose and provide counseling services to you. In addition, I may disclose medical information to other health care providers involved in your treatment.

2. Payment: I may use or disclose your medical information so that services you receive are appropriately billed to, and payment is collected from, your insurer or other payment source. It is my policy to release only demographics, diagnoses, date, and type of service when I have your consent to bill third party payers. If more information is requested by a payer, I will request your written

authorization for that disclosure.

3. Health care Operations: I may use and disclose medical information in connection with our health care operations, including quality improvement activities, certification, licensing or credentialing activities. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contact. I may also provide medical information to my consultants and others for operational purposes.

4. Your Other Health Care Providers. I may also disclose medical information to your other health care providers when such medical information is required for them to treat you, receive payment for services rendered to you, or conduct certain health care operations, such as quality assessment and improvement activities.

5. Follow-up Contact. I may also contact you (for example by calling you or sending a letter) to remind you about appointments, or to provide you information about treatment alternatives or other health-related benefits and services we provide and that may be of interest to you.

6. Governmental Purposes and Other Uses and Disclosures Required or Permitted by Law: I may use or disclose your medical information for certain governmental purposes and when I am otherwise required or permitted to do so by law. For example, I may disclose medical information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access medical information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as otherwise as authorized by law.

B. Uses and Disclosures When You Have the Opportunity to Object

1. Family and Other Persons Involved in Your Care. Unless you object, I will use my professional judgment to provide relevant medical information to your family member, friend, or another person that you designate to be involved in your care.

■ Notice of Privacy Practices

Effective date: 4/14/03

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C. Uses and Disclosures that Require Your Written Authorization

1. Other Uses and Disclosures. Uses and disclosures other than those described in Section I.A. and B. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send medical information to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

2. Use and Disclosure of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including

the subset of your medical information that: (a) is maintained in psychotherapy notes; (b) is about services provided for treatment of mental health disorders; (c) is about alcohol and drug abuse prevention, treatment and referral; (d) is about HIV and other sexually transmitted diseases. In order for me to disclose your Highly Confidential Information for a purpose other than those permitted by law, I must obtain your written authorization.

I YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive medical information by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on medical information I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of medical information made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact my office. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 14, 2003.

B. Changes to this Notice. I reserve the right to change this notice, and to make the revised or changed notice effective for clinical information I already have about you as well as any information I receive in the future. I will post a summary

of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.

■Notice of Privacy Practices

Effective date: 4/14/03