



In Touch Counseling Services
Gabriele M. Smith, MA, LPC

Child's Name: _____ Date: _____

Date of Birth _____

Parents Name: _____

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) _____

Gender: F M
Ethnicity: _____

School _____

Address _____

School Phone# _____ IEP-Yes No 504-Yes No

Grade _____ Contact Person _____



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Services	# per week	By whom, where
OT		
PT		
Speech		
Other		

Family Members

Name					
Relationship					
Age					
Living in household					

What is your primary concern?



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What have you tried?

Describe your discipline style.

List any medical issues-

Formal Diagnosis?	Diagnosis done by-	Diagnosis made in?



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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 am 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, 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 if you are unable to keep a scheduled appointment. *Appointments need to be cancelled with a 24 hour notice. Failure will result in a cancellation fee equal to your session.* 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.

Guardian/Parent Signature _____

Date: _____

Gabriele M. Smith, MA
Licensed Professional Counselor



Please check any of the services you would like to be included as part of your personalized counseling package. These services are in addition to the therapy/counseling process and therefore require payment at time of service.

- ABSC ADD Screening \$40.00
- ABSC Depression/Anxiety Screening \$40.00
- ABSC Brain System Screening \$40.00
- Dream Analysis/Nightmare Resolution session with workbook \$45.00
- Health/Fitness/Weight Loss Program and Goal Setting \$45.00

Out of office services

- IEP/school/educational meetings with travel time included \$95.00/60 minute

- Phobia's (panic attacks, fear of; cars, planes, elevators, bridges, dogs', open spaces, ect.) desensitizing \$180.00/60 minute with travel time included. Sessions start in office and progress towards out of office desensitizing within the environment or stimulus.



Counselor Disclosure Form WAC 246-810

In Touch Counseling Services Inc.

Gabriele M. Smith, MA, LPC, NCC
203 SE Park Plaza Dr. #105
Vancouver, WA 98684
360-718-8544

Licensed Professional Counselor #LH60078778

Type of Counseling trained to provide: Family, Group and Individual.

Course of treatment; Cognitive Behavioral, Ethnic acculturation, Play Therapy, Gestalt, Jungian, Relaxation training, Problem solving, Psychotherapy, Solution Focused, Parenting, Family systems, Rational Emotive, Physical fitness

Counselor's Education/Training/Experience: Master's in counseling Psychology from Lewis & Clark College, Portland, Oregon. Child and Family Therapist working with children with Autism, Asperser's, ADHD, Anxiety, Depression, PDD, SI, and Learning Disorders. Co-Founder of The Development Center a training program for private practice development for clinicians.

Counselor Credentialing Act

To provide protection for the public and safety; to empower the citizens of the state Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Counselors practicing counseling for a fee must be licensed, registered or certified with the Department of Health for the protection of the public health and safety. Licensure of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

In Touch Counseling Services is a private practice independently run and operating in a group setting.

I have read and received the required disclosure information and understand the information provided.

Consumer Signature	Consumer-Print name	Date
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Counselor Signature	Counselor-Print name	Date
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Gabriele M. Smith, MA, LPC

Treatment Agreement

FEES: The fee per 50-minute session is \$_____, the fee per 90 minute session is \$_____ (except for the first session, which is \$_____). This is payable at the time of our session, unless I have agreed to bill your Employee Assistance Program. NSF will incur a \$31.bank fee. We will review the fees after 90 days.

CANCELLATIONS: You will be charged \$_____ for missed sessions or for those cancelled without 24-hour notice, except in cases of sudden illness or family emergency. Note: Insurance plans will not pay for missed or late-cancelled sessions. If I forget an appointment I owe you a free session.

INSURANCE: I am a Out Of Network Provider, this means is you are required to pay in full at the beginning of the session and I will give you're a receipt/super bill, to turn into your insurance for reimbursement if applicable.

Please sign the following, if using your Employee Assistance Program:

“I authorize the release of any information (Including treatment summaries and diagnosis) necessary to process Employee Assistance claims, or to request additional sessions. I authorize payments of benefits to Gabriele M. Smith, MA for services rendered”.

Sign

here _____

CONFIDENTIALITY: What you say in therapy, your records and your attendance are confidential except:

1. When you give written permission to release information.
2. When your records are subpoenaed for legal reasons.
3. When reporting is required or allowed by law (ex. suspected child abuse or neglect, extreme danger to self, suspected elder abuse or danger to others).
4. Other exceptions as outlined in my *Notice of Privacy Practices*

IN AN EMERGENCY: Leave a message on my voice mail and state it is urgent that you reach me. In an emergency please dial 911 or go to your local emergency room.

ENDINGS: You may end therapy at any time. A final phone call or session is requested for closure.

DISCLAIMERS: It is understood that any agreements are made between you and I only. The other therapists in the suite operate independent practices and are not responsible for your care. I also cannot be responsible for the care provided by professionals or groups that I refer you to.

PRIVACY POLICY: By signing below, you acknowledge receipt of my *Notice of Privacy Practices*. This notice provides information about how I may use and disclose your private health information.

Signature

Printed Name

Date



Gabriele M. Smith, MA, LPC

I authorize Gabriele M. Smith, MA to charge my credit card the full session fee of _____.

I authorize Gabriele M. Smith, MA to charge my credit card the no show, less than 24hr notice cancellation full session fee of _____.

Credit Card Number _____

Expiration Date _____

Signature

Date