



Connections Counseling Services NW

33301 1st Way South Suite C140 Federal Way, WA 98003

5900 – 100th St SW Suite 17B, Lakewood, WA 98499

Office (253) 625-5942 Fax: (253) 314-5320

REGISTRATION FORM

CLIENT'S NAME _____ **Today's Date** _____

Social Security # _____ Birthdate _____ Marital Status _____

Address _____ City _____ Zip _____

Reason for appointment?

How were you referred? _____ May we thank them? Y N

May I send statements or other information to your home? Yes No

Mobile Phone: _____ Leave messages: Yes No

Home Phone: _____ Leave messages: Yes No

Work Phone: _____ Leave messages: Yes No

E-mail: _____

SPOUSE /SIGNIFICANT OTHER / OTHER PARENT INFORMATION:

Name _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Address _____ City _____ Zip _____

INSURANCE INFORMATION – PRIMARY INSURANCE – PLEASE PROVIDE CARD FOR COPY PURPOSES

Insurance Company: _____ Name of Insured: _____

Insured's Date of Birth: _____

Insured's Employer: _____ Policy Name: _____

Insured's Member ID #: _____ Insured's Group #: _____

Insured's Relationship to the Client: _____ Authorization # (if needed): _____

Customer Service Phone # (for MH/SA): _____

Address for Submitting Claims: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY, OTHER THAN FAMILY:

Name _____ Phone _____ Relationship _____



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Informed Consent & Agreement For Psychotherapy Services

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Information about Your Therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Connections Counseling Services NW is owned by Jennifer King, MSW, LICSW- Licensed Independent Clinical Social Worker. The therapists here share office space and some advertising. Each therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from that practice.

Fees. The fee for service is \$ 125 per 50 minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rate basis) for any calls lasting longer than 10 minutes.

Appointment Scheduling and Cancellation Policies. Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours' notice, you (not your insurance company) may be charged the full fee for that missed session. **Exceptions may be made if you are sick or have an unavoidable emergency.**

Credit Card to keep on file: This agency may ask for a credit card to keep on file to be utilized for any no shows/missed appointments that do not have advanced notice.

Insurance. Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. **You are responsible for payment of your services and co-pays at the time of sessions. Any balance left will be sent to collections after 30 days of non payment to your account.**

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees.

Risks and Benefits of Therapy. Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more



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Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Discussion of Treatment Plan. It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, EMDR, hypnotherapy, and/or psycho-educational techniques.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination of Therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

Professional Consultation. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with Other Professionals. In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and Record Keeping. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in



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writing. I reserve the right, under Washington State law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I typically maintain records for ten years following termination of therapy. After ten years, your records may be destroyed in a manner that preserves your confidentiality.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices" (copies available on my website and in the waiting room).

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information.

However, it is important that you know that I utilize a "no secrets" policy when conducting family or marital/couples therapy. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

Psychotherapist-Patient Privilege. The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding.** You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Patient Litigation. I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of \$ 300 per hour and will include travel and preparation time.

E-mail and Phone Communication. Some patients prefer to communicate about appointment times or other administrative issues via e-mail. Although information stored on my computer is encrypted, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. E-mail should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason I discourage sending any clinical or other sensitive information via e-mail. **Please use the telephone for anything urgent or time-sensitive,** as I cannot guarantee that I will see an emergency email.

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Therapist Availability / Emergencies. You may leave a message for me at any time on my confidential voicemail at _____. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). **Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room, and/or call the Adult Mobile Crisis Response Team at 1-866-998-2243.**

Acknowledgement

By signing below, Patient(s) acknowledge that Patient(s) have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Patient(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. **You acknowledge that you have received a paper copy of HIPPA notice of privacy practices from Connections Counseling Services NW.**

Patient Name (please print)	Signature of Patient (or authorized representative)	Date
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Patient Name (please print)	Signature of Patient (or authorized representative)	Date
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I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

Name of Responsible Party (Please print)	Signature of Responsible Party	Date
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Consent to Treatment of Minors

This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

Confidentiality with Minors

The State of Washington provides significant confidentiality to minors seeking mental health treatment. In fact, minors over 12 years of age have many privacy rights similar to those of adults. My role as a therapist is to help minors learn to communicate openly and directly with their parents, and thus, I typically involve parents in the counseling process. That said, when children are making poor and dangerous decisions parents will be brought into the conversation as soon as possible, which in the case of many situations – such as suicidal ideation or attempts – is immediately.

I hereby consent to treatment of my child(ren) per the terms outlined in the above pages of this document:

Name _____ Birthdate _____	Name _____ Birthdate _____
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Parent / Guardian Name (please print)	Parent / Guardian Signature	Date
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Parent / Guardian Name (please print)	Parent / Guardian Signature	Date
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CONFIDENTIALITY STATEMENT

Although, Confidentiality and privileged communications remain the right of all clients of mental health practitioners according to the law, some courts have held that if an individual intends to take harmful acts or dangerous action against another human being, or against themselves, it is the practitioner's duty to warn the person for the family who is likely to suffer the results of harmful behavior, or the family of the client who intends to harm himself of such an intention.

Counselors cannot disclose any information you've told them during a counseling session unless: You give written consent, the information contains information about harmful acts, or the counselor has reasonable cause to believe that a child or adult dependent or developmentally disabled person has suffered abuse or neglect; the counselor receives a subpoena to provide information or you bring charges against the counselor. It is the Counselor's responsibility to report to the police, and/or Child Protective Services any incidents of child abuse or neglect disclosed to me which has not previously been reported.

Therapists are required to report incidents of suspected child or elder/disabled person's abuse to Adult Protective Services. Or Information that leads the counselor to believe you or others are or could be in danger of harm may be reported to the authorities.

I, as a mental health practitioner, will under no circumstances inform such individuals without first sharing that intention with the client, unless it is not possible to do so. Every effort will be made to resolve the issues before such a breach of confidentiality takes place.

I have read the above statement and understand it is my social responsibility to make such decisions when necessary and report to the proper authority.

Therapist

Date

(TO BE FILED IN ADDITION TO THE MANDATORY SIGNED STATEMENT)



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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Connections Counseling Services NW LLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Connections Counseling Services NW LLC to:

- release to:**
 - obtain from:**
 - exchange with:**
- _____
- _____
- _____

the following information pertaining to myself:

- treatment summary**
- history/intake**
- diagnosis**
- psychological test results**
- psychiatric evaluation/medication history**
- dates of treatment attendance**
- other (specify) _____**

for the purpose of:

- evaluation/assessment and/or coordinating treatment efforts**
- other (specify) _____**

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Client

Date

