**INTAKE FORM**

The following information is designed to assist me in becoming better acquainted with you and in

providing you with the help you need. All information is confidential and will remain in your files.

\* Please print and fill out all forms to bring with you to the first session.

**Identification Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it acceptable to contact you on your cell phone? (circle) Y N

If “no,” then how may I contact you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone (see Disclosure Form concerning confidentiality)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it acceptable to contact you by e-mail? (circle) Y N

How often do you check your e-mail? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible For Bill, If Not Client**

Name (including prefix):

Today’s Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE NOTE: Claims submitted to Insurance are subject to individual plan provisions and are not a

guarantee of payment. \*\*The provider is not responsible for any unpaid claims; please check with your

Insurance Company to receive full benefits\*\*

PRIOR TO CLAIMS BEING PAID YOUR INSURANCE POLICY MAY REQUIRE ONE OR MORE OF THE FOLLOWING FROM YOU:

• Obtain preauthorization prior to your first appointment

• See a contracted plan provider

• A written referral through your primary care physician

Full fees charged for sessions cancelled with less than 48 hour notice.

By signing below I fully understand the above stated information, and I am responsible for my total fees

at the time of service and I may seek insurance coverage with this provider on my own.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Treatment:**

Goals for Treatment/Visit Today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why Now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

Marital Status: Single Married Divorced Separated Partnered Widow/Widower

Names of Children, Ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of (circle all that apply)

Depression Suicide Attempts Anxiety

Eating Disorders Mental Illness Violence

Sexual Abuse Emotional Abuse Divorce

Alcohol/Drug Addiction

Chronic Illness (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever thought about suicide? Yes No

Have you ever attempted suicide? Yes No If Yes, when?

Is there anything else that is important for me, as your therapist, to know about that you have

not written on any of these forms? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Personal Physician (see Disclosure Form concerning confidentiality) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any recent changes in any of the following? (circle all that apply) Sleep Nightmares Amount of Exercise Sexual Desire Eating/Appetite Weight

Do you consume any alcohol? Y N

Circle frequency: Less than 1x/mo 1-3x/mo 1x/week Several x/week Every day

How would you characterize your overall health? (circle)

Poor Fair Good Excellent

**Treatment Information**

Have you been under the care of a psychiatrist, psychologist or counselor? Y N

If yes, please give the name, date and location of therapy and briefly explain the nature of the issue(s) which required attention.

When was your last appointment with any of the above?

Please state the reason for which you are seeking counseling and what you would like to be different in your life when you are done with therapy:

Please indicate your major life stressors of the past 12 months (circle all that apply)

Serious Illness or Injury Death of a Close Friend or Family Member Major Illness in Family

Gain of New Family Member Divorce/Separation Job Change Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for a psychiatric or emotional health reason? (circle) Y N

When Where Reason Outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been in an alcohol or drug treatment program? (circle) Y N

(If yes, circle) Inpatient Outpatient

When Where Outcome

**Social/Relationship Information**

**Please indicate any of the following that you have experienced (circle)**

Death of mother Your age at occurrence\_\_\_\_\_\_\_

Death of father Your age at occurrence\_\_\_\_\_\_\_

Death of child Your age at occurrence\_\_\_\_\_\_\_ Child’s age\_\_\_\_\_\_\_

Death of sibling Your age at occurrence\_\_\_\_\_\_\_ Sibling’s age\_\_\_\_\_\_

Desertion by mother as a child Your age at occurrence\_\_\_\_\_\_\_

Desertion by father as a child Your age at occurrence\_\_\_\_\_\_\_

Divorce of parents Your age at occurrence\_\_\_\_\_\_\_

Sexual abuse Emotional abuse Physical abuse

Violence in the family Mental illness of a family member

How do you get along with your present spouse or partner?

How do you get along with your children?

How do/did you get along with the members of your family of origin?

**Employment Information (Student included)**

What is the nature of your employment?

How long have you been employed in your current job?

How satisfied are you in this job? (circle)

Not very satisfied Somewhat satisfied Comfortable Very satisfied

Are you satisfied that the income from your job adequately covers your living expenses? (circle)

Not very satisfied Somewhat satisfied Comfortable Very satisfied

Do you have any other sources of income? (circle) Y N

Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spiritual Resources**

How significant a role does spirituality play in your life? (circle)

None Somewhat important Significant Very significant

**Referral Information**

How were you referred to me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosure and Information Client Form**

**INFORMATION ABOUT SCARLET GONZALEZ**

I, Scarlet Gonzalez, MA, LMFT-A, am an expressive arts and family therapist, under the supervision of Jason Franklin, LMHC, license number LH60076391. I obtained my Master’s of Arts in Psychology, with a concentration in Marriage and Family Therapy, and a specialization in Drama Therapy from Antioch University, Seattle. My undergraduate degree is in Psychology from Post University, in Connecticut. I specialize in systems and family therapies, expressive arts therapies, and the treatment of trauma, stress, depression, and anxiety. I facilitate groups for traumatized mothers and parenting triggers and provide therapy for families, adults, people in relationships, and children.

**THERAPEUTIC ORIENTATION**

I frequently utilize a multi-modal approach in my psychotherapy practice depending upon the specific needs of the client. These include, but are not limited to, Cognitive-Behavioral Therapy, Dialectic Behavior Therapy techniques, Solution-focused, Strength-based, Client-Centered therapy, and play. As a trained professional in mental health counseling, I am aware of many safety-sensitive positions and some of the unique issues an individual may face while receiving counseling. I often adopt a coaching position in therapy, which invites client participation and responsibility for their own mental health and personal growth I strive to simultaneously honor the sacredness of each individual’s chosen spiritual orientation and welcome a diversity of clients including ethnic and sexual minorities.

I believe there are phases to therapy. The first phase involves getting to know the client and collaborating on the goals for therapy. Then after establishing goals, we use solution-focused techniques to develop the framework. Lastly, within the structure, we may use a combination of expressive arts therapies and behavioral interventions to align the body and mind in a forward movement toward our goals.

**Billing and Insurance Information:**

Intake Fee

Initial visits are called intakes. It is important to gather historical information so the first session time will be one to two hours, or as long as needed to complete assessment. Initial intakes, therefore, have a one-time charge of $160.00 and they are 60 minutes in length. If you require a longer session time to meet your needs, please discuss this with Scarlet and you can make a second appointment or schedule a longer intake.

Standard Fees

The fee for a standard 55 minute individual counseling session in the office is $130.00. A 55 minute couples session is $150.00. A 60 minute family session is $180.00. A 90 minute family session is $225.00. **Payment at time of service is required.** If you believe full payment at the time of service places you in a hardship situation, please discuss with Scarlet to see what payment schedule might work for you

Electronic Communication

Due to confidentiality threats and the sensitivity of information discussed in therapy, I do not provide counseling through email, however emails can be used for scheduling purposes. If you choose to email about scheduling or billing, you understand that I cannot guarantee confidentiality. By choosing to use email to schedule and billing, you agree to not hold me responsible for any breach in confidentiality.

Client Initial: \_\_\_\_\_

**PAYMENT & INSURANCE COVERAGE**

Fees for services are required at the time of your appointment and may be made by check, cash, money orders Visa, Mastercard, Debit Cards and/or leaving an approved card number on file. Please make arrangements to have payment for your appointment at time of service.

I understand and agree to have my credit card charged for balance owed.

Client initial:\_\_\_\_\_\_

It is your responsibility to inquire if your insurance company covers Licensed Marriage and Family Therapist Associate (LMFTA), or Professionally Licensed Counselors prior to your appointment.

You can ask whether they cover “out of network providers”, and if so, what the coverage is. Many insurance companies do not volunteer this information unless specifically asked. Others require that you obtain a referral from your medical doctor. If your insurance company does not cover, you are still responsible for the payment of service.

**If you elect to use your insurance benefits, you may ask for a receipt and diagnosis so you can submit them to your insurance company for any appropriate reimbursement**

**MISSED APPOINTMENTS/IMPROPER CANCELLATIONS/COLLECTIONS**

A 24-hour notice is required for cancelations of appointments. The established fee will be charged for an appointment which is missed or where notification is not received 24 business hours in advance of the designated appointment time. Insurance will not cover missed appointments, no-shows, or improper cancellations. Let us work together on this to make sure it doesn’t happen. Please give as much notice as possible since your missed appointment time may provide time for someone else who also has a need for counseling. Thank you in advance for your courtesy in this area.

Last minute sick calls (less than the 24 hour notice of cancellation) will be billed as a courtesy at a half-rate. Cancelations made over the weekend for a Monday appointment time will be considered a short cancellation and will incur a fee. Please ensure your request for cancellation or rescheduling is submitted 24 business hours before you appointment time. For example, if an appointment has been made for Monday afternoon at 2pm, a call to cancel would need to be placed before or at 2pm the preceding Friday.

**Scheduling Appointments:** Appointments will be scheduled after each session. Do not assume that a particular appointment time will be held for you each week, unless it is agreed upon.

**Your Rights As A Client**

**Choosing a Counselor:** It is your right to choose a counselor who will best suit your needs. You may seek a second opinion or terminate therapy at any time. Confidentiality: As a professional counselor in the state of Washington, I am bound by law and ethical standards to keep any information you share with me in the strictest confidence.

**Confidentiality is your legal privilege.**

**5 Legal Exceptions to Confidentiality:** I may legally and ethically share information with others if: 1) the client gives written permission, 2) the client suggests a crime or harmful act against self or others including; physical abuse, sexual abuse, homicide or suicide, 3) the client is a minor and there is reason to believe that the minor is the victim or subject of a crime, 4) the client brings legal charges against the counselor, and 5) if the counselor is required to testify in court under a subpoena. Please read the attached brochure entitled “Client and Counselor Responsibilities and Rights” as defined by the state of Washington.

Whenever possible, exceptions to confidentiality will be discussed before any action is taken.

**Consultations**: It is a regular part of my practice to consult with other mental health professionals regarding my clients. Client confidentiality is strictly maintained throughout these consultations. My purpose is to serve you best, which may include gaining other perspectives from trusted colleagues. **State** **Information**: I am a Licensed Marriage and Family Therapist Associate in the state of Washington. **Unprofessional Conduct**: If my behavior has been unprofessional in any way, please contact my licensed supervisor, Jason Franklin, LMHC and RDT at (206) 886-3877. If you are unsatisfied with this option, please contact the Department of Health.

**State Contact Information:**

Department of Health Counselor Programs

P.O. Box 47869

Olympia, WA 98504-7869

(360) 236-4903

**Contacting Me:** You may call and leave a message with my voice mail, which I check often. Phone calls should be limited to appointment scheduling and emergencies.

**Emergencies**: In case of emergency and I am unreachable, please use one of the following numbers for help:

**General Emergencies:** 911

**Care Crisis Response Service:** (800) 584-3578 (425) 258-4357

**Crisis Clinic:** (800) 244-5767 (206) 461-3222

**I have read the information regarding Family Therapy of Seattle. I have had the opportunity to ask any questions about her and/or my counseling program. I agree to the conditions in Scarlet Gonzalez’s disclosure and information statement. I understand and agree to the information contained in the Notice of Privacy Practices, Fee Agreements, Practice Policies, and Counselor Disclosure.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FamilyTherapyofSeattle.com***

**TREATMENT PROGRAM AND COUNSELING AGREEMENT FORM**

THE PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGEMENT OF ITS RECEIPT ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. WE WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR OUR TREATMENT AND EDUCATIONAL PROGRAMS.

**YOUR RIGHTS AS A CLIENT:**

As a client of a registered and/or licensed counselor, you have privileged communication under the laws of the State of Washington. You may give written permission for your counselor to disclose that information. If you are being seen in family or couples treatment; information shared in any individual meeting may be shared by your counselor. The informational brochure from the State of Washington lists additional exceptions to your right to confidentiality.

You always have the right to request a change in treatment or to refuse treatment. You also have the right to view, copy, or request a change in your records. The Counselor Credentialing Act provides protection for public health and safety and empowers Washington State citizens by providing a complaint process against those counselors who would commit acts of unprofessional conduct. The informational brochure printed by the State of Washington Department of Health lists conduct, acts, or conditions that constitute unprofessional conduct.

It is very important that your work here meets your needs. If you believe you are not being helped, it is important that you discuss it with your counselor so that the difficulty can be resolved. If the situation cannot be resolved, your counselor will assist you in finding appropriate, alternative treatment.

**APPOINTMENTS AND FEES:**

Appointments are scheduled with a frequency believed to be most beneficial. The time scheduled for your session is set-aside specifically for you. Please understand that payment of your bill is part of your treatment. If you miss a session without cancelling, or if you cancel with less than 24 hours notice, you will be charged in full for the missed time. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate. Full payment is due at the time of service and must be in the form of either cash or check. Extended payment plans are handled on an individual basis only.

Any work done related to a legal issue on your behalf will be charged on an hourly basis for the time spent on your case. This includes meeting with your attorney, writing reports, travel and preparation time.

The parent(s) or guardian(s) of a minor are responsible for full payment.

**DUTY TO WARN OR REPORT**

Washington State law requires counselors to report instances of abuse and we may be required to report harmful, dangerous or criminal action against intended another human being or oneself. In these cases, it is the therapist’s legal duty to warn specific individuals of such intentions. For example:

l. A family member of the client who is likely to suffer grave personal harm.

2. A family member of the client who intends to harm himself or someone else.

3. Law enforcement officials, hospitals, or child protective services.

Before informing anyone who may need to be warned or making any reports, I will first take steps to share that intention with you (if you are the client).

No child under the age of 18 may be left unattended in the building due to the need for child protection and safety. Other therapists in the building may be seeing high risk, court ordered clients. If you have a child under the age of 18, you must provide appropriate supervision and safeguarding while you are in your counseling session.

*Adolescents in this state who are of the age of 13 or higher may have specific rights to confidentiality with their therapist.* Parents bringing their children in for counseling

please take note and be apprised of your children’s legal rights to confidentiality. Please feel free to direct your questions or concerns to the counselor.

**INFORMED CONSENT AND REQUEST FOR SERVICES:**

It has been explained to me that counseling is not an exact science, and that I have the right to have a clear description of the nature and character of the proposed counseling. I also realize that I have treatment options outside Family Therapy of Seattle including counseling at all and that no guarantee or assurance has been made to me as to the results that may be obtained from treatment from Scarlet Gonzalez.

**My signature below verifies that:**

1. I have freely elected the counseling/treatment through Scarlet Family Therapy in good faith and without duress.

2. I give permission for Scarlet Family Therapy to release psychological reports to referring physician(s), mental health practitioners(s), or agencies.

3. I understand that any therapy, diagnostic work, testing, video and/or audiotaping (conducted at my consent) may be reviewed by a supervising or consulting psychologist designated by Scarlet Family Therapy.

4. I am aware that treatment through Scarlet Family Therapy is not an emergency service and I have been informed of phone numbers to call in the event of an emergency during evening and weekend hours. I am aware that therapy can cause distress, and there can be no guarantee of specific outcomes or positive results.

5. I have received a copy of the Washington State Department of Health brochure on Counseling and have been informed about the purpose of the Counselor Credentialing Act.

6. I have received a copy of the published fees for services provided by Scarlet Family Therapy and have made a financial agreement for services rendered to me.

7. I have received a written disclosure that includes the registration, certification, and/or license number of Scarlet Gonzalez. This disclosure also includes information regarding his treatment philosophy, education, and experience.

8. I agree to defend, indemnify, and hold Scarlet Family Therapy, its principles, agents, and employees harmless from and against any and all liability, loss, or damage that I, as a client may suffer as a result of claims, demands, cost, or judgments arising out of, in connection with, or incident to Scarlet Family Therapy performance of services.

9. I have read this Treatment Program Statement and Client Agreement and I understand it. I have asked any questions that I desired in regard to this agreement, fees, and payment policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature Date