Center for Child and Family Therapy
Client Information

Client Name: _____ DOB: _____ SSN Guarantor: _____

Age: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip code: _____

Employer/school: _____ Phone: _____

Person filling out form: _____ Relationship to client: _____

Emergency contact: _____ Phone: _____

Home phone: _____	Can a message be left?	❑ Yes	❑ No
Cell phone: _____	Can a message be left?	❑ Yes	❑ No
Email: _____	Can a message be left?	❑ Yes	❑ No

Preferred method for appointment reminders: ❑ **Home phone** ❑ **Cell Phone** ❑ **Email**

Primary Care Physician: _____ Phone: _____

Referred by: _____

FAMILY INFORMATION (Others in household)

	DOB	Relationship to client

Insurance information (only if you do not have a card) **Primary insurance name:** _____

Subscriber Name: _____ Subscriber SSN: _____

Date of Birth: _____ Relationship: _____

Policy number: _____ Group number: _____

Secondary insurance name: _____

Subscriber Name: _____ Subscriber SSN: _____

Date of Birth: _____ Relationship: _____

Policy number: _____ Group number: _____

If the client is a child, is he/she the subject of custody proceedings? ❑ **Yes** ❑ **No**

Please describe the main problems that led you to therapy: _____

When did these problems start? _____

INFORMED CONSENT

We are pleased to offer you therapy services and look forward to working with you. As with any treatment, there are some risks as well as many benefits with therapy. You should think about the benefits and risks when making any treatment decisions. You should understand that developing a treatment plan with your therapist and regularly reviewing your progress toward meeting the treatment goals are in your best interests. You agree to play an active role in this process. You understand that no promises have been made as to the results of treatment or of any procedures provided by your therapist. You are aware that you may stop your treatment with your therapist at any time.

APPOINTMENTS: The usual length of sessions are 45-55 minutes. Appointments can be made or rescheduled with the office staff. When office staff is not available, you may be able to schedule directly with your therapist. Please leave any messages regarding scheduling in the receptionist confidential voice mail. If you are late for a scheduled appointment without calling to let us know, your therapist may have left for the day and is considered a no-show. If your therapist decides to see you, the appointment will still end at the scheduled time and be charged accordingly. It is your responsibility for initiating rescheduling.

AT LEAST, 24 HOURS NOTICE IS REQUIRED FOR ANY CANCELLATIONS OR RESCHEDULING. EACH THERAPIST HAS THEIR OWN CANCELLATION/NO-SHOW POLICY, WHICH YOUR THERAPIST WILL DISCUSS WITH YOU.

FEES: YOU ARE RESPONSIBLE FOR PAYING ALL CHARGES FOR YOUR SERVICES, REGARDLESS OF PAYMENTS FROM YOUR HEALTH INSURANCE OR OTHER SOURCES. Payment is due at each session. We accept most major credit/debit cards, health care spending cards, checks, or cash. If you would like us to bill your insurance company or other third party, you are responsible for providing information, referral forms, etc., needed for reimbursement. You are responsible for any deductible and co-payment amounts, which are to be paid **at the time of service** unless other arrangements are specifically made with your therapist or the office manager.

PLEASE NOTE: When treating a child, it is NOT up to us to determine which parent is responsible for payment, nor any split payment (or other provision) that may be court ordered. Whichever parent or adult who brings in the child will be responsible for payment at the time of service.

Initial intake session $210

Individual/family/couples 53 minutes $150

Individual/couples 30 minutes $100

Individual/couples 45 minutes $130

Play therapy or complex problem add additional $20

Charges for other services, such as school meetings, consultation with other therapists or professionals, or any court related services, will be discussed by your therapist. Any questions about fees should be discussed with your therapist. In the event of a refund, any monies due to you will be sent no later than 60 days from discovery.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency, we use the *National Service Bureau*. In most collection situations, the only information that will be released is client name, kind of services provided, and the amount due. If your account remains unpaid, we must stop therapy with you. Again, fees that continue to be unpaid or without a payment plan after this may be turned to small-claims court or a collection service.

RECORDS AND COPYING: Your therapist has up to 14 working days to retrieve and copy records. Your therapist will keep your records for the length of time required by law unless your therapist is contractually obligated by your insurance company to keep them longer. You have the right to look at the health information we have about you. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You must make this request in writing or email and send it to your therapist. You must tell your therapist the reasons you want to make the changes. However, a therapist has the right to deny access to your PHI health care information if a therapist believes sharing this information could reasonably expect to cause danger to the life or safety of any person (RCW 70.02.090). You can get a copy of these records, but you may be charged for it (WAC 246-08-400).

$26 clerical fee for searching and handling records
$1.17 cents per page for the first 30 pages
$0.88 cents per page for all other pages starting with page 31

CONFIDENTIALITY: The counselor-client relationship is legally privileged; all issues discussed in therapy are confidential. A written consent needs to be signed in order to release any records or information about your therapy, except as what was discussed in the "Consent to Your Health Insurance" section or as provided for by current law. Your therapist will not tell anyone about you and will not reveal that you are receiving therapy. In the case of family/marital therapy, your therapist will treat everyone involved as the client requiring that everyone in attendance to sign a release of information.
In all but a few situations, your confidentiality is protected by federal and state laws. Here are the most common cases in which confidentiality is NOT protected:

1) If this therapist believes or has suspicions that a child under 18 years of age or an elder has been or will be abused or neglected, the therapist is legally required to report this to the authorities. This is under RCW 26.44.
2) If the client makes a serious threat to harm themselves or another person the law requires this therapist to try to protect the client or the other person from imminent harm. This is under RCW 26.44.
3) In the case of death or disability of the client, the client's personal legal representative can authorize release of records.
4) The Department of Health can access the client's records when they are investigating a grievance or to determine compliance with the therapist's licensure.
5) In the event that your records are subpoenaed by a judge or a judicial officer, information must be released.

Please tell us if you have other concerns. You have the right to refuse consent or withdraw consent, in writing.

TEENAGERS: RCW 71.34 allows teens to consent for their treatment and the release of PHI. Sharing of any sensitive information can result in a significant lack of trust and negatively impact the counseling process. When working with teens (13-18 years of age), the therapist will not share information with parents without a current release of information signed by the teen. A written consent must be signed by the teen in order to release any records or information about the their therapy, except as what will be discussed in the "Health Insurance Consent" section or as provided for by current law. In some cases, scheduling and billing may be discussed with the parent/guardian.

ELECTRONIC/SOCIAL MEDIA: Your therapist will not accept any invitations for any social media or video games. Therapy sessions cannot be audio or video recorded unless your therapist and all parties sign a recording consent form. This is to protect your confidentiality and to keep the boundaries of therapy clear.

COMPLAINT PROCEDURES: Problems can arise in the therapy relationship. If you are not satisfied with any area of your work, please raise your concerns with your therapist at once. Therapy together will be slower and harder if your concerns are not worked out. If you do not feel your concern has been resolved, you may contact CCFT management. If you continue to feel your concern has not been resolved you can also contact Washington State Department of Health to help with your concerns at www.doh.wa.gov.

PHONE CALLS: Your therapist will spend most of his/her working hours in session and will be difficult to reach directly. Therapy is conducted during person-to-person sessions. If you have a problem that cannot wait until your next appointment, you may leave a message for your therapist directly. Please keep in mind that your therapist has varied working days and typically they do not check their confidential voicemails when they are not working.

EMERGENCIES: When your therapist is away from the office for an extended period, the therapist will have a trusted fellow therapist from Center for Child and Family Therapy be available if you have any immediate issues. Therefore, he/she will need to know about you. This therapist is bound by the same laws and rules as your therapist to protect confidentiality. The nature of a therapy practice does not allow the therapist to provide continuous emergency services. If you have an EMERGENCY, call the Crisis Line at 360-479-3033; or in case of a life-threatening emergency, call 911.

TERMINATION: If you intend to terminate, one final session is requested for concluding the therapy experience. You should make every effort to discuss any concerns with your therapist before ending therapy. At the conclusion of therapy, this agreement shall be concluded. Your resumption of therapy with the same or another therapist at the Center for Child and Family Therapy shall require a new and separate agreement.

HEALTH INSURANCE CONSENT

Your health insurance may pay for part or all of your therapy, but the benefits cannot be paid until your health insurance authorizes treatment. If you choose to use your health insurance to pay for therapy, you must allow your therapist to communicate with your health insurance company about your treatment recommendations, progress during therapy, and about how you are doing in many areas of your life. This information is considered Protected Health Information (PHI). All of this information will become part of the health insurance records.

Your health insurance may set limits on the kinds of therapy your therapist can provide and can refuse to pay for services. You or your therapist can appeal the health insurance's decisions on payment and number of sessions. The health insurance will approve therapy aimed at improving the specific symptoms that brought you to therapy. If your health insurance authorizes your therapy, it may limit the number of therapy sessions within a calendar year. It may not agree to more sessions, even if your therapist feels they are needed to fully relieve your presenting issues. The health insurance company in charge of your medical and mental health benefits can change during the course of therapy. If this happens your therapist may have to go through the authorization process again. It is possible that the benefits or coverage for your therapy may change and your part of the costs may change as a result. It is your responsibility to let your therapist know when your benefits change.

In some cases, your therapist is required by your health insurance to contact your physician. This PHI is allowed to be shared under HIPAA and state regulations without consent (RCW 70.02 Medical Records).

By signing this form, you give your therapist permission to submit PHI in order to secure payment for mental health services. You agree to have payment from the health insurance be sent directly to the Center for Child and Family Therapy or to your therapist. You are aware that this may include faxing; sending encrypted PHI through Office Ally, our billing software vendor; and possibly exchanging information with your health insurance through HIPAA-compliant emails. **In the future, we may change how we use and share your PHI and we may change our Notice of Privacy Practices. If we change it, you can get a copy from our website, www.ccftherapy.com or by calling us at 360-698-9258.**

If, after reading this consent information and discussing with your therapist, you are concerned with any of the above, you have the option to pay your therapist directly and not use your mental health benefits. This means your PHI will not be shared with your health insurance.

I, the client (or his/her parent or guardian), acknowledge that I have read this document, and understand the informed consent and/or other information about therapy. I have been informed about my privacy rights and PHI disclosure under the Health Insurance Portability and Accounting Act by reading the complete description of the Notice of Privacy Practices (available in the office in print form or at www.ccftherapy.com.) I have had all my questions answered fully. If I have any future questions about any of the subjects discussed in this informed consent, I can talk to my therapist about them. My signature below shows that I understand and agree with all of these statements.

I, the client do hereby willingly and freely agree to enter into therapy with the therapist indicated below, and to cooperate fully and to the best of my ability. I understand that I may revoke this consent in writing at any time, except to the extent that your therapist has taken action relying on this consent.

_____ _____

Responsible Party/Client Signature Date

_____ _____

Additional Legal Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

❑ Copy accepted by client ❑ Copy accepted by additional person

AGREEMENT OF PARENTS/GUARDIANS IN CASES OF CUSTODY PROCEEDINGS

Therapy can be a very important resource for children experiencing separation and divorce. The therapist can provide an emotionally neutral setting in which children can explore these feelings. In this case, a child cannot be seen unless both parents agree to the child receiving therapy. An exception to this is if one parent has legal documentation (e.g., a legally signed parenting plan) stating they have sole decision making for mental health and medical treatment for the child. The parent would be required to provide a copy of this document to the therapist. However, the usefulness of therapy is extremely limited when therapy itself becomes simply another matter of custody dispute between parents. Any matter that is brought to the therapist's attention by either parent regarding the child may be revealed to the other parent unless otherwise stated in the parenting plan. It is requested that all parents or guardians remain in frequent communication with the therapist regarding the child's emotional well-being.

The therapist will not choose sides and cannot render a forensic opinion. The parent must understand completely that the therapist is providing treatment and is not acting as an evaluator. The parent must further understand that the therapist is not conducting a custody, visitation, or parenting evaluation. I want you to understand the reasons why I will not provide your records for custody dispute. I may not possess the professional skills to make a decision about issues besides those I deal with in therapy. Therapy often involves full disclosure of information that you might not want to have revealed in court. I might say in testifying or being deposed might change our therapy relationship, and I must put that relationship first. This would be counterproductive to the therapeutic process and relationship. If you want custody evaluations and recommendations, we will be happy to refer you to those with this expertise.

I, the parent/guardian is aware that requesting the release of treatment notes or plans, reports, or evaluations for forensic purposes or my testimony about the content of my child's treatment will interfere with the therapeutic process. Therefore, I knowingly and freely waive my right to request the release of information (beyond the attendance, dates, and length of our sessions) to my attorney. I understand that release of clinically significant information to any officer of the court shall only be in response to a court order or subpoena. If records are requested by either parent and the parenting plan states both parents have medical decision making, our policy is to send **BOTH** parents those records. Even if the other parent has not requested those records.

I have read and understand the issues and points made above. I have discussed those points I do not understand and have my questions answered. I agree to act according to the points covered in this form. I am the legal custodian of this child and have no court orders in effect that would prohibit me from consenting to the treatment of this child. I also understand that the therapist can rely on my representation that I am authorized to consent to health care for the minor patient as true without incurring any civil or criminal liability for such reliance, pursuant to RCW 70.02.130. My signature below indicates I agree to these points and follow fully to the best of my ability.

IF YOU DO NOT SIGN OR ALL LEGAL PARENTS/GUARDIANS DO NOT AGREE TO THIS AGREEMENT, THEN WE CANNOT PROVIDE THERAPY TO YOUR MINOR CHILD.

_____ _____

Responsible Party/Client Signature Date

_____ _____

Additional Legal Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

❑ Copy accepted by client ❑ Copy accepted by additional person