CARING SOLUTIONS COUNSELING CENTER
1800 112TH Avenue NE, Suite 320E,
Bellevue, Washington 98004
425.455.0300

CLIENT INFORMATION

First Name: _____Middle Initial: ____ Last Name: _____ Date of Birth: _____

Street Address: _____City: _____State/Zip: _____

Phone: Home _____Work _____Cell _____

Email Address: _____ Social Security Number: _____

Spouse Name: _____Date of Birth: _____

Child Name: _____Date of Birth: _____

Child Name: _____Date of Birth: _____

Child Name: _____Date of Birth: _____

Child Name: _____Date of Birth: _____

Parent Names (if minor): _____ Emergency Contact Person: _____Phone: _____

Referred By: _____ □ Internet, □ Friend, □ Other

May I have your permission to thank this person for referring you? □ yes, □ no

Why are you seeking therapy at this time? _____

How long have you been experiencing this problem? _____

How is this problem impacting your life? _____

What would you like to accomplish in therapy? _____

Are you currently in treatment for drug, alcohol, or mental health problems? □ yes, □ no

Are you having thoughts of suicide? □ yes, □ no

Do you have a plan for suicide? □ yes, □ no Explain: _____

INSURANCE INFORMATION (Provide a copy of your insurance card and driver's license.)

Name of Policy Holder: _____Middle Initial: _____Last Name: _____Date of Birth: _____

Street Address: _____City: _____ State/Zip: _____

Phone: Home _____ Work _____Cell _____

Your relationship to the policy holder: _____

I authorize the release of any medical information or other information necessary to process payment from my insurance company to Caring Solutions Counseling Center, INC.

_____

Signature of Client Date

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MEDICAL INFORMATION

Physician: _____ Phone: _____ Date of Last Physical: _____

Medication	Dosage/frequency	For what?	When began?

- What major/chronic illnesses, injuries, or operations have you had? _____
  _____
- Rate your overall health: □ poor, □ fair, □ good, □ excellent
- Have you experienced any recent changes in the following? □ sleep, □ exercise, □ sexual desire, □ eating, □ weight
- Do you drink alcohol? □ yes, □ no
- How often do you drink? □ under once a month, □ many times a month, □ every day
- What type of alcohol? □ beer, □ wine, □ hard liquor
- Do you use any street drugs or misuse prescription drugs? □ yes, □ no. Which drugs? _____
- Have you ever been in a drug or alcohol treatment program? □ yes, □ no. If yes, please indicate the name of the facility and if it was inpatient or outpatient? _____

FAMILY HISTORY

- Which of these have your family members experienced? □ depression, □ suicide attempts, □ anxiety, □ sexual abuse, □ emotional abuse, □ eating disorders, □ mental illness, □ violence, □ alcoholism or drug addiction,
- Your parents are: □ married, □ divorced, □ widowed, □ deceased
- What major life stressors have you had in the past 12 months? □ serious illness or injury, □ death of friend/family, □ major illness in family, □ gain of new family member, □ divorce / separation, □ job change, □ other, explain.

PAST TREATMENT

- Have you ever had psychological or psychiatric counseling before? □ yes, □ no. What problems did you address at that time? _____

EMPLOYMENT INFORMATION

- What do you do for work? _____How long have you been at the current job? _____
- How satisfied are you with your job? □ not satisfied, □ somewhat satisfied, □ comfortable, □ very satisfied
- Is your income covering your expenses? □ yes, □ no

SOCIAL / RELATIONSHIP INFORMATION

- Please indicate any of the following that you have experienced? □ death of a family member, □ divorce of parents, □ sexual abuse, □ emotional abuse, □ physical abuse, □ violence in the family, □ mental illness of a family member.
- How do you get along with your current spouse or partner? _____
- How do you get along with your children? _____
- How do you or did you get along with your family of origin members? _____

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FINANCIAL & CLINICAL AGREEMENT

- The fees for our services are one hundred thirty-five dollars ($135.00) per forty-five minute (45) clinical session. Upon your request, we will be happy to provide you with the current billing rates of the counselor treating you. Please be aware that our billing rates are subject to change.
- The fees for broken appointments or same day cancellations are seventy-five dollars ($75.00).
- Additional costs and disbursements incurred on your behalf will also be billed to you. Such costs and disbursements include, but are not limited to, testing, photocopy charges, postage, long distance telephone charges, facsimile charges, related outside service fees, and travel expenses incurred on your behalf.
- As a client, you are responsible for payment of the services rendered and for costs and disbursements incurred on your behalf. Although a third party (such as an insurance company or another party) may agree to pay all or a portion of your bill, you shall remain jointly and severally liable for any unpaid fees and costs.
- Please understand that our invoices are payable upon receipt. In the event you are unable to pay the amount due in full within ten (10) days of mailing the invoice, a compound interest charge of one and one-half percent (1.5%) per month will be imposed upon any remaining unpaid balance of the amount due.
- Counselors practicing counseling for a fee must be registered or certified with the department of licensing for the protection of the 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. Consequently, you should understand the educational background and qualifications of the counselor you select.
- Caring Solutions Counseling Center Inc. requires that its counselors be licensed by the State of Washington and have an advanced graduate degree in either Social Work or Clinical Psychology. The director and principal counselor at Caring Solutions Counseling Center Inc. is Eldon B. Vance, BS, MSW, LICSW, LCSW. Mr. Vance has a Master degree in Social Work (MSW) from Brigham Young University. Mr. Vance further obtained postgraduate certifications as both Licensed Independent Clinical Social Worker (LICSW) and a Licensed Clinical Social Worker (LCSW). Mr. Vance's Washington state license number is LW00004366.
- You should feel comfortable not only with your counselor, but also with your treatment. You have the right to refuse treatment. While you are in our care, please do not hesitate to ask questions about your treatment. We wish to address all of your concerns and assist you in your treatment.
- Confidentiality exceptions: As counselors we cannot disclose any information you have told us during a counseling session. Exceptions to this general rule are listed in RCW 18.19.180 (1) through (6). A copy of this statute is available upon request.
- The therapeutic orientation of Caring Solutions Counseling Center Inc. and the counselors it employs is that of cognitive, behavioral, socio-educational, and eclectic therapy. The particular therapy that will be applied in your case will depend upon your particular circumstances and mental state.
- At this time, we cannot propose a specific course of treatment, because a diagnosis has not yet been made. Depending upon your particular situation, it may take between two to four or more sessions to make a proper diagnosis. Thereafter, upon your request we will be happy to provide you with a written proposed course of treatment.
- Professional conduct: RCW 18.130.180 lists particular acts that are considered unprofessional conduct. A copy of this is available upon request. The purpose of the Counselor Credentialing Act is to provide protection for public health and safety; and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. We shall not participate in any of such acts, and respectfully request that you also respect the professional nature of our representation.

Please acknowledge that you have read and understand the foregoing and accompanying information and that you accept the above-stated terms and conditions by signing and dating this agreement where indicated below and returning it to us. If you are not yet twenty-one (21) years of age, a parent or guardian must co-sign this agreement with you.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are required by federal law to keep a copy of this completed form in your file whether or not you are requesting that we share protected health information at this time.

I, _____ authorize Caring Solutions Counseling Center, Inc. to disclose to and/or obtain
(Your name)

from: _____ the following information:
(Names of others who you authorize your protected information disclosed to and/or obtained from.)

Which protected information are you authorizing to disclose?

□ any and all general assessment or other information regarding my social, emotional, educational, religious, psychological, and/or medical histories, including assessments, background, opinions, and any other relevant data necessary to assist Caring Solutions Counseling Center in providing continuing service to me.

□ General Assessment Information Specific to _____

PURPOSE OF DISCLOSURE / EXCHANGE OF INFORMATION:
The exchange of information may be done by telephone, fax, electronic data transfer, or mail, at my request or to coordinate treatment, i.e. in order to process insurance billing.

RELEASE REQUIRING SPECIFIC CONSENT:
I am aware that my records may contain healthcare information relating to testing, diagnosis or treatment for HIV/AIDS, for any other STD, for chemical dependency, and/or for mental health. I specifically authorize Caring Solutions Counseling Center, Inc. to disclose any and all such information, if not excluded by initialing below: If I put my initials below then I intend to EXCLUDE from this Authorization healthcare information relating to testing, diagnosis, or treatment for the following: Chemical Dependency _____, Mental Health _____, HIV/AIDS _____, Sexually Transmitted Diseases _____.

REVOCATION / RE-DISCLOSURE:
I understand that I may revoke this authorization at any time by giving my health care clinician a written and signed statement of revocation, and that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure of my health information by the recipient is a potential risk. If re-disclosed, privacy laws may no longer protect the information.

DURATION:
If not previously revoked, this authorization will expire two (2) years from today's date OR on _____.

CONDITIONS:
I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so may condition treatment from Caring Solutions Counseling Center, Inc.

_____
Signature of Client Date

_____
Signature of Parent, Guardian or Personal Representative Date