WellSource Counseling LLC

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Clinician Statement and Informed Consent

I am a licensed mental health counselor in the state of Washington, License number LH60372271. I am also a National Certified Counselor by the National Board for Certified Counselors, certification number 283087. My education was a bachelor degree in Psychology and a Master of Science in Mental Health Counseling at Western Washington University, a CACREP accredited program. As a Nationally Certified Counselor I am required to complete 100 hours of continuing education every five years to maintain my certification.

I have 10+ years experience in the mental health field with 7+ of those specifically providing mental health therapy. I am experienced with many diagnoses and mental health concerns including sexual trauma, physical abuse, chronic pain, depression, anxiety, stress, OCD, psychosis, personality disorders, relationship conflict, codependency, substance abuse, grief and loss, among other concerns. I additionally have special knowledge and/or training around competent counseling for the LGBTQ+ population, alternative relationship systems such as polyamory, sex positive community, and leaving a fundamental religion.

The primary forms of therapy I provide are Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Mindfulness Based Cognitive Therapy, Person Centered Therapy, and Solution Focused Brief Therapy. I also sometimes provide Behavioral Activation, Existential Therapy, Mindfulness Based Stress Reduction, and skill training including meditation, mindfulness, and relaxation.

I provide individual and relationship counseling to adults usually meeting weekly or every other week for a 55 minute appointment. Specific reasons may come up to schedule a longer or shorter session or frequency of meeting. The frequency that we meet and the type of therapy I provide for you will be determined collectively with a focus on what style will be most therapeutic for you in meeting your goals.

As you attend appointments you may begin to find that counseling often has emotional and relational risks. Meaning that you may begin to talk about stories or feelings that you didn't know you had, or that you have worked hard to forget. This heightened sense of emotion can feel both exciting and frightening. Also, deciding to make changes in your thinking, beliefs, and behaviors may disrupt the nature of your current relationships. If you notice this and find it too overwhelming please bring your observations to your counseling appointments, so that we can address them collaboratively.

Additionally, please note that due to the nature of our conversations, our relationship may feel like a

friendship. This is completely normal, however it is important to remember that we have a professional rather than a personal relationship. Professional ethics require that our contact be limited primarily to our appointments and for the purposes of your mental health services. Therefore, please do not contact me via social networking, invite me to social gatherings or offer gifts. These professional boundaries exist, so that counseling can more effectively benefit you and address your mental health goals.

Client Rights

You have the right to informed consent (transparency) of your services. You have the right to choose a counselor that works best for you and your needs. You have the right to choose a modality of counseling that you believe suits your current struggles. Therefore, you are free to seek a second opinion or to end our therapeutic relationship at any time.

If you believe my conduct to be unprofessional, please contact the Washington State Department of Health. Department of Health: Counselor Programs P.O. Box 47869 Olympia, WA 98504-7869 P. 360.664.9098

Confidentiality and Privacy Practices.

As a Licensed Mental Health Counselor, I am bound by state and federal law and ethical standards to keep confidentiality. This means that I do not share your information with anyone unless you have given me written consent. However, there are a few exceptions where I am mandated by these same laws and ethics to break confidentiality without written consent (RCW 18.225.105):

> 1) If the client waives this privilege by bringing charges against the counselor. 2) If the counselor is required to testify in court as a result of a subpoena. 3) If the client reports information about a minor or vulnerable adult being abused or neglected. 4) If I have reason to believe that the client intends to cause imminent harm to the health and safety of another person, or to him/herself.

If you are using health insurance to pay for your services then information will be released to your insurance company regarding your services for the purposes of billing.

If you choose to contact me via voice over internet protocol, email, or texting these are not assured confidential ways of communicating. The information will be retained on the servers of the service provider, which could in theory be viewed by their personnel. Therefore please note that these forms of communication cannot be assured of complete confidentiality. I will do my best to maintain confidentiality in these domains however, if you choose to utilize these forms of communication the content should be kept to scheduling issues and brief statements or questions.

I consult regularly with other professional counselors regarding my practice. Please note that no identifying information will be shared, and that these practitioners are also bound by the same legal and ethical standards to keep our conversations confidential.

Billing Information

The fee for a 55-minute individual counseling session is $125. Payments can be made in cash or check and are due at the time of service. An additional $25 fee will be added for any returned checks. I do offer a few slots on a sliding scale for students and individuals who are struggling financially. Please let me know before our first appointment if this is something you are hoping to utilize.

At this time I primarily work as an out-of-network provider. Some insurance companies may offer reimbursement for a portion of the fee, if you choose to utilize a counselor who is out of their network. Please contact your insurance provider before our first appointment if you plan to use this option, so that you know how your particular insurance plan handles their reimbursements. I am able to provide the necessary paperwork should this option be available to you.

Scheduling and Cancellations.

During or after the initial appointment we will agree on a regular date and time that will be reserved for you. Once a day and time is agreed to, it becomes your financial responsibility until such time that we agree to end our therapeutic relationship. Please arrive on time noting that if you do arrive late, we will end at the regularly scheduled ending time, and you will be charged the full appointment fee.

I do have a 24 hour cancellation policy, which means that in the event that you miss an appointment without informing me 24 hours prior, you will be charged a 75.00$ no show fee. In the rare case of an emergency (i.e. medical or weather) you may not be charged. Please also note that if you have a regular appointment time reserved for you that missing this appointment time twice in a row without notifying the counselor will result in this appointment time no longer being reserved for you.

Crisis

You are always welcome to call or email me with questions or concerns. I will call you back as soon as I can, which is often the following business day. For more urgent matters it is important to note that I am not available for crisis or emergency assistance. If you ever feel you are in danger or in a life threatening emergency call **911**. If you are in a mental health crisis and I am not available please call the King County

24hr Mental Health Crisis Line: 866-4CRISIS (866-427-4747) Local 206-461-322 TTY 206-461-3219

Consent to Treatment: I have completely read and understand the information provided in this professional disclosure and consent to treatment. I have considered it carefully, asked questions where there has been any confusion, and I agree to its terms.

Client Name (printed)_____ Date of birth_____

Client Signature_____ Date _____

Counselor Signature_____ Date _____

Client Information

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone Number: _____ Cell Phone Number: _____

Emergency contacts:

Name: _____relationship: _____ Phone:_____

Name: _____relationship: _____ Phone:_____

Opt out of health insurance use and opt in for fee for service payment? Yes ( ) No ( ).

Are you Interested in utilizing the sliding scale for billing? Yes ( ) No ( )

If Using Health Insurance Provide Information about the Policy Holder:

Policy Holder Name_____Relationship to Client_____

Name of Insurance Company_____

Member ID_____ Group Number_____Effective date_____

Social Security #_____ Date of Birth_____/____/_____

I hereby authorize medical benefits to which I am entitled and are due to this office to be paid to this office. I authorize any information needed to be released to my insurance company for the purposes of authorizing and processing my claims. I understand that I am fully responsible for, and will assume all my charges not paid by my insurance. I understand that there is a 75$ no show fee and a 25$ bounced check fee. I understand that payment is due at the time of service in the form of cash or check.

Typed Name_____

Signature of Client_____Date_____

Intake Questionnaire

The following information will be kept confidential and will be used to help me get to know you and provide the best mental health care for the concerns you would like to address.

Current Concerns

What concerns prompted you to schedule this appointment?_____

_____

_____

_____

What concerns do you have about your mental health at this time?_____

_____

_____

_____

Are you currently experiencing significant change from your normal pattern in any of the following? Circle all that apply.

Sleep patterns	Energy Level	Amount of Exercise	Appetite/Eating
Nightmares	Weight	Sexual Desire	Ability to Focus
Mood	Thoughts	Managing Responsibilities	Self-Care

What stressors are you currently experiencing?_____

_____

_____

In the past 5 years have you experienced any of the following? Circle all that apply.

Anxiety	Divorce/separation	Suicidal Thoughts	Anger Outbursts
Depression	Sexual Identity Stress	Self Harm/injury	Impulsivity
Insomnia	Work Related Stress	Financial Stress	Grief/Loss
Phobias/Fear	Religious/Spiritual stress	Eating Issues	Body Issues
Obsessions	Gender Identity Stress	Compulsions	

Other:_____

Who are your current supports in your life?_____

Medical Information

Current physician's name: _____ Phone: _____

Do you have any diagnosed medical conditions?_____

_____

Are you currently experiencing any significant health concerns or changes?_____

_____

Are you currently or have you previously received mental health counseling or medication services?
Yes( ) No ( ). If yes, please list below.

Date	# of visits	location	Provider's Name	Primary Concern
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you previously received a mental health diagnosis? Yes ( ) No ( ). If yes please describe._____

_____

Have you ever been hospitalized for psychiatric or mental health concern? Yes ( ) No ( ). If yes, please briefly describe the date, location, nature of treatment, and outcome._____

_____

Have you ever attempted suicide? Yes ( ) No ( ) If yes briefly describe_____

_____

Do you currently have any concerns about alcohol or drug use? Yes ( ) No ( ). Please describe._____

_____

_____

Have you attended an alcohol or drug treatment program? Yes( ) No( ) If yes, list below.

Date	Length	Name	In Patient/Out Patient	Primary Concern
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family Information

Marital Status_____If partnered, briefly describe your relationship. _____

_____

_____

Are there currently relationship concerns you would like to address in counseling? _____

_____

_____

Do you have children? Yes ( ) No ( ) If yes, please list their names and ages._____

_____

Whom did you grow up with (parents/siblings)?_____

_____

Do any of your family members have a history of any of the following? Circle all that apply.

Depression Anxiety Suicide/Suicide Attempt Alcoholism/Drug Abuse

Other Mental Health Concerns:_____

Briefly describe your childhood_____

_____

During childhood did you experience any of the following? Circle all that apply.

Physical abuse Sexual Abuse Emotional/Psychological Abuse Witness Violence

Spiritual/Religious Abuse Traumatic accidents Natural Disasters

Significant Health Concerns/Surgery

Other traumatic experiences:_____

Would you like to address one or more of these in counseling? Yes ( ) No ( ) Unsure ( ).

As an adult have you experienced any of the following? Circle all that apply.

Physical abuse Sexual Abuse Emotional/Psychological Abuse Witness Violence

Spiritual/Religious Abuse Traumatic accidents Natural Disasters

Significant Health Concerns/Surgery

Other traumatic experiences:_____

Would you like to address one or more of these in counseling? Yes ( ) No ( ) Unsure ( ).

Additional

What type of education have you completed?_____

Please briefly describe your employment status and/or history. _____

Do you have a history of any legal issues (i.e. Arrest, incarceration etc.) Yes ( ) No ( ) If yes, please describe.

_____

Goals for Counseling

Briefly describe your hopes/goals for counseling._____

_____

_____

_____

_____

_____

Are there any specific symptoms or behaviors you would like to primarily address?_____

_____

_____

Are there any specific skills or mental health areas you would like to learn more about?_____

_____

_____

Are there any specific styles of therapy that you are interested in?_____

_____

What change would let you know that you have completed your current time in counseling? _____

_____

_____

Any additional information you would like your counselor to know at this time?_____

_____

All of the information above is true to the best of my knowledge.

Client printed name_____ Date_____

Client signature_____ Date_____

Patient Health Questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0	+ _____	+_____	+ _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Generalized Anxiety Questionnaire.

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
FOR OFFICE CODING	0	+ _____	+_____	+ _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult