Elizabeth A. Snyder MS, LMHC
Mental Health Services for Adolescents and Young Adults

214 N. Commercial Street, Bellingham WA 98225
Phone (360) 734-5552 ♦ fax (360) 733-1928
Licensed Mental Health Counselor # LH0007502

DISCLOSURE STATEMENT

Welcome to my practice! Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

EDUCATION:
2000 M.S. Psychology, Mental Health Counseling, Western Washington University
1997 B.S. Psychology, University of Washington
1993 B.A. Business Administration-H.R., Western Washington University

MY APPROACH TO COUNSELING:
I believe that individuals have the knowledge and ability to help themselves with the collaboration and understanding of another individual. In my practice I work with clients from a strength-based perspective of the individual in context, including an awareness of the contributions of their history, gender, environment and culture. I use a variety of integrated therapeutic approaches for treatment including, but not limited to the following: Testing and assessment, existential-phenomenological, cognitive-behavioral, and dialectical behavior therapy. I have completed the Intensive Training in Dialectical Behavior Therapy (DBT), as well as many other training offerings in the area of DBT. I have also participated in training regarding the areas of grief/loss, attachment, trauma and eating disorders.

Therapy may be offered in either an individual, couples, family or group format. I will also collaborate with any medical providers involved in a client's treatment as seen necessary, and with a client's consent. We will evaluate our progress towards treatment goals to allow for adjustments to the therapy process and/or individual goals. My intent is to provide a respectful, holistic and relationship-based approach to therapy, rather than one that in narrowly focused and/or impersonal.

CONFIDENTIALITY**:**
You have the right to choose a counselor who best suits your needs and purposes and if ever you or I feel that our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area. You also have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6).

I will keep all information about you confidential, including the fact that you are my client.
With teens age 13 and over: I will keep your individual information confidential, even from your parents/guardians. I may need to communicate with your parents regarding appointment scheduling and payment, or if I am worried that your life is in danger.
When I am required to release information:
If I suspect that a child or dependent person is being abused; if you intend to seriously harm yourself or someone else; to consult with my confidential clinical team regarding my counseling work; or if a judge subpoenas my records.

I have been provided a copy of the required disclosure information the "Notice of Practices Regarding Protected Health Information" and read and understand the information provided.
Initial here to acknowledge receipt_____

BILLING PRACTICES:
Payment for services will be due at the beginning of each session. My basic individual counseling rate is $150.00 per 50-minute session and family rate is $200.00 per 50-minute session. In some cases, your insurance company may pay a percentage of the cost of your therapy per session. In this case, your co-pay becomes your fee, while I collect the remainder of your fee from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company. In the case of court involvement, (including letters or court evaluations), my fee is $220.00 per half hour.

In addition I hold a certain number of spaces for Adjusted Fee situations on a "space available" basis. The adjusted fee will be determined between the two of us at the intake session. My sliding fee scale ranges from 50 to 80 dollars. Costs per session will be determined at the first session and will remain at that level for six months, when it will be renegotiated.
(If using sliding fee, the rate we have agreed on is: _____ per hour.)

APPOINTMENTS:
Your appointment times are reserved for you alone. I try very hard to begin and end on time, out of respect to both of our schedules. If you need to cancel an appointment, please notify me by voice mail at least **24 hours in advance**. If you do not show for an appointment, you will be charged a **"No Show Fee"** at your full regular session rate. If you cancel with less than 24 hours notice, you will only be charged a **"Late Cancellation Fee"** at half your regular rate. (There will be no fee if you have to cancel due to an emergency.) I will adhere to the same policy if I need to change your appointment.

PHONE CONTACT:

If there is an emergency between sessions, I can be reached by phone at 360-739-5575. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If you are a client of mine, getting coaching from me over the phone is an important way for you to learn to apply skills during the stressful times in your life. The best time to call me is when you are feeling stressed or emotional and *BEFORE* you do an impulsive action (i.e.: hurt yourself, get drunk, yell at someone). We will not have a whole therapy session on the phone, but a brief conversation to help you use skills to get through the moment.

**If a phone contact of more than 10 minutes is necessary, a fee will be charged at our usual hourly rate.

**If you are unable to reach me when you feel the need for urgent help, you can call:

Your skills group leader or co-leader for coaching (their numbers are in your skills binder)
Care Crisis Line at 1-800-584-3578 (24 hours a day, 365 days a year, toll free)
If life-threatening, call **911** or go to the nearest **Emergency Room**.

CLIENT RIGHTS:

As a client, you have the right to refuse treatment, and the responsibility to choose the provider and type of treatment which best suits your needs.

COMPLAINTS:

If you are ever dissatisfied with my services, I encourage you to talk to me about your concerns. Your thoughts provide very important feedback for me, and may be growth for you as well. If I am not able to resolve your concerns, you may write to the WA Department of Health, Health Professions Quality Assurance Division.

TREATMENT CONSENT:

I have been informed of the type of counseling I will receive from Elizabeth A. Snyder, MS, LMHC, the methods and techniques used, her education, training and experience and the cost of counseling services. Furthermore, I have received this information in writing.

Counselors practicing for a fee must be registered with the Department of Health for the protection of public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

_____

I have read and understood these policies, have received my own copy of this Disclosure, and consent for treatment with Elizabeth A. Snyder, MS, LMHC:

_____ _____
Client Signature(s) Date

_____ _____
Parent/Guardian Signature Date

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Counselor Signature Date

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_____ _____
Parent/Guardian Signature Date

_____ _____
Counselor Signature Date

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CLIENT INTAKE FORM

Please complete all pages of form.

Client's Full Name:_____ Social Security#:_____
Date of Birth:_____ Gender at Birth:____ Current gender identification:____
Identified Pronouns:_____ Referred by:_____
Primary Care Physician: _____
Client lives with: ☐ Mother ☐ Father ☐ Both ☐ Other:_____
Mothers Name:_____ Social Security#:_____
Fathers Name:_____ Social Security#:_____

Client's Address:_____
_____
Home Phone:_____ ☐ day ☐ evening OK to leave msg? Y N
Work Phone:_____ ☐ day ☐ evening OK to leave msg? Y N
Cell Phone:_____ ☐ day ☐ evening OK to leave msg? Y N

PRIMARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#:_____
Subscriber's Name: _____
Subscriber's Date of Birth:_____
Subscriber's Relationship to client: _____
ID#:_____ Group/Plan #:_____

SECONDARY INSURANCE INFORMATION

(information found on insurance card)

Insurance Company: _____ Phone#:_____
Subscriber's Name: _____
Subscriber's Date of Birth:_____
Subscriber's Relationship to client: _____
ID#:_____ Group/Plan #:_____

COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

MEDICAL HISTORY

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your primary concerns and why you have sought counseling at this time:_____

_____

_____

When was your last comprehensive medical evaluation?_____

_____

Have you ever been hospitalized for psychological reasons? ☐ Yes ☐ No
If yes, when and where?_____

_____

_____

Please check whether you currently have, or have ever had any of the following:

__drug/alcohol abuse	__sleeping problems	__changes in appetite	__flashbacks
__running away	__frequent headaches	__epilepsy or seizures	__ulcers
__disturbing thoughts	__lack of interest	__sexual abuse	__depression
__memory problems	__low self-esteem	__speech problems	__confusion
__irritability	__emotional abuse	__hearing problems	__seizures
__bowel problems	__irregular heartbeat	__visual problems	__bedwetting
__weight loss	__sexual concerns	__difficulty managing anger	__mood swings
__asthma	__chronic illnesses	__stress	__anxiety
__hormone disorder	__difficulty concentrating	__physical abuse or neglect	__panic attacks
__serious infection	__allergies	__racing thoughts	__head trauma
__frequent stomachaches	__feelings of paranoia	__broken bones	__gender issues
__family/relationship issues	__communication problems	__phobias:_____	
__blood pressure concerns	__school/work difficulties	__problems with coordination	
__suicidal ideations/attempts	__feelings of hopelessness	__homicidal thoughts	
__frequent or uncontrolled crying		__self-destructive or self-injurious behavior	

__Other physical or emotional issues (please describe):_____

_____

_____

Are you currently taking medication? ☐ Yes ☐ No
Medication: _____ Dosage: _____
Date Started: _____
Medication: _____ Dosage: _____
Date Started: _____
Medication: _____ Dosage: _____
Date Started: _____
Medication: _____ Dosage: _____
Date Started: _____

List any serious illnesses for which you have required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has you ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

FAMILY SITUATION

Relationship/Marital Status of parents: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating ☐ Remarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Names and ages of other individuals residing in the home:

Name	Age	Relationship to Client

Client's-
Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation:_____
Employer: _____ For how long?_____

Father's-
Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation:_____
Employer: _____ For how long?_____

Mother's-
Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation:_____
Employer: _____ For how long?_____

Are there any family members who have experienced significant medical problems, mental health problems or substance abuse? (Please indicate relationship to client):
Medical Problems-
Past:_____
_____
Present:_____
_____

Alcohol Use-

Past:_____

_____

Present:_____

_____

Drug Use-

Past:_____

_____

Present:_____

_____

Tobacco Use-

Past:_____

_____

Present:_____

_____

Caffeine Use-

Past:_____

_____

Present:_____

_____

GOALS FOR THERAPY

What would you like to see happen as a result of your work here?_____

_____

_____

_____

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ph: 360.734.5552 fax: 360.733.1928
emergency: 360.739.5575
liz@elizabethasnyder.com
www.elizabethasnyder.com

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Client Name: _____ Birth date: _____/_____/_____ SS#:_____

Previous Name(s): _____ Address: _____

Treating Provider: _____

Information is to be disclosed to ☐ and/or received from ☐:

Name of Person/Agency: _____

Address: _____ Phone: (_____)_____Fax: (_____)_____

For purposes of: _____evaluation _____treatment _____forensic assistance _____other: _____

I authorize Elizabeth A Snyder, MS, LMHC to release my:

_____ General Mental Health Record

_____ Information related to chemical dependency/substance abuse

_____ Psychotherapy Notes (the private content of your conversations with your therapist)

_____ Information related to HIV/AIDS and/or sexually transmitted diseases

_____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 90 days after the last dated signature.

_____ _____

Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date

[90-Day Signature Updates]

_____ _____

Signature of Client/Parent/Guardian or Authorized Representative Date

_____ _____

Signature of Client/Parent/Guardian or Authorized Representative Date

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NOTICE OF PRIVACY PRACTICES REGARDING PROTECTED HEALTH INFORMATION

effective April 14, 2003

To my clients: *I am required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for me to "***use***" your PHI within my practice group, or "***disclose***" your PHI to an outside entity for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when I consult with another health care provider, such as your family physician.

- ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when I disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations*****:** activities that relate to the performance and operation of my practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, I will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

I would also need to obtain your authorization before releasing your "***Psychotherapy Notes***"—notes I have made about your conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, I must immediately report it to the appropriate authorities.

- **Health Oversight:** If the State Department of Health subpoenas me as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, I must comply. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, I will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)

- **Serious Threat to Health or Safety: I** may disclose your mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If you file a worker's compensation claim, I must make all mental health information in my possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, I am not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in my mental health and billing records. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request if I believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that I have made of your PHI. Some exceptions do apply.

V. Therapist's Duties

- I am required by law to maintain the privacy of your PHI and to provide you with this Notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this Notice. Unless I notify you by mail of changes, I am required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way I have handled your privacy rights, please contact me at the above address or you may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. I can provide you with the appropriate address upon request.