Arie Poot M.A., M.Div.

16300 SE Lake Holm Rd, Auburn, WA 98092 (360)-421-2436
117 North 1st Mount Vernon, WA. 98273

APPLICATION FOR THERAPY

Date of Application: ____/____/____

Client Name:_____Spouse_____ *Client's Birthdate:_____/_____/_____

Address:_____City_____Zip_____

Phone (Day):_____ Phone (Night): _____Gender: ☐ Male ☐ Female

Marital Status: S☐ M☐ D☐ Occupation_____*Client's SSN# _____/_____ / _____

Primary Care Physician:_____ Referred by:_____

Emergency Contact Phone Number:( ) _____E-Mail_____

Soon I will be able to send a text to your phone or email to your computer as a 24 hr reminder of upcoming appointment. If you want a reminder please fill in email above or put your mobile phone number here: ( ) _____ _____

INSURANCE INFORMATION:

Insurance Company:_____ Plan Name:_____

Group Number: _____ *Your Insurance ID#:_____

Name of Policy Holder_____

Address:_____City_____Zip_____ Phone:_____

**Policy Holder's* SSN:_____/_____/_____ * Policy Holder's Birthdate:_____/_____/_____

Patient Relationship to Insured: ◉ Self ○ Spouse ○ Child ○ Other

Employer: _____

*** Must have those lines in red filled for Insurance reimbursement!!**

If you seek insurance reimbursement, your insurance company will require information about your diagnosis, the dates, type, length of service and fees. The (*) information is essential for processing claims. Although I will do my best to protect your privacy and interests, I cannot control what use your insurance company may make of information about you.

Release of Information:

I hereby authorize a mutual exchange of information between my therapist, **Arie Poot, M.A.** and my insurance company _____ necessary to support claims for reimbursement.

Signed: _____

Referral: If you were referred by a physician or other treatment provider, please fill out the following information:

Name:_____ Phone:_____

Please Check this box if you **do not** want your Primary Care Physician to know you are in counseling.

Diagnosis #

Release of Information: I hereby authorize a mutual exchange of information between my physician _____ and my therapist, **Arie Poot M.A.** for the purpose of coordination of treatment.

Signed: _____

Or, please do not contact my physician. (Some insurance companies require we notify them that you have entered therapy.)

Please place an "X" next to any of the following that apply to you:

☐ Depression	☐ Parenting difficulties
☐ Suicidal thoughts	☐ Concerns with elderly parents
☐ Suicide attempts	☐ Blended family difficulties
☐ Anxiety	☐ Problems making decisions
☐ Panic attacks	☐ Alcohol / Drug Abuse (self)
☐ Sleep problems	☐ Alcohol / Drug Abuse (others)
☐ Eating disorders	☐ Marital / Relationship Problems
☐ Social isolation	☐ Legal difficulties
☐ Health problems	☐ Death of a loved one
☐ Job related problems	☐ Compulsive gambling
☐ Financial concerns	☐ Low self-esteem
☐ Domestic violence	☐ Career choice concerns
☐ Sexual problems	☐ Problems with siblings
☐ Sexual abuse	☐ Divorce / Separation
☐ Flashbacks	☐ Nightmares

ADDITIONAL INFORMATION:

If you are currently taking any medication, please list: _____
_____

Are you allergic to any medications? _____

If you have been in therapy before, or have been hospitalized for mental health reasons, please give the names and addresses of those you have seen. _____
_____
_____

Please describe your current living situation: _____
_____

If you have a history of alcohol or drug abuse, please describe:_____
_____
_____

Please describe why you are seeking counseling at this time:

How would you describe your goals for counseling?
1.

2.

3.

We're glad we can offer our services to you. Please feel free to ask questions about our statement or policy and purpose, as well as any other concerns you may have. We request that if you need to cancel an appointment, **please give us 24 hours notice**--otherwise you will be charged for the missed appointment.

Release of Information from previous Therapists:

I hereby authorize a mutual exchange of information between my previous therapist _____and **Arie Poot M.A**. for the purpose of facilitating my treatment.

Legal Action: If you are involved in a legal action that may require a report from this office, please sign the following release of information between my therapist, **Arie Poot M.A.**, and my lawyer, _____.

Signature: _____ **Date:** _____/_____/_____

CLIENT DISCLOSURE STATEMENT

In accordance with Washington State Law, (WAC 308-190-040, Chap. 18, 19 RCW) we are providing you with information about the counseling services provided by this office.

Counseling is provided by Arie Poot. Arie Poot is a 1982 graduate of Gonzaga University in Spokane, WA., with a Masters of Arts Degree in Marriage, Family and Child Therapy. He also holds a Masters of Divinity Degree from Calvin Seminary in Grand Rapids, Michigan and his undergraduate Degree was earned at Dordt College, in Sioux Center, Iowa. Arie has been practicing since 1982. His Washington State Registration is #PO-OT-*A-510D7.
Mr. Poot's speciality is marriage and family problems, treatment of anxiety and depression, eating disorders, self-esteem issues and adolescent therapy. In the counseling session he uses a cognitive approach to therapy utilizing insight orientation. His approach in individual therapy is psychoanalytical and he integrates the theories of Satir, Adler, and Bowen into the therapy process. When counseling with family systems, conflict resolution and conjoint techniques are used. Mr. Poot utilizes psychological testing and assessment as a part of the therapeutic evaluation process, and these tests are scored and evaluated by a licensed psychologist.

Fee per session is $125.00 or what your insurance declares is an allowable fee. Client discounts are at times given, please discuss this with Arie. The sessions are 50 minutes in length.

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.

If there is no insurance coverage the Fee agreed on is:_____per session.

Course of Treatment if known_____

_____ Date_____ _____Date:_____
Client Signature Therapist

_____ Date_____
Client Signature

Office Standards of Care

Introduction: Since trust in clear understanding are of a paramount importance in the provision of psychological services it is my intention that business and professional matters be explained and discussed openly. If, after reviewing this information, or at any time there after you have any questions about my business or professional practices, please do not hesitate to ask.

Appointments: Individual appointments are 50 minutes in length. It is important to be on time because your appointment will not be extended beyond the schedule time as a result of your late arrival. Your appointment time is held exclusively for you. If you are unable to keep your appointment for any reason, the regular fee will be charged unless 24 hours notice is given.

Fees in payments: You are responsible for your account and are expected to pay for all services you receive. The fee for my professional time spent in therapy, consultation, is $125.00 per session. Unless we have made other arrangements, I request that you pay at the time of the session. **If insurance is used, it is your responsibility to call your insurance company and get your co-pay, and deductible amounts. Co-pays are to be paid at the time of your appointment.**

Confidentiality: All issues discussed in the course of the therapy are strictly confidential. By law, information concerning treatment or evaluation may be released only with the written consent of the person treated or such person's parent or guardian. However, the law requires the release of confidential information in three situations: suspected child abuse, potential suicidal or dangerous behavior, or threatened harm to another. In addition and certain select circumstances, the court may subpoena treatment records. Any release of confidential information will be discussed with you. Professional standards of care require us to consult and staff are cases with other professional therapist.

Emergencies: If I cannot be reached at my business number, you may want to call the 24-hour crisis line at 1-800 -584 -3578. I will inform you if I am planning and being out-of-town for any length of time and will provide alternative coverage for my absence.

Treatment goals: I'm interested in working with you to clarify and resolve the problems you are presenting.. Periodically, these goals of treatment will be reviewed an may be revised to suit your needs. I am accountable for my work with you. If you feel I am not being effective, please discuss this with me. If you still feel unsatisfied or uncomfortable with your treatment, you can ask that I assist you finding another therapist.

I hereby authorized Arie Poot to render a psychological services to me or my child,_____. This authorization constitutes informed consent without exception. I read and understand the office policy statement and have received a copy if I have so requested.

_____ _____/_____/_____
Signature Date

_____My initials indicate that I have read throughly the above statements and have discussed them throughly with my therapist.

Arie Poot, LMHC, M. Div.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1 am required by applicable federal and state law to maintain the privacy of your health reformation. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section 11 G of this notice.

USES **AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

A. Permissible Uses **and Disclosures without Your** Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead arc meant to describe the types of uses and disclosures that are permissible under federal and stale law.

1. Treatment: I may use and disclose PHI m order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. Payment: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example. I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or pertained to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safely or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities: health oversight activities including disclosures to slate or federal agencies authorized to access PHI: disclosures to judicial and law enforcement officials in response to a court order or other lawful process disclosures for research when approved by an institutional review board: and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses **and Disclosures Requiring Your Written Authorization**

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing, Communications: I will not use your health information for marketing communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I, A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. 1 may charge a fee for tile costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for yo to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required lo agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. 'This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be i writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privac Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights or arc concerned that I have violated your privacy rights, you may contact me. Arie Poot, at 360-421-2436 117 North 1st, Mount Vernon, WA. 98273, You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services at 200 Independence Avenue S. W., Washington. D.C. 20201.1 will not retaliate against you if you file a complaint, with the Director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE A.

Effective Date. This Notice is effective on April 14,2003.

B. Changes to this Notice: I may change the terms of this Notice at-any time. If I change this Notice, I may make the new-Notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF

PRIVACY PRACTICES

By my signature below _____, acknowledged that I received a copy of the Notice of Privacy Practices for Arie Poot, LMHC, M.Div.

_____ _____

Signature of Client (or Personal Representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client:_____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign.

□ Communication barriers prohibited obtaining the acknowledgment.

□ An emergency situation prevented us from obtaining acknowledgment.

□ Other (Please Specify) _____

_____

This form will be retained in your medical records.

Send this intake application online from our website. Go to pootcounseling.com and scroll down to the end of the page to see the form. Then attach and submit this PDF.