

# Koala Smiles Counseling, PLLC

Helping You Find Your Smile Again!

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*Child, Adolescent, Adult & Family Therapist*

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## CHILD INITIAL ASSESSMENT FORM

### Identifying Information

Today's Date: \_\_\_\_\_

Name of child \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Race: \_\_\_\_\_ Religion \_\_\_\_\_, Sex: M F Present Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Email Address: \_\_\_\_\_ Preferred Contact Method: \_\_\_\_\_

Okay to Leave Voicemail: Y N Okay to Email: Y N Okay to identify as Mental Health Provider: Y N

Name of person completing form (if different than child): \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about Koala Smiles Counseling, PLLC: \_\_\_\_\_

Who has current legal custody of child? (Please attach a copy of the current parenting plan)

Is there now, or has there been in the last 5 years, an Order For Protection or Restraining Order in place from any state on a member of this household? No , Yes  (please explain) \_\_\_\_\_

Is there any current or pending legal actions against any member of the household (including the child)?

No , Yes  (please explain) \_\_\_\_\_

Has there been mental health services involved with child before? No , Yes  (please explain) \_\_\_\_\_

Is the County Social Services involved with this child or family? No , Yes  (how?) \_\_\_\_\_

### Family History

#### Parents

Parents are / were married \_\_\_\_\_ years.

Are parents divorced?  Yes  No If yes, how old was the child at time of divorce: \_\_\_\_\_

Is there any significant information about the parents' relationship or treatment towards the child which might be beneficial in counseling:  Yes  No If yes, explain: \_\_\_\_\_

#### Client's Mother (Step-mother)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Natural parent  Step-parent  Adoptive parent  Foster parent Other: \_\_\_\_\_

Is there anything unusual or stressful about the child's relationship with the mother?  Yes  No

If yes, explain: \_\_\_\_\_

#### Client's Father (Step-father)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Natural parent  Step-parent  Adoptive parent  Foster parent Other: \_\_\_\_\_

Is there anything unusual or stressful about the child's relationship with the father?  Yes  No

If yes, explain: \_\_\_\_\_

**Siblings and Others in Household**

| Names | Age | Gender |     | Lives |      | Quality of Relationship w/ Client |         |      |
|-------|-----|--------|-----|-------|------|-----------------------------------|---------|------|
|       |     | M      | F   | Home  | Away | Poor                              | Average | Good |
| _____ | ___ | ___    | ___ | ___   | ___  | ___                               | ___     | ___  |
| _____ | ___ | ___    | ___ | ___   | ___  | ___                               | ___     | ___  |
| _____ | ___ | ___    | ___ | ___   | ___  | ___                               | ___     | ___  |
| _____ | ___ | ___    | ___ | ___   | ___  | ___                               | ___     | ___  |

Others in child's life

|       | Age | Gender |     | Lives |      | Relationship to child | Quality of Relation w/ Client |         |      |
|-------|-----|--------|-----|-------|------|-----------------------|-------------------------------|---------|------|
|       |     | M      | F   | Home  | Away |                       | Poor                          | Average | Good |
| _____ | ___ | ___    | ___ | ___   | ___  | _____                 | ___                           | ___     | ___  |
| _____ | ___ | ___    | ___ | ___   | ___  | _____                 | ___                           | ___     | ___  |
| _____ | ___ | ___    | ___ | ___   | ___  | _____                 | ___                           | ___     | ___  |

**Medical Information**

Child's Physician's Name and/or Clinic: \_\_\_\_\_ Phone \_\_\_\_\_

Are there any physical or medical problems I should be aware of? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

Is the child currently taking any medication? No \_\_, Yes \_\_ (please state the medication and dosage) \_\_\_\_\_

Has there been any history of head trauma, seizures or loss of consciousness? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

**Developmental / Social**

**Pregnancy, Labor and Delivery**

Duration of Pregnancy \_\_\_\_\_

Did the mother smoke during this time? No \_\_, Yes \_\_ (if yes, how much per day?) \_\_\_\_\_

Was there any drinking or drug use by mother during this time? No \_\_, Yes \_\_ (please describe fully) \_\_\_\_\_

Were there any complications during pregnancy (i.e., illness, injuries, hospitalization, etc.)? No \_\_, Yes \_\_ (please describe) \_\_\_\_\_

Any complications during labor/delivery (i.e., premature, lack of oxygen, injuries to mother or child, incubator care, infections, etc.?) No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

**Infancy - Toddler Period (Birth to 2 years of age)**

Primary caregiver(s) during this time: \_\_\_\_\_

Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

**Early Childhood (3 to 5 years of age)**

Primary Caregiver(s) during this time: \_\_\_\_\_

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No \_\_, Yes \_\_ (please explain) \_\_\_\_\_

Please rate your opinion of the child's development (compared to others the same age) in the following areas:

|              | Below Average | Average | Above Average |
|--------------|---------------|---------|---------------|
| Social       |               |         |               |
| Physical     |               |         |               |
| Language     |               |         |               |
| Intellectual |               |         |               |
| Emotional    |               |         |               |

For each type of development that you rated above as below average, please describe current areas of concern. Be specific.

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List your child's three greatest strengths:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List your child's three greatest weaknesses or needed areas of improvement:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List your child's main difficulties in school:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List your child's three main difficulties at home:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Briefly describe the child's friendships: \_\_\_\_\_

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Briefly describe the child's hobbies or interests: \_\_\_\_\_

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What report card grades does the child usually receive? \_\_\_\_\_

Have these changed lately? \_\_\_Yes \_\_\_No If yes, how: \_\_\_\_\_

Briefly describe the child's way of expressing the following emotions or behaviors:

1. Anger: \_\_\_\_\_
2. Happiness: \_\_\_\_\_
3. Sadness: \_\_\_\_\_
4. Anxiety: \_\_\_\_\_

**Current School Information**

Present school and grade: \_\_\_\_\_ Class placement: \_\_\_ Mainstream; \_\_\_  
Special Class (where) \_\_\_\_\_ Teacher or Advisors' name: \_\_\_\_\_ IEP in place?  
No \_\_, Yes \_\_ Please rate the child in school on the following:

|                     | Very Poor | Poor | Average | Good | Very Good |
|---------------------|-----------|------|---------|------|-----------|
| Writing Skills      |           |      |         |      |           |
| Arithmetic Skills   |           |      |         |      |           |
| Reading Skills      |           |      |         |      |           |
| Attendance          |           |      |         |      |           |
| Behavior Management |           |      |         |      |           |
| Work Completion     |           |      |         |      |           |
| Social Interaction  |           |      |         |      |           |

**Counseling Goals**

What goals or changes would you like to see your child work towards in their counseling experience?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Current Symptoms:** Please rate the child on the following as occurring now or in the recent past:

| Symptom                                                                           | Frequently | Sometimes | Rarely | Never |
|-----------------------------------------------------------------------------------|------------|-----------|--------|-------|
| Fails to give close attention to details or makes careless mistakes               |            |           |        |       |
| Has difficulty sustaining attention in tasks or play activities                   |            |           |        |       |
| Doesn't seem to listen when spoken to directly                                    |            |           |        |       |
| Doesn't follow through on instructions and fails to finish tasks                  |            |           |        |       |
| Has difficulty organizing tasks and activities                                    |            |           |        |       |
| Avoids, dislikes or is reluctant to engage in tasks that require sustained effort |            |           |        |       |
| Loses things necessary for tasks or activities                                    |            |           |        |       |
| Is easily distracted by external stimuli                                          |            |           |        |       |
| Is forgetful in daily activities                                                  |            |           |        |       |
| Fidgets with hands or feet or squirms in seat                                     |            |           |        |       |
| Leaves seat in situations in which remaining seated is expected                   |            |           |        |       |
| Runs about or climbs excessively in situations in which it is inappropriate       |            |           |        |       |
| Has difficulty playing or engaging in leisure activities quietly                  |            |           |        |       |
| Is "on the go" or acts as if "driven by a motor"                                  |            |           |        |       |
| Talks excessively                                                                 |            |           |        |       |
| Blurts out answers before the questions have been completed                       |            |           |        |       |
| Has difficulty awaiting turn                                                      |            |           |        |       |
| Interrupts or intrudes on others (e.g., butts into conversations or games)        |            |           |        |       |
|                                                                                   |            |           |        |       |
| Symptom                                                                           | Frequently | Sometimes | Rarely | Never |
| Loses temper                                                                      |            |           |        |       |
| Argues with adults                                                                |            |           |        |       |
| Actively defies or refuses to comply with adults' requests or rules               |            |           |        |       |
| Deliberately annoys people                                                        |            |           |        |       |
| Blames others for his or her mistakes or misbehavior                              |            |           |        |       |
| Is touchy or easily annoyed by others                                             |            |           |        |       |
| Is angry or resentful                                                             |            |           |        |       |
| Is spiteful or vindictive                                                         |            |           |        |       |
|                                                                                   |            |           |        |       |
| Symptom                                                                           | Frequently | Sometimes | Rarely | Never |
| Bullies, threatens or intimidates others                                          |            |           |        |       |
| Initiates physical fights                                                         |            |           |        |       |
| Has used a weapon that can cause serious physical harm to others                  |            |           |        |       |
| Has been physically cruel to people                                               |            |           |        |       |
| Has been physically cruel to animals                                              |            |           |        |       |
| Has stolen while confronting a victim                                             |            |           |        |       |
| Has forced someone into sexual activity                                           |            |           |        |       |
| Has deliberately engaged in fire setting with intention of causing serious damage |            |           |        |       |
| Has deliberately destroyed others' property (other than by fire setting)          |            |           |        |       |
| Has broken into someone else's house, building or cars                            |            |           |        |       |
| Has stolen valuable items without confronting a victim (i.e., shoplifting)        |            |           |        |       |
| Stays out at night despite parental prohibitions                                  |            |           |        |       |
| Has run away from home overnight or longer                                        |            |           |        |       |
| Is truant from school                                                             |            |           |        |       |
|                                                                                   |            |           |        |       |

| Symptom                                                                           | Frequently | Sometimes | Rarely | Never |
|-----------------------------------------------------------------------------------|------------|-----------|--------|-------|
| Depressed or irritable mood most of the day                                       |            |           |        |       |
| Markedly diminished interest or pleasure in all or nearly all activities          |            |           |        |       |
| Weight loss when not dieting, or weight gain, or increase or decrease in appetite |            |           |        |       |
| Insomnia (not sleeping) or Hypersomnia (sleeping too much)                        |            |           |        |       |
| Overly agitated or slowed down in movements                                       |            |           |        |       |
| Fatigue or loss of energy                                                         |            |           |        |       |
| Feelings of worthlessness or excessive or inappropriate guilt                     |            |           |        |       |
| Diminished ability to think or concentrate, or indecisiveness                     |            |           |        |       |
| Recurrent thoughts of death (not just fear of dying)                              |            |           |        |       |
| Suicide thoughts without a plan for committing suicide                            |            |           |        |       |
| Suicide attempts or planning of suicide                                           |            |           |        |       |

| Symptom                                                                            | Frequently | Sometimes | Rarely | Never |
|------------------------------------------------------------------------------------|------------|-----------|--------|-------|
| Has experienced traumatic event(s)                                                 |            |           |        |       |
| Has recurrent and intrusive distressing memories of traumatic event(s)             |            |           |        |       |
| Does repetitive play with themes or aspect of the traumatic event(s)               |            |           |        |       |
| Recurrent distressing dreams (with or without recognizable content)                |            |           |        |       |
| Acts or feels as if the traumatic event were recurring                             |            |           |        |       |
| Psychological distress at internal or external reminders of the traumatic event(s) |            |           |        |       |
| Physical reacting to internal or external reminder of the traumatic event(s)       |            |           |        |       |
| Tries to avoid thoughts, feelings or conversations associated with the event(s)    |            |           |        |       |
| Tries to avoid activities, places or people that arouse memories of the event(s)   |            |           |        |       |
| Inability to recall important aspects of the trauma(s)                             |            |           |        |       |
| Markedly diminished interest of participation in significant activities            |            |           |        |       |
| Feeling of detachment or estrangement from others                                  |            |           |        |       |
| Restricted range of affect (i.e., unable to have loving feelings)                  |            |           |        |       |
| Sense of foreshortened future                                                      |            |           |        |       |
| Difficulty falling or staying asleep                                               |            |           |        |       |
| Irritability or outbursts of anger                                                 |            |           |        |       |
| Difficulty concentrating                                                           |            |           |        |       |
| Hypervigilance                                                                     |            |           |        |       |
| Exaggerated startle response                                                       |            |           |        |       |

| Symptom                                                                             | Frequently | Sometimes | Rarely | Never |
|-------------------------------------------------------------------------------------|------------|-----------|--------|-------|
| Excessive distress when separation from home or loved ones is anticipated           |            |           |        |       |
| Excessive worry about losing, or harm happening to, a loved one                     |            |           |        |       |
| Excessive worry that some bad event will lead to separation from loved ones         |            |           |        |       |
| Reluctance or refusal to go to school or elsewhere because of fear of separation    |            |           |        |       |
| Excessive fear to be alone at home or elsewhere without loved ones                  |            |           |        |       |
| Reluctance or refusal to go to sleep without being near loved ones                  |            |           |        |       |
| Nightmares involving themes of separation                                           |            |           |        |       |
| Complaints of physical symptoms when separation occurs or is anticipated            |            |           |        |       |
| Substance use resulting in a failure to fulfill major obligations at school or work |            |           |        |       |
| Substance use in situations in which it is physically hazardous (i.e., driving)     |            |           |        |       |
| Substance use related to legal problems                                             |            |           |        |       |
| Substance use despite recurring social or interpersonal problems caused by use      |            |           |        |       |

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## **OUTPATIENT SERVICES CONTRACT / INFORMED CONSENT**

Welcome to my practice. This document contains important information about my professional services and business policies as well as the rights and responsibilities for our therapeutic relationship. Please read it thoroughly before you sign it and consent to treatment and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

### **CLINICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

### **QUALIFICATIONS/EDUCATION/EXPERIENCE**

- Licensed Marriage and Family Therapist through the state of Washington, Licensure #LF60462717.
- Clinical Fellow Member of the American Association for Marriage and Family Therapy (AAMFT), Member # 151675.
- Master's Degree in Counseling Psychology with emphasis in Marriage and Family Therapy at Chapman University in 2011.

- Bachelor's Degree in Psychology at Saint Martin's University in 2008.
- Child Mental Health Provider with experience working with children, adolescents, adults, couples, and families with a wide range of issues from mild to severe, as well as previous experience in training and mentoring young adults / college students on job related skills and resume/career development skills.
- Experience working in school systems (Bonney Lake High School, Daffodil Elementary & Orting School District) providing counseling services for children and adolescents while coordinating with school officials and parents.
- I am committed to furthering my knowledge and expertise by regularly participating in specialized training and receiving ongoing clinical consultation.

### **TREATMENT ORIENTATION**

My primary approach to counseling is client-centered and focuses on clients' strengths and abilities to make positive changes in their lives. I believe that one of the essential ingredients for therapeutic change is trust between the therapist and client. Clients are encouraged to set their own goals for therapy and to be full and active participants in their own approaches. Guided by the client's needs and issues, I use a variety of tools drawing from many therapeutic approaches, such as Psychoeducation, Client-Centered, Behavioral, Cognitive-Behavioral (including Trauma Focused Cognitive Behavioral Therapy), Mindfulness, Gottman Methods and Solution-Focused strategies. Together, we will explore your values and beliefs as well as those of your family. I am trained from a systemic perspective and believe that a person's role in their family of origin can be translated to their relationships, behaviors and beliefs. For this reason, I believe that family of origin exploration and family therapy can be helpful and is sometimes necessary to see change.

### **MEETINGS**

During our initial sessions I will be gathering information as we formulate goals and a plan together. Sessions typically last 50-minutes. They are expected to begin promptly, and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. As your therapist, I am also expected to be on time, and will offer appropriate remedy if late, such as making the time up, prorating the fee, etc. Occasionally there is a need for sessions to go longer depending on the amount of processing a client needs. Longer sessions will be billed at a prorated amount based on my standard fee. The total number of sessions is dependent on several factors including your goals, timeframe, rate of progress, etc. I offer both short and long-term therapy. The therapeutic process is different for each person. On average, client sessions are at least once a week for the first 3 sessions and then can be tapered to weekly or every other week for at least 10-12 sessions. We will discuss your course of treatment at intake. All of this can be updated as needed by any of us at any time.

### **FEE POLICY**

I charge \$175 for the initial session (intake session) as there is quite a bit of paperwork and information gathering required to set you up as a new client. Thereafter, fees are \$150 per 50-minute session. Fees are adjusted annually in January, and will not increase more than \$15 per year. Payments (cash, check or credit card) are to be made at the beginning of each session unless we have made other arrangements. A \$30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.



I charge for other professional services you may need based on a prorated rate of my standard fee. I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations lasting more than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

For those who cannot afford my fees, I do offer a sliding scale fee on a limited basis for lower income individuals/families. Sliding scale fees are based on family income and number of dependents using the Federal Poverty, Sliding Scale Guidelines and are updated annually in February. If finances are a concern to you, please check with me to see if this is an option. Please note, this option is only available for private pay clients.

### **Insurance/Managed Care**

If I am billing your insurance, your copayment is required at the time of service. If your insurance coverage requires you to pay a co-insurance, you may either pay at the time of service or you will be billed after insurance has paid. I will bill insurance companies directly, unless you request otherwise, and I will provide you with a monthly statement for any outstanding balances. Unpaid balances more than 90 days past due will be charged an 18% interest rate (1.5% monthly). Accounts more than 180 days past due may be referred to collections. Any collection legal fees or costs necessary to collect unpaid balance will be your responsibility.

It is your responsibility to follow any plan requirement that applies to you including co-pay amounts, co-insurance and deductibles. I recommend you clarify with your insurance company the specific benefits provided under your insurance plan and to follow any plan requirements that apply to you. For example, some plans require that you obtain an authorization/referral from your insurance/managed care company prior to your first session. Most plans limit the services for which they will reimburse. *If you request or agree to a service for which reimbursement is later denied by your insurance company or its agent (i.e. not pre-authorized, considered medically unnecessary, beyond the benefit limit, etc.) then you assume the responsibility for paying the entire fee.*

### **Out of Network Provider**

I participate in many insurance plans, but not all. If I am not yet a preferred provider for your insurance carrier then I am considered an out of network provider. Most often, companies will provide reimbursement based on your specific reimbursement rate for out-of-network care. Usually, the amount returned is calculated as a percentage, so if you have financial concerns please check with your agency to learn more about its particular policies. I offer two options as an out of network provider:

- Option 1) You pay my fees up front and I will provide you with a SuperBill (Receipt) that can be submitted directly to your insurance company for reimbursement to you. If needed, I can help you figure out what forms need to be attached to this receipt and where to send them. Many clients choose this option to avoid receiving any bills later. Instead they are likely to receive a reimbursement check from their insurance provider (based on their out of network coverage) and will receive no further bills from me as services were paid for in advance.
- Option 2) You pay my fees up front and I will submit the claims to your insurance company electronically for you. Whatever amount of funds your insurance pays for this claim

will be reimbursed directly to you once the claim has been processed. I will do my best to verify your out of network insurance benefits and give you an estimate on how much you will be reimbursed for, but I cannot guarantee the exact amounts until your insurance company processes the claim. If your insurance company denies the claim, you will receive no reimbursements, as the full session fee was your responsibility.

### **APPOINTMENTS AND CANCELLATIONS**

*Regular psychotherapy typically promotes faster healing and progress, so it is important that you attend your scheduled therapy session consistently. My policies are outlined below.*

**Missed Appointments:** In the event that you are unable to keep an appointment, please notify me via phone a minimum of two days (**48 hours**) in advance. E-mail and text messages are not adequate notice. Monday appointments require notification before 5:00pm the preceding Friday. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** Emergency needs are an exception, so please discuss this with me to avoid a charge. To change or cancel an appointment, please call (253) 733-1975. If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Two or more late cancellations or no shows will result in the requirement of non-refundable prepayment for sessions at the time of scheduling. A pattern of frequent rescheduling, even if a 48-hour notice is given, may result in a requirement of prepayment for sessions at the time of scheduling, unless due to extenuating circumstances and agreed upon by the therapist. As an alternative you may be limited to scheduling appointments at times in low demand (typically mornings and early afternoons).

### **CRISIS INFORMATION/TELEPHONE/MESSAGES**

I do not provide ongoing crisis services. If you are experiencing an emergency or crisis situation that requires an immediate response, call the National Crisis Line at (800) 273-8255, the 24-hour crisis clinic at (800) 244-5767 for King County or (800) 576-7764 for Pierce County, call 911, or go to the nearest hospital emergency room.

Non-emergency messages may be left on my confidential voice mail at (253) 961-0552. I check my voicemail several times a day during business hours, Monday through Friday. Due to the nature of an outpatient practice, it may not be possible to respond immediately.

### **CONFIDENTIALITY**

All issues discussed in the course of therapy will remain confidential except those for which you may choose to sign a release of confidential information (e.g., for your medical doctor, other treatment provider, or family member). Also, your insurance company or its agents may have the right to audit your records for the purposes that may include but not be limited to accuracy of claims, coverage of services, medical necessity, proper utilization and appropriateness of services, and appropriateness of billing.

I seek ongoing consultation from colleagues in order to provide you with the best services

possible. In the course of clinical consultation, your case information may be discussed with other professionals, in which case I will limit the information I disclose to the minimum amount necessary. I have an agreement with an office assistant to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to my office assistant accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

Your participation in therapy, the content of our sessions, and any information you provide to me is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- With your authorization, to effect billing of a third-party payor for the services I provide to you;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

If you elect to communicate with me by email at some point in our work together, please be aware that I cannot guarantee the confidentiality of information sent via email. Emails may be retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be saved in your electronic treatment record.

### **TELEHEALTH**

At your request and if it is therapeutically appropriate, I may make use of technology assisted telehealth tools such as telephone communications and internet enabled video and/or audio services as an adjunct to our in-person work together. It is important that you understand the benefits and limitations of such services.

- Telehealth services may improve your access to counseling, may reduce your costs associated with counseling, and may support more effective use of in-person counseling.
- If you are located outside of the State of Washington, the counseling services I am allowed to provide to you may be limited or prohibited. If you are located outside of the State of Washington, we will discuss what services I may be able to provide to you.

- Telehealth services are not appropriate for all clients and all situations. If you or I determine that telehealth services are not appropriate for you, I will assist you in obtaining appropriate alternative services.
- Successful use of telehealth services requires a reasonable level of access to computer hardware and software. If you do not have access to such resources, we can discuss available alternatives.
- At times it may become necessary for me to allow access to my computer hardware and software for purposes of system maintenance, repair, upgrades, or other similar purposes. In such cases, I will make reasonable efforts to protect your confidential information.
- Telehealth services are often not reimbursed by insurance. In such cases, payment for telehealth services remains your sole responsibility.
- In case of hardware, software or other system failure, you may reach me by phone to coordinate our continued work together.

At the beginning of each session I will ask you to provide me with the following information:

- Your physical location and address;
- A phone number I can use to contact you in case of technology failure or other loss of internet connection during our telehealth session;
- An email address I can use to contact you as an alternative if we cannot connect via phone.

At the initiation of our therapeutic relationship I will ask you to provide me to the following contact information if you and I are in different geographic locations:

- Your local hospital emergency room phone number;
- Your local crisis line phone number.
- The phone number of a local clinician who can provide you with appropriate alternative services in case you or I determine that my telehealth services are no longer appropriate for you.

### **SOCIAL MEDIA POLICY**

Professional ethics standards do not permit me to communicate with clients via personal social media. For this reason, I cannot accept any client requests to connect on Facebook, or other similar social media platforms.

### **AGE OF CONSENT — OUTPATIENT TREATMENT OF MINORS**

Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW [7.70.065](#), is required for outpatient treatment of a minor under the age of thirteen. Parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission.

### **COURT TESTIMONY**

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$185 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child

custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

### TERMINATION OF THERAPY

The client (or the parents if the client is a minor) has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that the client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering appropriate referral resources to the client. If, without having made prior arrangements, I have not heard from you in 30 days I will assume that you would like me to terminate our current episode of care and close your active clinical file. In such cases, we may re-open the file and initiate a new episode of care once we meet in person again.

### STATE OF WASHINGTON DISCLOSURES

The State of Washington requires that I provide you with the following information.

As an individual, you have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs. A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake  
Post Office Box 47857  
Olympia, WA 98504-7857  
Phone: 360-236-4700  
E-mail: HSQAComplaintIntake@doh.wa.gov

**YOUR AGREEMENT:** I have read and understand all of this information, including my rights as a client. I agree to all of the above policies and procedures. If my fees are determined by a sliding scale, I agree to notify my therapist of changes in my income or household size that could affect my fee. I hereby agree, whether signing as an agent or as a patient, to be financially responsible for all charges not paid for by insurance. I hereby authorize Shawnda Brese, MA, LMFT, to render mental health services to (client's name):

**ACKNOWLEDGEMENT OF KNOWLEDGE OF CONFIDENTIALITY AND PRIVACY PRACTICES:**  
I have received a copy of my HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
Client Signature                                          Date                                          Parent/Guardian Signature                                          Date

\_\_\_\_\_  
Client printed name                                          Parent/Guardian printed name

\_\_\_\_\_  
Clinician Signature                                          Date

# Koala Smiles Counseling, PLLC

Helping You Find Your Smile Again!

*Shawnda Brese, MA, LMFT*

*Child, Adolescent, Adult & Family Therapist*

*601 Valley Ave NE, Suite F, Puyallup, WA 98372*

*Mail to: 10715 Valley Ave E, Puyallup, WA 98372*

*(253) 733-1975 www.koalasmiles.com*

## COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER ELECTRONIC MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, can not be guaranteed as confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your therapist
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with me about ways to keep your communications safe and confidential.

**\*\*As a practice policy, I do not communicate with patients and/or their families via social media nor accept any "friend" requests. Therapists are required to ignore all such requests.**

## CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY ELECTRONIC MEANS

I, \_\_\_\_\_ REQUEST: Shawnda Brese, MA, LMFT  
(name of client)

to use email and mobile phone text messaging to transmit to me the following protected health information to this email address(es): \_\_\_\_\_

Information related to the scheduling of meetings or other appointments. Initial here: \_\_\_\_\_

Information related to billing and payment for health care treatment. Initial here: \_\_\_\_\_

Information related to administrative matters such as sending forms, including forms that have been filled out and signed. Initial here: \_\_\_\_\_

[ ] Information directly related to therapy or other clinical matters. Initial here:\_\_\_\_I have been informed of and understand the confidentiality risks inherent in sending therapeutic information by non-secure communication methods. Initial here:\_\_\_\_\_

[ ] Other information. Describe here:\_\_\_\_\_ Initial:\_\_\_\_\_

BY THE FOLLOWING NON-SECURE MEDIA:

[ ] I request to receive text messages for the purpose of appointment reminders. I agree to not use texting for any other purposes other than to cancel or reschedule an appointment. If I need to share any other information regarding treatment I will contact my therapist by other means. Initial here: \_\_\_\_\_

I understand that Shawnda Brese, MA, LMFT does not receive or send text messages other than for scheduling and/or appointment reminders or use any other media form, such as Skype or Facebook to communicate my Protected Health Information.

I understand that emails are not a way to communicate crisis/safety information and that it may take up to 24 hours for my therapist to respond to my emails. If I have an emergency, I agree to pick up the phone and dial 911, go to the nearest hospital emergency room or call the 24-hour crisis clinic at (800) 244-5767 for King County or (800) 576-7764 for Pierce County.

I understand that this agreement can be revoked at any time at my request.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of signing this agreement. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that Shawnda Brese, MA, LMFT makes secure means of communication available to me, but I prefer to use the above non-secure means for the above purposes.

\_\_\_\_\_  
(Signature of client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of parent/guardian)

\_\_\_\_\_  
Date

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## CLIENT EASY PAY CONSENT

**(Optional payment plan for those paying by credit/debit card)**. This form is for those who wish me to keep your debit/credit card number on file and I will automatically deduct any payments owed from your debit/credit card. (Examples of payments deducted are copays, deductibles, coinsurances, late cancels, no- shows or full payment if not using insurance). Your payment information will be entered into an encrypted system and then blacked out on this form for security purposes.

I authorize **Koala Smiles Counseling, PLLC (Shawnda Brese)**, to charge my credit/debit card for fees charged (including late cancels and no shows) and if using insurance, copays, coinsurances, deductibles and the balance of charges not paid by insurance within 90 days.

Please charge my credit card:

- The amount of my copayment, coinsurance or other amounts due                      OR
- \$ \_\_\_\_\_ Each session

I authorize Koala Smiles Counseling, PLLC (Shawnda Brese) to charge my credit card for counseling services at the rate listed above. I understand that this form is valid for up to three months after I close out of counseling services unless I cancel the authorization through written notice to Koala Smiles Counseling, PLLC. I agree to update this information with my counselor if/when it changes.

|                                                                                                                                                                               |       |     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----|
| Client Name                                                                                                                                                                   |       |     |
| Cardholder Name Exactly as it Appears on the Card                                                                                                                             |       |     |
| Cardholder Address                                                                                                                                                            |       |     |
| City                                                                                                                                                                          | State | Zip |
| <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discovery <input type="checkbox"/> American Express <input type="checkbox"/> Other |       |     |
| Card Credit Card Number _____                                                                                                                                                 |       |     |
| Date of Expiration ____/____                                                                                                                                                  |       |     |
| V-code (3-digit Security code on back of card) _____                                                                                                                          |       |     |
| Cardholder Signature                                                                                                                                                          |       |     |
| _____                                                                                                                                                                         |       |     |



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## BEHAVIORAL HEALTH INSURANCE INFORMATION

Today's Date: \_\_\_\_\_

Client's full name: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person to contact in emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

## INSURED / RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage

Full Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Primary Ins. Co.: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Ins. Co.: \_\_\_\_ No \_\_\_\_ Yes; Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Job Related Injury-Workmens Comp. Co.: \_\_\_\_ No \_\_\_\_ Yes; Company: \_\_\_\_\_

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Insurance Phone # Listed on insurance card: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided.

A \$30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.