DRAYTON FAMILY COUNSELING
Client Information/Intake Form

DFC Counselor Name ________________________________ **Initial Session Date** ____________

Client:	Client DOB:
Client Phone #:	Email:
Client Address:	
Parent/Guardian:	Guardian Phone #:
Guardian Address:	
Emergency Contact:	Emergency Phone #:

How did you hear about us? ____

Occupation: *(Circle)* Student Employee at _________________ Other ____________

How many people are living in your household? ________
Please tell us about your family.

Name	**Relationship** ***(child, parent, etc)***	**Age**

Please describe your reasons for seeking therapy:

What outcomes are you hoping for?

Client Name ______________________________ DOB ______________

What or Who are some positive supports in your life? *(people, groups, hobbies, etc)*

Client's Medical Information

Medical Provider	Clinic/Organization	Contact Info
Primary Care Dr:		
Previous Therapist:		
Psychiatrist:		
Specialist:		
Specialist:		

Previous Psychiatric Hospitalizations? Yes / No When/Where? ______________________

Current Medications

Medication	Dosage	Prescribing Physician	Reason

Current Symptoms: Please rate your/client's experience with the following over the past six months:
(0-none, 1-mild, 2-moderate, 3-severe)

____ Hopelessness
____ Depressed Mood
____ Anxiety
____ Suicidal Thoughts
____ Homicidal Thoughts
____ Panic Attacks
____ Anger
____ Guilt
____ Tearful/Sadness
____ Difficulty concentrating
____ Weight change
____ Appetite change
____ Sleep Difficulties
____ Racing Thoughts
____ Fear
____ Nightmares
____ Startle Response
____ Hypervigilance
____ Difficulty with motivation
____ Mood swings
____ Sensory Issues
____ Hyperactivity
____ Arguing w/parent (child)
____ Physical Aggression ______
____ Ongoing Family Conflict
____ Problems w/ School or Work
____ Other: ______________

Substance Use/History

Is there a history of substance use in your family? YES / NO Who? ________________

Has substance use impacted your/client's life? YES / NO

Have you received drug/alcohol treatment? YES / NO

What substances are you/client currently using, or have used in the last month? *(circle all that apply)*

Alcohol Cigarettes Marijuana Opiates Meth Prescription Abuse

Person Completing Intake Form ______________________________ Date ____________

Carrie Cochran, M.A., LMHCA
WA License #MC60826744

1316 King Street, Suite 4, Bellingham, WA 98229
Phone: 360-436-6288 Fax: 360-224-7460 Email: carrie@draytonfamilycounseling.com

Professional Disclosure Statement

Professional Qualifications

I have an M.A. in Clinical Mental Health Counseling from Messiah College in Mechanicsburg, Pennsylvania, and a B.A. in Psychology from Western Washington University. I am a Licensed Mental Health Counselor Associate in Washington, currently earning the required hours for full counselor licensure.

My Approach to Counseling

My training is a multicultural, integrative, social justice framework that tailors counseling to meet the needs of each client. I have many years of social service experience in the areas of trauma, sexual and physical violence, and the needs of vulnerable children, youth, and families. This background allows me to help clients explore whatever areas of life may be currently impacting them. I believe that past experiences affect us, but I also recognize the importance of addressing current issues as they are faced.

My counseling orientation tends to be a blend of Narrative Therapy, Adlerian, Motivational Interviewing, and Cognitive-Behavioral Therapy. I frequently use assessment tools in therapy. These assessments are meant to increase our understanding of your symptoms, concerns, and strengths. The results will be shared with you and can be used to track growth over time. You are welcome to decline any assessment.

My Christian faith affects how I see the world and the value of each person I meet. I support spiritual healing, and I am comfortable discussing issues of faith when they are important to a client. I welcome any faith background to counseling and strive to ensure a sensitive environment to explore past experiences and current growth.

Contact

If you need to reach me, you may call and leave a message for me on my business cell phone: 360-436-6288 or email me at carrie@draytonfamilycounseling.com. This number & email are only checked during normal business hours (Mon-Fri 9-5) and are only meant for scheduling appointments or relaying information before an appointment.

Emergencies. In case of a life-threatening crisis, please call 911. The Care Crisis helpline is available at: 1-800-584-3578. It is important for you to know that I am available by appointment only.

Consent to Treat

I understand that therapy may sometimes feel uncomfortable and I may be challenged to experience new emotions. Sometimes symptoms may increase as I am healing. I will remain in communication with my therapist about any concerns I have. My therapist may use evidence-based treatment when appropriate and may also use treatment techniques not considered evidence-based. I understand that my therapist cannot guarantee I will find relief of my symptoms, and acknowledge that this is a journey of discovery. I give my consent to treatment.

____________________________ ____________________________

Client Printed Name Name of Guardian if Client is Under 13

____________________________________ __________

Client Signature Date

Drayton Family Counseling

INFORMED CONSENT, DISCLOSURE, RIGHTS & RESPONSIBILITIES

Chris Cochran, Ed.D. LMHCA
WA License # MC60469381

Carrie Cochran, MA, LMHCA, NCC
WA License # MC60826744

Services

Your appointment time is reserved for you. If you need to reschedule, you need to contact your provider more than 24 hours in advance, by phone or email, to avoid a no-show fee. We charge $60 each time there is less than 24-hours notice. This fee is due prior to any future appointment. After 3 no-shows we will discuss a plan and whether to resume scheduling sessions. We intend to be present for all scheduled appointments. In the event your therapist has an emergency, you will be notified as soon as possible. All payments, including co-pays are due at the time of each session.

Affiliations and Confidentiality

We work directly with **Prestige Medical Billing, Northwest Family Life, and Billflash** to process insurance payments and billing. By signing this form, you are giving consent for billing-related information to be shared with them as needed. As agencies that specialize in medical/mental health billing, they are bound by HIPAA confidentiality laws. Their contact info is:
Northwest Family Life, (206) 363-9601, 12360 Lake City Way NE, Suite 420, Seattle, WA 98125
Prestige Medical Billing Co. (360) 805-0323, P.O. Box 1175, Monroe, WA 98272

We share office space in the **Turning Point Counseling and Coaching** office with Lisa Jeffries, Carol Beebe, and other providers subletting office space. Staff at Turning Point Counseling and Coaching abide by HIPAA requirements. We have a shared fax machine and waiting room, and we share equal concern for the confidentiality of all our clients. Chris and Carrie Cochran are the only Turning Point staff who have access to your billing and case file information. We have a business agreement, recognizing office confidentiality, in place with all providers who share our office space.

Confidentiality Exceptions

Client confidentiality is very important to me. I will protect your privacy as required by law. The only exceptions to the protection of confidentiality are in the following specific circumstances:

- If you request me to share information, I will need a written release form from you.
- I am required by law to break confidentiality in these cases:
    1. When there is a clear threat or risk of serious self-harm (suicide) or harm to another person (homicide).
    2. When there is reason to suspect abuse or neglect of any child, disabled, or vulnerable older adult.
    3. An order from a court of law mandating that I release information.

Emergencies.

In case of a life-threatening crisis, please call 911. The Care Crisis helpline is available at: 1-800-584-3578. It is important for you to know that your therapist is available by appointment only. Email and cell phone messages are for the purpose of scheduling appointments and relaying non-emergency information prior to an appointment. They are only checked during normal business hours.

Minors and Custodial Issues

As mental health providers, we are ethically unable to conduct any type of custody/parenting evaluation, determine whether a parent is "fit" or not, or make any legal recommendations. We will share progress in treatment with custodial parents and guardians, and with step-parents when authorized through a signed release. We will notify guardians of any risk of harm we become aware of and include guardians in treatment for the benefit of the child.

Minor Consent
In Washington, a minor who is 13 years or older can consent to mental health treatment without consent of a guardian. Even if counseling is initiated independently by an adolescent client, it is our policy to notify parents on or before the third (3) session, unless there is a clear clinical/safety reason not to do so. In most cases it is our policy to request the minor client sign a release to allow their therapist to speak with a guardian. We strive to include important family members in treatment whenever possible. If physical or emotional safety are a concern for you, please let your provider know and we will make a plan together.

Payment
It is our hope that finances not be an obstacle in seeking treatment. We are committed to working with clients to creatively minimize obstacles, so please contact us if you have any specific questions or concerns.

Clients are responsible for payment prior to each session. Please let us know how you wish to pay, and we can work together to set up a payment method that works for you. Services may not continue if payment is not made in a timely manner. The person who signs the Payment-Insurance Information page authorizing payment is agreeing to be the "financial guarantor", which means this person agrees to pay fees for services provided. If there is a balance owed on your account, we will send you a statement. We ask that you complete payment within 30 days. If the fees are not paid, we reserve the right to send your account to a collection agency. You are responsible for paying the fees, as well as any court/legal fees. Checks may be made to Drayton Family Counseling and are welcome since there is no associated credit card processing fee. There is a $30 service charge for returned checks due to insufficient funds.

Washington State Client Rights
Counseling is a voluntary and mutual relationship. You are welcome to provide feedback and we welcome any questions or concerns about direction and approach. You may decide to terminate counseling at any time. Washington State law states "Counselors practicing counseling for a fee must be credentialed with the Department of Health for the protection of the public health and safety. Credentialing of an individual with the Dept. of Health does not include recognition of any practice standards, or necessarily imply the effectiveness of any treatment. Clients have the right to choose counselors who best suit their needs and purpose". It also advises "The purpose of the Counselor Credentialing Act, chapter 18.19 RCW, is to: (A) provide protection for public health and safety; and (B) empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct."

If you ever have any questions/concerns about your treatment or these policies, please let your provider know. Your concerns are important to us. Unresolved complaints may be directed to the Department of Health at 360.236.4700 or send mail to HSQA Complaint Intake, Post Office Box 47857, Olympia, WA 98504-7857.

Disclosure Consent
In signing this form, I agree that I have read, understood, and agree to the practices and policies listed.

______________________________ Client Printed Name

______________________________ Name of Guardian if Client is Under 13

______________________________ Client Signature

__________ Date

______________________________ Provider Signature

__________ Date

Drayton Family Counseling

Financial Policy

INSURANCE VERIFICATIONS - Before the initial office visit, my billing company will contact the client's insurance company to determine specific benefits. We will inquire if there is a deductible, co-pay, co-insurance, what services are covered, and whether or not a referral or prior authorization is necessary.

The information we receive is not a guarantee of the client's actual benefits and is subject to final processing by the client's insurance company. The client is responsible for all fees not covered by the insurance company.

PAYMENT ARRANGEMENTS – Should clients need to make special payment arrangements, please speak with our billing company, Prestige Medical Billing, by calling (360) 805-0323. Payment arrangements are based on the total balance due. Alternative payment arrangements may also be available.

PRIVATE BILLINGS - For clients without insurance coverage, full payment is due at time of service. All clients are quoted a fee for the office visit and are expected to pay at the time of the appointment. My financial policy does offer a fee at time of service discount if you do not have insurance or do not wish to utilize your insurance.

FORMS OF PAYMENT – In addition to cash or check, we kindly accept Visa and MasterCard for payment of services. There will be a $35.00 fee for checks returned for insufficient funds.

COLLECTION NOTICE – I understand that any and all accounts that become 90 days delinquent are subject to collections.

Insurance Company:________________________________ **ID#:**________________________________

Subscriber Name:________________________________ **Group#:**________________________________

______**I certify that I am eligible for benefits under my prepaid health benefit plan. In the event that I am later found to be ineligible or in consideration of being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees then in effect.**

_______**I understand that all Co-pays, co-insurances, deductibles and non-covered services will be due at the time of service unless other payment arrangements are made with the provider or billing company directly.**

_______**I grant permission to Prestige Medical Billing Co., Inc. to submit claims on my behalf to my insurance carrier for services provided by Drayton Family Counseling, LLC.**

_______**I authorize the release of any medical or other information necessary to process my claims.**

_______**I authorize payment of medical benefits to Drayton Family Counseling, LLC directly from my insurance carrier.**

CLIENT FEE SCHEDULE

Initial-Psychiatric diagnostic interview (90791)	$180.00
Individual Session 30 min. (90832)	$75.00 – 16-37 minutes
Individual Session 45 min. (90834)	$112.50 – 38-52 minutes
Individual Session 60 min. (90837)	$140.00 – 53-60 minutes
Family Session w/ Patient Present (90847)	$175.00 – 60 minutes
Family Session w/out Patient Present (90846)	$175.00 – 60 minutes
Interactive Complexity Add On (90785)	$15.00
Prolonged Services Code (99354)	$100.00 – 30-74 additional minutes
Assessment Add On (96127)	$15.00

SERVICES NOT COVERED BY INSURANCE

No show or late cancel fee for follow-up clinic visits	$60.00
Forms and letters outside of appointment	$150.00/hour, billed in increments of 15 min.
Letters for attorneys billed at separate rate	$250.00/hour
Clerical fee for searching/handling records, per WAC	$26.00
Pages 1-30 (copying fee), per WAC	$1.17 per page
Pages 31+ (copying fee), per WAC	$0.88 per page
Editing of confidential information, per WAC	$150.00/hour
Returned check fee, plus original amount due	$35.00

I have read and understood the above information and have been provided with a copy at my request.

______________________________ ______________________________

Patient Signature or Parent/Guardian (if under 18 years of age) **DATE**

______________________________ ______________________________

Patient Name **Patient Date of Birth**

Drayton Family Counseling

NOTIFICATION OF PRIVACY PRACTICES, *Rev 3/1/2018*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. / USES AND DISCLOSURES:

TREATMENT – Your health information may be used by our providers and staff members or may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

PAYMENT – Your health information may be used to seek payment from your health plan, other sources of coverage such an automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS – Your health information may be used as necessary to support the day-to-day activities and management of Drayton Family Counseling. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.

LAW ENFORCEMENT – Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting. For example, any known or reasonably suspected cases of child abuse or neglect, any known or suspected intentions of harming oneself (suicide), and/or any known or suspected intentions of harming others.

PUBLIC HEALTH REPORTING – Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

BUSINESS ASSOCIATES – The following companies may have access to your Protected Health Information for the purpose of carrying out Treatment, Payment, and/or Health Care Operations: Prestige Medical Billing Company, Inc., Sharefile, Billflash, Northwest Family Life, Lisa Jeffries, and Carol Beebe.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION – Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure or use of your information, you may submit a written revocation of the authorization. However, your decision to revoke your authorization will not affect or undo any disclosure or use that occurred before you notified this practice of your decision.

ADDITIONAL USES OF INFORMATION:

APPOINTMENT REMINDERS – When applicable, your health information will be used by our staff to call / send you appointment reminders.

_______ **PLEASE CHECK HERE IF IT IS OKAY TO LEAVE MESSAGES AT YOUR CONTACT NUMBER(S) PROVIDED OR EMAIL.**

Email:____

INFORMATION ABOUT TREATMENT – Your health information may be used to send you information on the treatment and management of your health condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS - YOU HAVE CERTAIN RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS. THESE INCLUDE:

The right to request restrictions on the disclosure and use of your protected health information; The right to receive confidential communications concerning your medical condition and treatment; The right to inspect and copy your protected health information; The right to request an amendment or to submit corrections to your protected health information; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice.

PROVIDER / OFFICE DUTIES – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. These revised policies and practices will be applied to all protected health information we maintain.

RIGHT TO INSPECT PROTECTED HEALTH INFORMATION – As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your individual practitioner or the front office. If you request a copy of your records, the following fees will be assessed: $24 Clerical fee, $1.09 per page fee for the first 30 pages and then $0.82 per page for any pages 31 and over. This fee must be paid prior to the copies being released.

COMPLAINTS AND CONTACT PERSON – If you would like to submit a comment or complaint about our privacy practices or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint. Drayton Family Counseling, 1316 King St. Suite 4, Bellingham, WA 98229, 360-436-6288 or 360-358-3408, OR YOU MAY ALSO CONTACT: Office for Civil Rights-U.S. Dept of Health and Human Services, 701 Fifth Avenue, Suite 1600, MS – 11, Seattle, WA 98104, Voice Phone (800) 368-1019, FAX (206) 615-2297

Please sign to acknowledge receipt of the Drayton Family Counseling Privacy Practices Policy.

Signature:______________________________ **Date:**____________________