Juliana Pope Counseling and Consulting, Inc
1800 Westlake Ave, Suite 104
Seattle, WA 98109
(206) 271-4874

INTAKE FORM

Name _____ Date _____

Address _____
City _____ State _____ Zip _____
Sex (M/F) _____ Birth Date _____
Employer_____
Name of Emergence Contact_____
Emergency Contact Phone Number _____

May I contact you by email or text for scheduling purposes? _____
Email Address: _____
Local Phone _____ *Can I call you here?* ____ *Can I leave a message?* ____
Cell Phone _____ *Can I call you here?* ____ *Can I leave a message?* ____

Briefly describe the concerns that have brought you here.

_____
_____
_____

Please check any current or past issues that still affect you.

____ Eating Disorders
____ Academic Issues
____ Childhood Abuse *(i.e. physical, sexual, emotional)*
____ Depression
____ Pornography
____ Sexual Identity Issues
____ Sexual Assault/Rape
  ____ *recently (when: _____)*
  ____ *in the past*
____ Death of someone close
  ____ *recently (when: _____)*
  ____ *in the past*
____ Family Issues *(i.e. divorce, alcoholism, violence)*
____ Other: _____
____ Suicidal Thoughts
____ Pregnancy Issues
____ Spiritual Concerns
____ Stress/Anxiety
____ Phobias *(type: _____)*
____ Alcohol/Other Drug Use
____ Relationship Concerns
  ____ *family*
  ____ *parent*
  ____ *significant other*
  ____ *friend*
  ____ *roommate*
____*other:* _____

Your History

Current medical problems

_____
Current medications (all, including herbal)

_____
Are you currently working with a Personal Physician? _____
Phone Number: _____ Physician Name _____
Have you been on any medications in the past for mental health issues?

_____
For what diagnosis did you require medication?_____

Have you previously seen a therapist? _____
Who/Where? _____ How long ago? _____
For what types of issues? _____
Are you currently seeing a therapist? _____
Have you ever been hospitalized for physical or mental health issues? (Briefly describe and include dates)
Are you currently suicidal?_____
If yes, do you have a plan?_____
Have you had any previous suicide attempts? _____
(Briefly describe)_____
_____
If you currently experience any of the following symptoms, please rate them using the key below:

Never = **0** | Seldom =**1** | Often = **2** | Always = **3**

_____ Difficulty concentrating	_____ Memory loss or blackout
_____ Crying	_____ Difficulty sleeping
_____ Missing classes	_____ Stealing
_____ Feeling helpless	_____ Anger
_____ Feeling uptight	_____ Eating binges
_____ Worrying	_____ Drinking heavily
_____ Feeling hopeless	_____ Other drug use
_____ Feeling afraid	_____ Guilt feelings
_____ Lying to others	_____ Withdrawing socially
_____ Feeling out of control	_____ Sexual preoccupation
_____ Feelings of self-doubt	_____ Physical symptoms
_____ Nervous around others	(i.e. headaches, digestive)

_____ Injuring self (List) _____
_____ Suicidal Thoughts Other: _____

Have you seen a health care provider for these? _____

Please use the scale below to answer the following questions.
4=True to a great extent | **3**=Mostly true | **2**=Somewhat true | **1**=Not at all true

My current concerns affect my success in life. ____
My current concerns affect my ability to interact and connect with others. _____
I am optimistic that I will make positive changes as a result of counseling. _____

Please briefly describe your family of origin:_____
_____
_____

Please briefly describe your relationship history_____
_____

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DISCLOSURE STATEMENT

Juliana F. Pope, M.S. Licensed Mental Health Counselor (LH00005317)

Welcome! Before we start counseling it is both my desire and a requirement of Washington State law to provide you with the following information. Signing this form establishes our contract for therapy services.

The Washington State Counselor Credentialing Act (WAC 246-810) requires that any counselor practicing counseling for a fee must be registered or certified with the Department of Health. This law was designed for the protection of the public health and safety, and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. However, registration of an individual with the Department does *not* include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment (WAC 246-810-031**).** ***It is every individual's right and responsibility to choose the provider and treatment modality which best suits their needs.***

Formal Training and Background: I have a Master's of Science degree in Counseling Psychology from the University of Oregon and became a Licensed Mental Health Counselor in the state of Washington in 2000. I have been practicing as a professional psychotherapist since 1996 both in private practice and working for agencies. My professional therapeutic experience is varied with extensive training in are variety of techniques to treat marital and family discord, depression, anxiety and generalized issues related to attachment difficulties. Additionally, I served as a professor of social sciences at Puget Sound Christian College from 1998-2005 in addition to my work as a psychotherapist at Northwest Family Life from 2000-2007.

Counseling Approach: My theoretical approach to counseling tends to draw from Psychodynamic and Cognitive orientations. Thus, I believe that our experiences within our family have a profound effect on us and I tend to watch for related themes. Further, I listen closely to a client's self-talk and inner perspective that may contribute to unhappiness or despair. I view the counseling process as a profound alliance in which we, together, explore the problem that brought you into therapy as well as the relational problems that may be arising in your life. Since I believe that relationships are the source of our greatest joy and deepest pain, we will inevitably explore how your way of being in relationship may interfere with your ability to have meaningful and successful relationships. Finally, I believe spirituality to be of deep importance in psychological well-being and am happy to discuss these issues with you if you so choose. If you do not initiate exploration in this direction, spiritual aspects will not be explored in the therapy process.

Confidentiality: I am bound by professional ethics to protect client rights to confidential communications in regards to their involvement in counseling. *All issues discussed in the course of counseling are strictly confidential*. By law, health care information pertaining to you may be released only with your written consent or the consent of a parent or guardian. For this reason, if you want me to release information about your participation in therapy, I will require a signed "Release of Information" from you. A release is legally valid for ninety (90) days from the date of signature. However, the law (RCW 18.19.180) provides **exceptions to client confidentiality** where *information may be released without your consent*:

1. In the event of a medical emergency information deemed necessary for treatment *may* be released.
2. In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individuals *must* be contacted. This may include the individual against whom a threat is made.

3. In the event of suspected abuse of a child, dependent adult or elder, the proper authorities *must* be contacted. The abuse does not have to be personally witnessed by the counselor.
4. If you register a complaint with the Washington State Department of Health, information will be released as requested or required by the State to resolve the issue.
5. If ordered by a judge or other judicial officers, information regarding your treatment *must* be disclosed.
6. If an attorney in the state of Washington duly subpoenas your records, they will be released unless you file a protection order within 14 days of the subpoena.
7. In the event of a client's death or disability, information will be released as authorized by the client's personal representative or beneficiary.
8. A counselor is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act.
9. Evidence that a minor client was a victim of a crime *may* be released to the proper authorities.

Records Review & Correction: I keep a record of the health care services that I provide to you. You have a right, by law (RCW 70.02.070), to see and copy that record. Also, you may ask to make correction(s) to your record. A reasonable fee will be charged for reviewing and/or photocopying any portion of your record.

Case Consultation: I advocate and practice professional consultations for the purposes of professional training, accountability and providing the best counseling service possible to clients. I may at times discuss your situation with other professionals while being very careful not to disclose your identity. Please speak with me if you have concerns regarding this practice. Use of data derived from counseling for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved.

Unprofessional Conduct & Complaint Process: A handout is provided listing legally recognized acts of unprofessional conduct (RCW 18-130-180). If you have any concerns about the course of your treatment I ask that you attempt to resolve them with me individually. If you are not heard or satisfied, and/or the matter is not resolved, you have the right to file a complaint with the Dept. of Health (Dept. of Health, Health Professions Quality Assurance Division, Counselor Registration/Certification, PO Box 47869, Olympia, WA 98504-7869, 360-753-1761).

Dual Relationships: Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to: volunteering for the agency, familial, social, financial, business, or close personal relationships with clients.) When a dual relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs.

Termination: It is every client's right to disengage from counseling with or without notice to the treatment provider. However, I request notification of termination of therapy. I find it helpful to arrange a final session to explore termination, and review counseling goals and progress. Please understand that your file will be considered closed 90 days after the last counseling appointment.

Schedule: Please be advised that I take the time off during the holidays and summer as a time of renewal.

Cancellation of Appointments: If you need to cancel your appointment, please let me know at least 24 hours in advance. Missed sessions or cancellations within 24 hours of a scheduled appointment will be charged to your credit card at the **full** session fee. Charges for missed sessions cannot be billed to insurance.

Credit card # on file: _____ Expiration Date _____

Name on card_____ CCV _____ ZIP CODE _____

Session Fees: Payment of fees are expected at the time of the appointment. Sessions begin at the scheduled time. Session fees are: **$130 for individual (50 minutes), $140 for couples and families (50 minute), or $200 (for a 90 minute session).**

Insurance Coverage & Payments: Insurance company carriers, plans, coverages and provider contracts are so varied in regards to mental health benefits that *there is no way of guaranteeing that your insurance plan will cover my services for your diagnosis and counseling*. Although I automatically bill insurance for all my clients unless requested to do otherwise, I *STRONGLY* advise each client to call their insurance company to *estimate* what coverages *may* apply *before* entering into therapy. Insurance companies require a formal diagnosis to determine eligibility for payment. *Please be aware that a mental health diagnosis then becomes part of your medical record.*. Also, be aware that insurance company contracts with both clients and providers include authorizations to review actual counseling case notes if they request to do so. Insurance benefits are received directly to my office.

I, _____, authorize Juliana Pope, M.S., to engage in counseling services with me. I have read and understood the preceding disclosure and policy statements. I have also read and understood the Unprofessional Conduct handout. I understand I may have copies of both this contract and the Unprofessional Conduct form. I agree to the conditions of this therapy contract.

_____ _____

Client's Signature Date Parent/Guardian's Signature (if applicable) Date

_____ _____

Client's Signature Date Therapist/Counselor's Signature Date

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EMAIL AND TEXT RELEASE OF INFORMATION

Attention clients: If you wish to have me communicate with you via e-mail or text, please complete this form. Be aware that Juliana Pope Counseling & Consulting Inc. does not have encrypted e-mail software and cannot guarantee that information transmitted by e-mail or text will not be intercepted or read by other parties. By signing this form you are agreeing not to hold Juliana Pope responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any e-mails or texts sent to or from Juliana Pope.

I have read the above and agree to hold Juliana Pope harmless for any breach of confidentiality that may result from someone accessing confidential information from e-mails or texts sent to or from my counselor.

Signature: _____ Date: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

This release may be revoked at any time by writing a written revocation and is valid until such revocation is received in our office.

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INSURANCE VERIFICATION – MENTAL HEALTH BENEFITS

In order to have insurance pay for mental health treatment, you must be diagnosed with a "mental health disorder". Thus, a mental health diagnosis does go on your medical record.

Please note that when you apply for insurance (medical, disability, or life insurance) it's very likely that your diagnosis will be a factor in determining your acceptance and premium rates.

I believe it's very important for you to be aware of this risk. Please weigh these considerations before deciding to use your insurance to pay for psychotherapy or medication. If you decide that using insurance is not right for you, we can talk about private pay.

Date_____

Subscriber's Name_____ Date of Birth_____

Client's Name_____ Date of Birth_____

Client's Phone Number_____

Insurance Company_____

Policy/Group #_____ Subscriber ID # from card_____

Customer Service Phone #_____

In Network Mental Health Benefits: _____
Out of Network Mental Health Benefits:_____

Annual deductible is $_____ How much used to date? _____

Copay _____

I_____, authorize Juliana Pope to obtain my mental health benefits and payment from my insurance company. I am aware that **this is a quote of benefits and not a guarantee of payment.** If my insurance does not provide payment for the services I receive from Juliana Pope Counseling & Consulting or if there is a discrepancy in the quoted benefits, I will assume responsibility for all payment owed. For further questions in regards to my benefits, I understand it is my responsibility to confirm quotes and benefits from my insurance company.

_____ _____

Client's Signature Authorized Representative

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NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me. I will maintain the privacy of your health information and will hold all information confidential unless you allow me to release that information or unless the law authorizes or requires me to do so.

Federal law known as the HIPPA law requires that I provide you with the following Notice of Privacy Practices. If you have any questions about this notice or your information, please contact me at the above address and phone number or by email at julianapope.com@comcast.net.

Use and Disclosure of

Personal Healthcare Information in Compliance with HIPPA

This notice describes how medical information about you may be used and disclosed. It also describes how you may get access to this information. Please read it carefully.

Your personal healthcare information in a psychotherapy office refers to any medical or financial information that can reasonably be used to identify you and that relates to the treatment, payment, and operations of providing your mental health care. Psychotherapists keep written records that may include your name, address, phone number, social security number, employment, medical history, health records and claims or payment information. Your healthcare file may also include a diagnostic impression, a plan of treatment, dates of service, incidences of emergency, and progress notes or documents pertinent to your healthcare.

With your written consent, your healthcare information may be given to others providing care for you if such information is necessary to the coordination and continuity of your care. Your healthcare information may also be obtained from other practitioners and kept or recorded in your file for the purpose of assessing the best course of treatment for you. These communications may be in written, verbal, or electronic format. With your approval, your healthcare information may also be used to process claims and to assess quality of care and improvement of services by your insurance company. It may also be used and/or disclosed in returning your phone calls/text messages or contacting you about appointments using voicemail or text messages and answering machines or in phone communications. Therapists may also release information while consulting with other professionals for the purpose of improving your treatment.

Your Health Information Rights The healthcare and billing records we create and store are the property of Juliana Pope Counseling & Consulting. The protected health information in it belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask me to restrict certain uses and disclosures. You must deliver this request in writing to me.
- Request and receive from me a paper copy of the most current Notice of Privacy Practices.
- Request that you be allowed to see and get a copy of your records.
- Have me review a denial of access to your records.

- Ask me to change something in your records. Please give me this request in writing. If your request is denied you may write a statement of disagreement. It will be stored in your medical record and included with any release of your records.
- You have the right to request a list of disclosures of your health information – you may receive this information without charge once every twelve months.
- You have the right to ask to be contacted by using another means or at another location.
- You have the right to cancel prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released.
- Please note that all such requests from you regarding your rights listed above must be in writing with your signature and the date

COURT ORDERS, EMERGENCE AND CRITICAL INCIDENCE

In the State of Washington all personal healthcare information is considered privileged.

Counselors are required to keep this healthcare information for a period of only five years following a client's last visit. In most cases, you must sign a release of information or give your written consent before any disclosure of your records can be made to other individuals, agencies, or insurance companies. As required of all psychotherapists however, there are some situations when identifying or healthcare information must be released, even without your written consent. Under the following circumstances, I am required by law to provide information to the appropriate authorities:

When it is required by federal, state or local laws (i.e. when it is ordered by the court in judicial or administrative proceedings.)

When there is reasonable cause to believe that child or elder abuse/neglect has occurred.

When there is reasonable cause to believe that there is a clear and imminent danger to

you/others or if you are no longer able to meet your basic needs.

Questions and Complaints

Please speak with me if you have any questions or complaints concerning your

protected healthcare information and your privacy rights. If you believe your rights have been

violated, I urge you talk with me immediately. You may also notify or file a complaint with the U.S. Department of Health and Human Services or with the Washington State Department of Licensing.

These privacy policies are stated and practiced in compliance with HIPAA - The Federal Health Insurance Portability and Accountability Act.

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ACKNOWLEDGMENT OF RECEIPT OF 'NOTICE OF PRIVACY PRACTICES'

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may ask to see and copy your records at your expense. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels it.

By my signature below I acknowledge I have read or received a copy of the Notice of Privacy Practices, which includes a: "Patient Bill of Rights".

_____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name of patient | Relationship to patient (parent, legal guardian, personal representative)

Office use only:

Unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to;

( ) The patient refused to sign
( ) Communication barriers
( ) Emergency situation
( ) Other_____ Name_____Date_____

This form will be retained in your medical record.