



To new clients:

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason you are unable to complete the paperwork before our session I will have copies in my office and we will use your session time to complete the paperwork.

The **Disclosure Statement (Pages 2-4)** outlines my policies regarding financial matters, confidentiality of information, and other administrative issues.

The **Credit Card Authorization Form (Page 5)** provides me with a backup form of payment in the event of a missed appointment or absence of payment at the time of session.

The **Intake Form (Pages 6-7)** provides me with your basic identifying and contact information.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I look forward to meeting with you.

**Benjamin Deu, MA, LMHC**  
**Licensed Counselor and Supervisor**

**Checklist for completing paperwork:**

- Please print your name in the space provided on this page (Page 1)
- Read my **Disclosure Statement** found on pages 2-4. Sign and date on page 4.
- Complete, sign and date **Credit Card Authorization Form** on page 5.
- Complete your **Intake Form** found on pages 6 and 7.
- Please sign that you have received the Notice of Privacy Practices on page 8.
- Read through the **Notice of Privacy Practices** regarding your therapy on pages 8-9.
- Initial all pages in upper right hand corner to indicate that you have read and understand the information provided.

Client Name: \_\_\_\_\_ (please print)



## **DISCLOSURE STATEMENT**

**Training and Degrees:** I received my Master of Arts in Counseling Psychology from Mars Hill Graduate School in August 2005. This program is fully accredited by the Transnational Association of Christian Colleges and Schools (TRACS), a national accrediting agency that is recognized by the Council for Higher Education Accreditation (CHEA). In addition to my formal training, I have experience working with youth and adults in a variety of settings over the past 15 years. I practice under the title of a state Licensed Mental Health Counselor (LH00010988). I consult weekly with other professional therapists to ensure quality and performance for my clients.

**Counseling Orientation:** My theory is an eclectic mix, but I work primarily from existential, object relations, psycho-dynamic and relational approaches. Basically what this means is that I believe your earliest relationships have deeply affected who you are today in ways that you are aware of and in ways that you may be unaware. I view our work together as an opportunity to stop and reflect on your life story so that you are more capable to choose the life you want to live. In addition to exploring the issues that bring you to counseling, we will also look at your relationships with other significant people in your life. Our work will focus on the ways that you thrive in relationships and also the areas where you are hindered from reciprocity and enjoyment in your relationships. My role as a counselor is to create a safe space for you to locate and live out of your truest self. We will work together to identify the hindrances and obstacles preventing you from living your most meaningful and authentic life. Your ability to be open and honest with me will greatly enhance the effectiveness of your therapy. In addition, I believe that certain problems can have a physical component. In such cases, medical consultation will be advised. If at any point you have questions or concerns about our relationship or the direction of our work together, please feel free to address these with me.

**Fees:** The fee for counseling is \$130.00 per 50-minute session. Fees are adjusted annually on January 1 and will not increase more than \$10 per year. Payments (cash or check) are to be made at the beginning of each session. Payment via credit or debit cards is also available in office for an additional fee of \$3.00 per session. A \$35 fee will be debited to your credit card in the event of a returned check. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

**Credit Card Authorization and Purpose:** In the event that you forget to bring cash, check or a credit card to your session; in the event that you fail to give adequate notice by phone of missing an appointment. In such a case you are authorizing me to charge your credit card for any therapy related fees plus a 3.5% keyed in credit card processing fee. If you prefer not to provide a credit card number as a backup form of payment you will need to pay cash or check 1 session in advance for me to hold your session time.

**Insurance Information:** You may be eligible to receive reimbursement from your insurance company for your counseling sessions. When you are negotiating with your insurance company, it might be helpful for you to know that I have a master's degree in counseling psychology and am licensed by the State of Washington. I do not file insurance claims on your behalf. If your insurance provider will be covering the cost of your counseling, then you need to make arrangements for the insurance provider to reimburse you directly. I can provide a receipt with a procedure code and a diagnosis if necessary. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. The initial session will be billed as an Assessment (CPT Code 90801) while subsequent sessions will be billed as Individual Psychotherapy (CPT Codes 90806 or 90808). A provisional diagnosis will be included on the bill so the insurance provider can reimburse you. This diagnosis is subject to change based on further assessment. I assume no responsibility for the continuation of confidentiality of the information once it is released to the insurance company.



## DISCLOSURE STATEMENT

**Missed Appointments:** In the event that you are unable to keep an appointment, **please notify me via phone a minimum of three days (72 hours) in advance. E-mail and text messages are not adequate notice. 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.** 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.

**Termination of Treatment:** When you wish to terminate treatment, **please give a minimum of one week's notice.** You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

**Testifying in Court:** 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 my full fee per hour (\$130) for preparation, travel, and attendance (waiting and participation) at any legal proceeding.

**Choosing a Counselor:** You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

**Confidentiality:** There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, **I can assure you that I strive to maintain the strictest ethical standards of confidentiality.** For this reason, if you want me to release information about your participation in therapy to anyone, I will require you to sign the "Authorization to Release Health Care Information" form. This confidentiality has the following exceptions provided by law:

- a) In the event of a medical emergency, emergency personnel or services may be given necessary information.
- b) In the event of a threat to harm 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 the threat is made.
- c) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.
- d) If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed.
- e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released.
- f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena.
- g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
- h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities.
- i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities.



**DISCLOSURE STATEMENT**

The client understands and agrees that the therapist’s working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity.

**State Information:** Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

**Unprofessional Conduct:** The brochure titled "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs  
P.O. Box 47869  
Olympia, WA 98504-7869  
360.664.9098

**Contacting Me By Phone:** You may leave me a voice message at 425.736.1676. I check these messages periodically and will typically return your call within 24 hours. Please limit your phone conversation needs to appointment scheduling and emergencies.

**Emergencies:** If you are in an emergency situation and cannot reach me, please call one of the following numbers for help:

General Emergencies: 911  
Crisis Clinic: 800.244.5767 or 206.461.3222

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In addition to your signature below, please initial all pages of this document.

I have read and understand the information presented in this form.

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Client Signature

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Date

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Benjamin Deu, MA, LMHC (therapist)

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Date



**Credit Card Payment Authorization Form**

Sign and complete this form to authorize Greenlake Counseling, Inc. to debit your credit card as listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with Greenlake Counseling, Inc., and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

**Please complete the information below:**

I \_\_\_\_\_ authorize Greenlake Counseling, Inc. to charge my credit card  
(full name)

account indicated below. Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of \$130/hour and charged 3.5% for keying in a credit card number. This is the exact same fee that I am charged by my credit card processing company.

Billing Address \_\_\_\_\_

Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_

Account Type:  Visa     MasterCard     AMEX     Discover

Cardholder Name \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

I authorize Greenlake Counseling, Inc. to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.



**INTAKE FORM PART 1**

Date \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex (M/F) \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

May I contact you by email 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? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Has anyone urged you to come here? \_\_\_\_\_

***Briefly tell us about the concerns that have brought you here.***

\_\_\_\_\_  
\_\_\_\_\_

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

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



**INTAKE FORM PART 2**

***Your History***

Current medical problems \_\_\_\_\_  
 Current medications (*all, including herbal*) \_\_\_\_\_  
 Are you currently working with any Personal Physician? \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Name \_\_\_\_\_ What for? \_\_\_\_\_  
 Have you been on any medications in the past for mental health issues? \_\_\_\_\_  
 (*Please list*) \_\_\_\_\_

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*) \_\_\_\_\_

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.***

<i>Never = 0</i>	<i>Seldom = 1</i>	<i>Often = 2</i>	<i>Always = 3</i>
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- |   |   |
|---|---|
| <p>_____ Difficulty concentrating</p> <p>_____ Crying</p> <p>_____ Missing classes</p> <p>_____ Feeling helpless</p> <p>_____ Feeling uptight</p> <p>_____ Worrying</p> <p>_____ Feeling hopeless</p> <p>_____ Feeling afraid</p> <p>_____ Lying to others</p> <p>_____ Feeling out of control</p> <p>_____ Feelings of self-doubt</p> <p>_____ Injuring self</p> <p>_____ Nervous around others</p> <p>_____ Suicidal Thoughts</p> | <p>_____ Memory loss or blackout</p> <p>_____ Difficulty sleeping</p> <p>_____ Stealing</p> <p>_____ Anger</p> <p>_____ Eating binges</p> <p>_____ Drinking heavily</p> <p>_____ Other drug use</p> <p>_____ Guilt feelings</p> <p>_____ Withdrawing socially</p> <p>_____ Sexual preoccupation</p> <p>_____ Physical symptoms (<i>i.e. headaches, digestive</i>)</p> <p>List: _____</p> <p>Have you seen a health care provider for these? _____</p> <p>Other: _____</p> |
|---|---|

Would you be interested in a counseling group? \_\_\_\_\_ For what issues/topics? \_\_\_\_\_

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 be able to make some positive changes as a result of counseling. \_\_\_\_\_



**ACKNOWLEDGEMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Benjamin Deu.

Signature of Client (or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client (or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**If a personal representative signs this acknowledgement on behalf of the client, please complete the following:**

Name of Personal Representative: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**FOR OFFICE USE ONLY**

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

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)-

*This form is educational only. It does not constitute legal advice, and covers only federal, not state, law.*



## **NOTICE OF PRIVACY PRACTICES INTRODUCTION**

The privacy of your health information is important to me. I will not disclose your health information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

A new federal law, the Health Insurance Portability and Accountability Act, commonly known as HIPAA, requires that I inform you about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign an acknowledgement that you received it. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding the health information I maintain about you and a brief description of how you may exercise these rights.

## **NOTICE OF PRIVACY PRACTICES**

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

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

### **I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)**

#### **A. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION**

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

1. **TREATMENT:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **PAYMENT:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health insurance provider. For example, I may disclose PHI to enable your health insurance provider to take certain actions before it approves or pays for treatment services.
3. **HEALTH CARE OPERATIONS:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, and licensing or credentialing activities.
4. **REQUIRED OR PERMITTED BY LAW:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; disclosures to health and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions, or otherwise as authorized by law.



## NOTICE OF PRIVACY PRACTICES

### B. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

1. **PSYCHOTHERAPY NOTES:** My notes documenting the contents of a counseling session with you (“Psychotherapy Notes”) will be used only by me and will not otherwise be used or disclosed without your written authorization.
2. **MARKETING COMMUNICATIONS:** I will not use your health information for marketing communications without your written authorization.
3. **OTHER USES AND DISCLOSURES:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

### II. YOUR INDIVIDUAL RIGHTS

#### A. RIGHT TO INSPECT AND COPY.

You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under some circumstances, I may deny access to your records. I may charge a fee for the cost of copying and sending you any records requested. *[Note: State law may regulate such charges.]* If you are a parent or legal guardian of a minor, please note that certain portions of the minor’s medical record will not be accessible to you. *[Note: Examples should be included consistent with state law (e.g., records related to mental health, drug treatment, or family planning services).*

**B. RIGHT TO ALTERNATIVE COMMUNICATIONS.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

**C. RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

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

**E. RIGHT TO REQUEST AMENDMENT.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

**F. RIGHT TO OBTAIN NOTICE.** You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

**G. QUESTIONS AND COMPLAINTS.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me at (425)736-1676. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the director or me.

### III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

**A. EFFECTIVE DATE.** This Notice is effective on April 14, 2003.

**B. CHANGES TO THIS NOTICE.** I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. You may also obtain any revised notice by contacting me.

*This form is educational only. It does not constitute legal advice, and covers only federal, not state, law.*