CONFIDENTIAL CLIENT INTAKE INFORMATION

M. Reid Stell, MA
Reid Stell Counseling
901 Boren Avenue, Suite 701
Seattle, WA 98104
(206) 457-3038
ReidStellCounseling@gmail.com

CONTACT INFO: Today's Date: ____________________

Name: ____ Date of Birth: ____________________

Address: ____

City: ____ State: ___ Zip Code: ____________________

Cell Phone: __________________________________ Okay to leave detailed message? __________

E-mail: ______________________________________ Okay to leave detailed message? __________

Emergency Contact: __________________________________ Phone Number: __________________

Relationship: ____

RELATIONSHIP INFO:

Relationship Status: Single Married Cohabitating Divorced Widowed

Sexual Identity: Straight Gay/Lesbian Bisexual Questioning Transgender/Transsexual

EMPLOYMENT/EDUCATION INFO:

Employment Status: Full-Time Part-time Unemployed Self-Employed

Occupation: ______________________________ Employer: _______________________________

Student Status: Full-Time Part-Time Non-Student Current School: ______________________

Highest Level of Education: ______________________ Degree: _____________________________

HEALTH INFO:

Health Issues: ____ Date of last Physical: _______

Medications & Dosages: ____

ADDITIONAL INFO:

For this section, please give concise, honest answers. If you are uncomfortable answering a question, feel free to leave it blank.

What is your opinion about counseling? Have you been before?

____

What is your most pressing issue at the moment?

____

Do you have any prior diagnoses from a doctor or mental health professional?

____

Do you have any physical or learning disabilities I should know about?

____

Have you ever attempted suicide or been hospitalized for hurting yourself? If so, when?

____

Are you or have you ever suffered from addiction of any sort?

____

Is there other information that could be helpful for me to know?

____

GROUP THERAPY DISCLOSURE STATEMENT

Your Rights and Responsibilities, Under Washington State Law
As a Client of Reid Stell Counseling

M. Reid Stell, MA
Reid Stell Counseling
901 Boren Avenue, Suite 701
Seattle, WA 98104

(206) 457-3038

ReidStellCounseling@gmail.com

State of Washington Department of Health License Number: LH 60425029

Therapeutic Orientation

Whether you want to solve a particular problem, make a decision, or understand what is happening in your life, my commitment to you is to collaborate with you as a partner. Though this is your journey, you need not face the challenges alone.

In this therapy group, we will explore what has worked for you in the past as well as patterns that may have proven counterproductive. We will use psychodynamic, cognitive-behavioral, existential, and other therapies to focus on building solutions based on achievable goals. If you would like clarification about these therapeutic orientations, I will be happy to explain them.

Education and Supervision

I hold a Master of Arts degree in Counseling Psychology from City University of Seattle, where I also fulfilled my internship. I have been granted the title of Licensed Mental Health Counselor by the Washington State Department of Health. This license is current as of the date of the signing of this document.

Course of Treatment

How long will treatment take? The answer to this question very much depends on the group's members. This is an open group. You may remain in it as long as is productive. Others members may join the group at any time. The group will meet weekly for 90 minutes per session in my office. Decisions about the direction of the group may be put before the members to decide.

Fees and Other Information

The fee for a 90-minute group session is $20, payable at the time service is rendered by cash, check, or credit card. *In order to avoid being charged your session fee for missed sessions, a 24-hour notice of cancellation by telephone is required.*

Client Rights

According to Washington State Law, you, as my clients, have the right to refuse treatment and the right to choose whether or not to employ me as your practitioner. You also have the right to decide which methods or modalities might best suit your needs.

Department of Health Contact Information

If you have a question, comment, or complaint about service provided, you may contact:

Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

(360) 236-4700

The undersigned practitioner has gone over this document with the undersigned client and has answered all questions to the client's satisfaction.

____

M. Reid Stell, MA

____

Date

The undersigned client has been provided a copy of this disclosure statement, has read the statement, and understands the rights and responsibilities contained herein. The undersigned further authorizes treatment under the conditions of this document.

____

Client

____

Date

Reid Stell Counseling
Client Rights and Authorization for Treatment

ReidStellCounseling@gmail.com
901 Boren Avenue, Suite 701
Seattle, WA 98104
(206) 457-3038

Notice of Client Rights

In accordance with Section 275.57.340 of the Washington Administrative Code, each client of this agency's services is hereby informed that he/she has the right to:

1. Be treated with respect and dignity.
2. Receive treatment which is nondiscriminatory and sensitive to differences of race, culture, language, sex, age, national origin, disability, creed, socioeconomic status, marital status, sexual orientation, and ability to pay.
3. Receive appropriate care and treatment, employing the least restrictive alternatives available.
4. An individual service plan reflecting problems and/or needs identified for, or with, the client.
5. Refuse any proposed treatment, consistent with the Revised Code of Washington.
6. Review his/her own clinical record, according to agency policy and conditions specified in the Washington Administrative Code.
7. Confidentiality as specified in relevant federal and state statutes and regulations except:
   a. where a properly endorsed release and/or exchange of information form is signed by the client or legally responsible other;
   b. where there is reason to suspect the occurrence of child abuse or neglect;
   c. where there is a clear threat to do serious bodily harm to self or others;
   d. to a court, under court order;
   e. to hospital or emergency personnel for purposes of dealing with an emergency or unexpected admission;
   f. to any other healthcare providers who are believed to be providing care to the client;
   g. to law enforcement or public health officers, only to the extent necessary to carry out the responsibilities of law enforcement or public health;
   h. in other circumstances, as required or permitted by law.
8. Be free of any sexual exploitation or harassment.
9. Lodge a grievance with the agency if he/she has reason to believe that his/her rights have been violated, or is dissatisfied with the plan or quality of services being provided. A copy of the grievance procedure is available upon request.
10. Lodge a complaint with the Washington State Health Department licensing division or City University if you believe your rights have been violated. If you lodge a complaint or grievance, you shall be free from any act of retaliation.
11. Consent in writing before any treatment or procedure is initiated.
12. Protection if he/she is a minor child, in that no child shall be seen more than once without parental/guardian consent, except as specified in the Washington Administrative Code (under current Washington state law, minor children aged 13 and older may receive treatment without parental consent).

Authorization for Treatment

I hereby request and authorize Reid Stell to evaluate, treat, or provide consultation to me or to the individual named below of whom I am the parent or legally constituted guardian.

I acknowledge that I have received 1) a copy of my rights as a client of Reid Stell Counseling, and 2) a Disclosure Statement identifying Reid Stell's education, training, and clinical orientation.

________________________	____________	________________________	____________
Client Signature	Date	Reid Stell, MA	Date

Reid Stell Counseling
Notice of Privacy Practices

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in our office or disclose it outside of our office without your written permission. In some limited situations, the law requires us to disclose your health information without either written or verbal consent.

I will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and healthcare operations in this office. I am allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment, payment, and healthcare operations:

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities, and utilization review. For example, I may disclose treatment information when billing a medical plan for you.
- Healthcare operations include the business aspects of running our practice.

You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization or as permitted by law.

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples may never come up at our office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by your insurance plan, or for investigation of possible violation of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information to any person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyers, healthcare research firm, etc). Please complete our written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is originally effective March 17, 2003 and revised on January 1, 2007. I am required to abide by the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected healthcare information that I maintain. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about my privacy practices:
Reid Stell Counseling
901 Boren Ave
Suite 701
Seattle, WA 98104
206.457.3038

For more information on HIPAA or to file a complaint:
The US Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington DC, 20201
877.696.6775

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been given a copy of Reid Stell Counseling's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that Reid Stell Counseling has the right to change this *Notice* at any time. I may obtain a current copy by contacting Reid Stell Counseling.

Date: ________________ Client Signature: ____

Group Therapy Rules

Keep our discussions confidential, just between us. Contact with members outside the office is your own business, but share with the group any "subgroup" conversations afterward.

Be honest about who you are and what you think and feel. Take turns and say what you mean.

Practice empathy, compassion, and kindness with each other.

Be willing to try new behaviors. If your old ways of doing things are not working, let us help you with new ones.

Attendance and punctuality are important and appreciated. We are in this together. Give 24-hour notice for absences—excluding illness.