RAIN CITY COUNSELING

INFO@RAINCITYCOUNSELING.COM
206.855.3347

1421 34TH AVENUE, SUITE 205
SEATTLE, WA 98122

RAINCITYCOUNSELING.COM

NEW CLIENT INTAKE

CLIENT INFORMATION

Preferred Name:

Legal Name:

Date of Birth: **Age:** **Pronouns:**

Gender Identity:

Racial/Ethnic Identity:

Sexual Orientation:

CONTACT INFORMATION

Address:

City: **State:** **Zip Code:**

Mailing Address or P.O. Box:

City: **State:** **Zip Code:**

Phone (primary): **OK to leave message?** ☐ **YES** ☐ **NO**

Phone (secondary): **OK to leave message?** ☐ **YES** ☐ **NO**

E-mail: **OK to leave message?** ☐ **YES** ☐ **NO**

RAIN CITY COUNSELING

EMERGENCY CONTACT

Name:

Relationship: **Phone:**

EDUCATION/EMPLOYMENT

Highest Level of School Completed:

Occupation: **In School currently?** ☐ **YES** ☐ **NO**

If yes, what school?:

Employer:

Hours worked per week: **Salary:**

RELATIONAL

Relationship status:

If in relationship, how long?

If separated/divorced/widowed, how long?

Do you have any children? ☐ **YES** ☐ **NO**

If yes, do you have custody? ☐ **YES** ☐ **NO**

If yes, please note ages and names:

RAIN CITY COUNSELING

With whom do you currently reside?

MEDICAL INFORMATION

Primary Care Physician:

Phone: Fax:

Address:

City: State: Zip Code:

Are you currently receiving medical treatment? ☐ YES ☐ NO

If Yes, please specify:

Current Medications and what taking for:

Prescriber's Name: Phone:

Name of prior Therapist/Clinic (within 3 years):

RAIN CITY COUNSELING

PRESENTING ISSUES

Why are you seeking therapy?

What are your concerns or goals for therapy?

How long have you experienced these concerns?

Please check any of the following areas related to current or past experience:

- ☐ Addictions
- ☐ Aging
- ☐ Anger
- ☐ Anxiety
- ☐ Auditory or visual hallucinations
- ☐ Bullying
- ☐ Childhood Abuse
- ☐ Chronic Pain
- ☐ Coming out issues
- ☐ Cultural Identity
- ☐ Depression
- ☐ Difficulty focusing
- ☐ Dissociating
- ☐ Domestic Abuse
- ☐ Other (Describe):
- ☐ Drug/Alcohol Abuse
- ☐ Eating Disorders
- ☐ End of Relationship
- ☐ Family issues
- ☐ Fears/Phobias
- ☐ Financial issues
- ☐ Gender care
- ☐ Grief/Loss
- ☐ Health problems
- ☐ Insomnia
- ☐ Legal Matters
- ☐ Negative thought patterns
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Parenting issues
- ☐ Past/current trauma
- ☐ Postpartum Depression
- ☐ Racial/Ethnic oppression
- ☐ Relationships
- ☐ Self harm
- ☐ Sexual Assault
- ☐ Sexual identity
- ☐ Social Anxiety
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Work problems

RAIN CITY COUNSELING

Have you been previously diagnosed with a mental health/psychiatric condition?
☐ YES ☐ NO

If Yes, please list:

Are you currently having suicidal thoughts? ☐ YES ☐ NO

Have you experienced suicidal thoughts in the past? ☐ YES ☐ NO

Have you ever attempted suicide? ☐ YES ☐ NO

If Yes, when and how:

Have you had any previous psychiatric hospitalizations? ☐ YES ☐ NO

If Yes, when and where:

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family, immediate or extended; been diagnosed or suffer from any mental health issues or substance related disorders? (If yes, please indicate the diagnosis and the family member):

RAIN CITY COUNSELING

SUPPORT SYSTEM

Describe your current support system (people, activities, etc):

REFERRAL SOURCE

How were you referred? ◯ Online Directory ◯ Website ◯ Friend/Family ◯ Other

Name of person/directory/other:

May I have your permission to thank this person for the referral? ◯ YES ◯ NO

Official Use only

Diagnosis(es):

Diagnostic/Procedural Code:

Date: _____

RAIN CITY COUNSELING

INFO@RAINCITYCOUNSELING.COM
206.855.3347

1421 34TH AVENUE, SUITE 205
SEATTLE, WA 98122

RAINCITYCOUNSELING.COM

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 CAREFULLY.

WHY IS THIS NOTICE PUBLISHED? As medical/mental health professionals, it is our legal duty to safeguard your Protected Health Information (PHI) and maintain its privacy. The PHI constitutes information created or noted by this practice that can be used to identify you. It contains data about your past, present or future health or condition, the provision of healthcare services provided to you or the payment for such healthcare. Use of PHI means when we share, apply, utilize, examine, or analyze information within this practice; or PHI is disclosed when this practice releases, transfers, gives, or otherwise reveals it to a third party outside of this practice (such as an insurance company).

USING YOUR PERSONAL HEALTH INFORMATION: Each time you attend an individual, group, joint, or family session with this practice, a record of your session is created. Typically, this record contains symptoms, diagnosis, treatment, payment, healthcare information, authorizations, and consent for treatment. This information, often referred to as your health or medical record, serves as a:

1. **Basis for planning your session and treatment goals.**

2. **Means of communication amongst other healthcare professionals involved in your treatment.**

3. **Legal documents describing the treatment you receive.**

4. **A source of information for public health officials charged with improving the health of the general public.**

5. **Means by which you or an insurance company can verify that services billed were actually provided.**

6. A tool with which this practice can assess and continually work to improve the care provided and the outcomes achieved.

Understanding what is in your health record and how that health information is utilized helps you to ensure accuracy; better understand who and why others may access health information; and make a more informed decision when authorizing disclosures to others. There are certain circumstances in which the use of disclosures will not require prior authorization from you. This includes:

1. Obtaining payment for treatment. This practice will use and disclose your PHI to bill and collect payment for the treatment and services provided you.

2. If disclosure is mandated by the Washington Child Abuse/Neglect, and Elder/Dependent Adult Abuse Reporting Law.

3. Your consent in not required if you need emergency treatment provided. This also may include providing information to law enforcement, personnel, crisis response teams, or an inpatient psychiatric setting. An emergency may be defined as preventing a serious threat to the health or safety of another person, yourself, or the public health.

4. This practice will use your information to carry out healthcare operations. This practice may also provide your PHI to its attorneys, accountants, consultants, and others to make sure that it is in compliance with applicable laws.

5. Your health information may also be used to contact you to remind you of an appointment, to inform you of changes in treatments, or to advise you about other health related benefits and services.

YOUR INDIVIDUAL RIGHTS: As patients, you have individual rights over the use and disclosure of your personal health record. There are certain federal and state laws that provide special protections for certain kinds of PHI. In these situations, this practice will let you know if there are other authorizations needed to comply with federal and state laws.

RAIN CITY COUNSELING

1. Limit Use: You may request in writing that we do not use or disclose your information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally required to accept it.

2. Received Confidential Communications: You have the right to receive confidential communications from us at another address you provide to this practice.

3. Inspect and Copy: You have the right to look at your information. You may obtain a copy of all or any part of your medical records. We may charge you a clerical fee and copying charge of $.25 per copy.

4. Request Corrections: If you believe the information in your record is incorrect or if important information is missing, you have the right to request that we correct the missing or existing information. If we determine not to change the record, you are entitled to a statement of your disagreement to be included in your healthcare records.

5. Knowledge of Disclosures: You have the right to receive a list of instances where we have disclosed information for reasons other than treatment, payment, or related administrative purposes.

6. The Right to Get This Notice by Email: You have the right to receive this Notice by email, or request a paper copy of it.

RAIN CITY COUNSELING

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES: If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in the next Section below. You may also file a complaint with:

Department of Health
Health Systems Quality Assurance (HSQA)
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

Phone: 360-236-4700

Email: HSQAComplaintIntake@doh.wa.gov

If you file a complaint about our privacy practices, we will not take retaliatory action against you.

RAIN CITY COUNSELING

INFO@RAINCITYCOUNSELING.COM
206.855.3347

1421 34TH AVENUE, SUITE 205
SEATTLE, WA 98122

RAINCITYCOUNSELING.COM

PROCEDURES AND FINANCIAL POLICY

OFFICE HOURS: Monday, Wednesday, and Thursday from 9:00 am- 12:00 pm and Saturday 12:00 am-6 pm. Messages can be left on the confidential voice mail, or via email at colleen@raincitycounseling.com. Be aware that email is not a confidential medium. Your call will be returned as soon as possible. The Crisis Clinic is also available 24 hours a day, 7 days a week. The number is (206) 461-3222. If it is an emergency, please call 911.

MEDICAL RECORDS: All your records are confidential. NO information will be released (even to family) without your signed consent on a release of information. If you authorize us to release information to others, this process may take up to 2 weeks. Please review the Privacy Policy Notice for a full disclosure of how your health information will be managed.

APPOINTMENTS: If your schedule changes and you will be unable to keep your appointment. PLEASE CALL MORE THAN 24 HOURS IN ADVANCE or email: colleen@raincitycounesling.com so that another client can be scheduled. You WILL BE charged a full session fee for missed appointments or appointments without 24-hour notice. Insurance does not cover this fee. It is payable immediately.

FINANCIAL POLICY: All fees are due at the time of the session. Fee is payable by check, debit/credit card, or cash. Please make checks out to RAIN CITY COUNSELING, PLLC. Statements or receipts are provided upon request. Any balance unpaid after 60 days will accrue a 1.5% finance charge per month and appropriate financial payment arrangements made. Balances not paid after 120 days will be turned over to COLLECTION. We charge a $35.00 fee for all returned checks (RCW62A.3 515520).

RAIN CITY COUNSELING

INSURANCE: For all insurers, I can provide a receipt for out of network reimbursement. We cannot guarantee you that we will be covered by your insurance policy. If we provide services to you for which you are determined not eligible, then you are responsible to pay for those services. We will, however, do our best to provide support with the reimbursement process.

RATES AND FEES

- Individual or Couples/Relationship Psychotherapy Session (50minutes)
  $120
- Individual or Couples/Relationship Psychotherapy Session (90 minutes)
  $185
- Home or Hospital Visits $160
- Billing forms to your primary insurance company
  $ 0
- Written correspondence, letters of support, or disability claims
  $120 per hour (will be prorated for time)
- Phone sessions billed at Psychotherapy Session rates listed above (will be prorated for time)
- Phone calls/Case management under 15 minutes
  $0
- Sliding scale fee sessions available. This fee is based on income, affordability and availability.

CONFIDENTIALITY OF SERVICES: Confidentiality and privileged communication remain the rights of all clients according to a state law. If a client wants information released to another resource, they must sign an authorization to release information form. State law mandates I must report all suspected cases of prior (within 7 years), current, or threatened harm to self or others. This includes suicide intentions, serious threats against another person, and child or developmentally disabled adult abuse or neglect. Many of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

RAIN CITY COUNSELING

CONFIDENTIALITY OF COMMUNICATION: It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Please notify this therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use email for emergencies.

I understand and accept the terms of the above Procedures and Financial Policy for Rain City Counseling, PLLC/ Colleen Thompson, MA.Ed, LMHCA. I understand I am individually responsible for payments of all charges. I have had an opportunity to view the NOTICE OF PATIENT PRIVACY PROTECTION. I am aware that this Financial Policy and Privacy policy may change, without notice. I understand that fees charged may be partially discounted due to a preferred insurance plan or other contract.

Print Name: _____

Client Signature: _____

Date: _____

Parent/Legal Guardian Signature (if under 14 years old): _____

Date: _____

RAIN CITY COUNSELING

INFO@RAINCITYCOUNSELING.COM
206.855.3347

1421 34TH AVENUE, SUITE 205
SEATTLE, WA 98122

RAINCITYCOUNSELING.COM

THERAPIST DISCLOSURE STATEMENT AND INFORMED CONSENT

I.THERAPIST DISCLOSURE

- **Credentials:** I am a Licensed Mental Health Counseling Associate in Washington State (#MC.60691518)
- **Education, Training, and Experience:** I received a Bachelor of Arts from the University of Michigan. I completed my Master of Arts in Community Counseling at Seattle University. I have been a practicing therapist since 2015, specializing in working with members of LGBTQ, nonbinary, polyamory, and kink communities, but experienced in working with clients of diverse backgrounds.
- **Professional Memberships:** I am a member of the American Counseling Association, the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, and the Washington State Coalition of Mental Health Professionals and Consumers.
- **Services Provided:** I provide psychotherapy for individuals (adults over the age of 18), couples/relationship units, and groups. I provide consultation to other mental health professionals and independent mental health evaluations.

II. WORKING RELATIONSHIP

Confidentiality: I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality. Please review these limits in my Notice of Privacy Practices.

RAIN CITY COUNSELING

Record keeping: I will keep a confidential file containing your private health information (PHI) on Electronic Health Records. Your file will include your client forms, financial and contact information, treatment goals, progress notes, and copies of any correspondence or medical records that have been compiled or obtained on your behalf. Washington State Department of Health requires documentation and retention of records for seven years after last contact.

Emergency, Urgent, or Other Contacts: You may call and leave a voicemail at (206) 855-3347 and I will get back to you as soon as I can. I retrieve all messages daily and whenever possible I will get back to you within 24 hours. You may also email your message to colleen@raincitycounseling.com. I do not save any client phone numbers in my phone, so if you text, please include your name. Anything sent over email or text message is not confidential. Do not use email/text to communicate crisis information. I am not able to provide on-call crisis or emergency services.

If you have a life-threatening emergency, call 911. The King County Crisis Clinic has 24-hour availability, community resources, and emergency information and can be reached at (206) 461-3222. If I will be out of town or unavailable for an extended period of time, I will provide you with alternate contact information should you need extra support during my absence.

Therapeutic Relationship and Professional Boundaries: Professional boundaries are essential for the protection of therapeutic relationship and confidentiality. Therefore, I uphold the following practices:

1. I will not provide any services outside my scope of practice, in any capacity.
2. I will only provide appropriate referrals to other health professionals, with your consent.
3. I will uphold confidentiality standards during the course of therapy and thereafter. By law, sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

RAIN CITY COUNSELING

4. In public settings, I will not initiate contact with you in order to maintain your confidentiality. If you choose to initiate a visible or audible greeting, I will reciprocate.

Termination: You may choose to end our therapeutic relationship at any time. If you would like to end therapy, if possible, I would like to discuss prior to terminating therapy. We may also come to a mutual decision to end the therapeutic relationship. I reserve the right to terminate services with a client as necessary and support client with referrals if needed.

III. Confirmation of Informed Consent

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Rain City Counseling, PLLC and I understand it and had the opportunity to ask questions.

_____ I agree to follow the terms in the Disclosure Statement and consent to treatment as outlined in this Disclosure statement.

_____ If requested, I have a copy of this Disclosure Statement with my signature.

_____ I understand that my therapeutic relationship with Rain City Counseling, PLLC may be discontinued if the terms in this agreement are not fulfilled by either of us.

Print Name: _____

Client Signature: _____

Date: _____