ELIZABETH A. BELLMER, MA, LMHC, AT
Washington License No. LH00009896
12360 Lake City Way NE, Suite 420
Seattle, WA 98125
425-406-7373

# CONFIDENTIAL CLIENT INTAKE FORM

Date _____ (Please print) Client ID # _____

Patient Name _____ Age _____ Birthdate _____

Address _____ Patient Cell Phone (_____)_____

_____ Patient Home Phone (_____) _____

Email _____ Ok to contact via email? ❒ Yes ❒ No

Employer _____ Work Phone (_____) _____

Status: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Partnered for ____ years ❒ # of Previous marriages____

Emergency Contact _____ Phone (_____)_____

**PRIMARY INSURANCE INFORMATION** (present insurance card)

*It is **your responsibility** to know your own insurance benefits, including deductible, co-insurance, copay amounts, as well as authorization requirements.*

Person responsible for account _____ Birthdate_____

Relation to client_____ SS # _____

Address (if different from client) _____ Phone (_____)_____

_____

Person responsible Employed by_____ Occupation _____

Insurance Company _____ Group # _____

Contract/ Authorization # _____ Plan # _____

Subscriber # _____

Names of Other Dependents Covered Under this Plan _____

Is client covered by other insurance? ❒ Yes ❒ No

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with (Name of insurance company/ies)_____ _____ and assign directly to Elizabeth A. Bellmer, MA, LMHC, AT, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Elizabeth A. Bellmer, MA, LMHC, AT, may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
**Signature** **Date**

_____
**Print Name**

Relationship to insured: ❒ Self ❒ Spouse ❒ Other _____

## CONFIDENTIAL CLIENT INTAKE FORM
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**SPOUSE/ PARTNER INFORMATION** (for couples counseling and/or you have secondary insurance coverage)

Spouse Name _____ Birthdate_____

Address (if different from client) _____ SS # _____

_____ Home Phone (_____)_____

Cell Phone (_____)_____

Email _____ Work Phone (_____) _____

Employer _____

Insurance Company _____ Group # _____

Contract/ Authorization # _____ Plan # _____

Subscriber # _____

_____

**PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED, INCLUDING DATES, NAME OF THERAPIST AND NATURE OF PROBLEM:** _____

_____

_____

_____

**PLEASE DESCRIBE THE CURRENT ISSUES THAT ARE CONCERNING YOU:** _____

_____

_____

_____

**WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?** _____

_____

_____

_____

**PLEASE DESCRIBE ANY MEDICAL OR HEALTH PROBLEMS THAT YOU HAVE HAD OR ARE EXPERIENCING:** _____

_____

_____

_____

NAME OF PHYSICIAN: _____ DATE OF LAST EXAM: _____

**Do you smoke?** ❒ Yes ❒ No **Do you drink alcohol?** ❒ Yes ❒ No

If yes, what kind, how much and how often do you drink alcohol? _____

**Do you use any other substances** (marijuana, cocaine, etc.)**?** ❒ Yes ❒ No

If yes, what kind, how much and how often do you use? _____

**Are you taking any prescribed medication?** ❒ Yes ❒ No

If yes, please list the medications: _____

**Do you have sleep problems?** ❒ Yes ❒ No **How many hours do you sleep per night?** _____

**Have you recently** ❒ **Gained or** ❒ **Lost Weight?** If so, how much weight and over what period of time? _____

_____

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# DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT

PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGEMENT OF ITS RECEIPT ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.

Persons providing therapy must be licensed with the Department of Licensing for the protection of health and safety. Licensing of an individual with the Department does not necessarily imply the effectiveness of any treatment.

## YOUR RIGHTS AS A CLIENT IN COUNSELING

As a client in counseling, you have certain rights that are important for you to know about. There are also certain limitations to those rights of which you should be aware.

As a client of a therapist licensed by the State of Washington, you have privileged communication under state law. With the exception of the situations listed below, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The privilege is yours, not mine, and cannot be waived without your consent. I will always act to maximize your privacy even when you waive your right to confidentiality.

The following situations are exceptions to your right of confidentiality:

**1.** If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.

**2.** If you reveal that you have committed or are contemplating the commission of a crime, I may report that to appropriate authorities.

**3.** If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective Services, a state agency.

**4.** If you are currently in litigation, or become involved in litigation during the treatment process or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that process. Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation so that I can exercise due caution to protect your privacy.

**5.** If you submit claims to your insurance company, they will likely require some information regarding your treatment with me. Most insurance companies only require basic information, often including a psychiatric diagnosis. You have the right to know your diagnosis that I use in any communication with your insurance company or other third-party payor or agency. All of the diagnoses that I use come from the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition, DSM-5). A copy of this book is available for you to look at in the public library as well as in my office. You may look at this book by requesting to do so from me.

*Should you decide to use your medical insurance to cover my services, there are a few things you should know. Most insurance companies will partially or, in a few cases, fully cover my services. Please check with your insurance company regarding your eligibility for benefits and discuss with me the policies and procedures I use concerning medical insurance or third-party coverage. You may pay by cash, check, or credit card. Checks should be made out to "Elizabeth Bellmer." If you decide to use your credit card, let me know so I can have you complete the "Electronic Payment Authorization" form. When using insurance, your portion of the full fee is based on the specifics of your insurance benefits. In all cases, you are responsible for fees not reimbursed by your insurance, i.e., co-payments and deductibles.*

**6.** If you have been referred to me by an **Employee Assistance Program (EAP)** for evaluation, I may be required to disclose basic information about the evaluation such as a description of the problem, diagnosis, and treatment recommendations. I will share with you all information I will be sending to the EAP representative at your request. You are free to get a second opinion, although the financial obligations you incur in obtaining one must be settled between you and your EAP.

**7.** If you are seeing me in couples or family therapy and you, your partner, or another family member should happen to see me in an individual session, information shared with me in that meeting will be shared by me in a couple or family session if I believe it to be in the best interest of the work we are doing together. I will discuss this matter with you before sharing that information.

If our therapeutic relationship involves more than one person (e.g., spouse, parent, partner), I will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on the "Consent for Treatment" represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together.

In some cases it may be useful to the therapy for me to discuss your situation with others such as your physician, your former therapist, your attorney, etc. In such cases, I will seek your written permission for this exchange of information.

I do consult with colleagues regarding my work with clients to gain feedback and suggestions about treatment. My work with you may be discussed in formal or informal sessions with my colleagues, or with other professionals. During these consultations, neither your last name or any other unique identifying information will be used. All discussions of this type with other professionals are subject to the same provisions of confidentiality discussed above.

If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to them that you have contracted with me for services and I will thank them for the referral. I will not discuss your situation with them unless I have your written permission. If you do not want me to advise them that you have made an appointment, please let me know and I will not disclose that information.

You always have the right to request a change in the treatment process or refuse treatment. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist.

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My voice mail number is 425-406-7373. I check my mailbox regularly throughout the day and will respond to your message as soon as I am able. If you are unable to reach me and are urgently in need

of help, call the **Seattle Crisis Clinic at 206-461-3222.** If you are outside of this area, you may need to contact another crisis line. ***For immediate help if this is a life-threatening situation, please call 911.***

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to you that the counseling relationship be closed in a straightforward manner, ensuring that all counseling issues have been dealt with to the best of your and my ability. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice or rescheduling, I may not be able to hold your time slot. Please call as soon as you are able so an appointment can be scheduled.

**APPOINTMENTS AND FEES**

Appointments are usually scheduled once per week or once every other week. The session lasts 50 to 60 minutes. The scheduled time for your session is set aside for you. **If you miss a session without canceling with less than 24-hour notice, I will bill you for that time unless the situation was such that it was not reasonably possible for you to give 24-hour notice.** Insurance or other third-party payors generally do not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your schedule time and charged the full rate.

My standard fee is $165.00 per 50-minute session. This fee is standard regardless of the number of people attending the session. Due to the additional work and time involved, the first session is charged at a higher rate. The fee for the first session is $180.00. My policy is to collect any fees you are responsible for at each session. A $25.00 fee will be charged for returned checks. If you are covered by insurance, you will most likely only be responsible for a co-payment. If you have a high deductible plan, then you will be responsible for the full fee until your deductible is met.

If I am doing work related to your treatment that is outside the bounds of our scheduled sessions, I will bill you on an hourly basis for all the time I spend on your situation, including travel time to another location (such as a hospital, your home, an attorney's office, or another setting), required meetings with other professionals, written reports, preparation time, etc. My fee for this work is $20.00 for every ten (10) minutes.

**MY TRAINING AND APPROACH TO THERAPY**

I have a Master's Degree in Psychology with a double major in Clinical Mental Health Counseling and Art Therapy from Antioch University Seattle. I am a Licensed Mental Health Counselor in the State of Washington and I am a member of the American Mental Health Counselor's Association, the American Counseling Association, and the American Art Therapy Association.

My overall treatment orientation is developmental, holistic, and person-centered. I utilize Cognitive Behavioral Therapy in my practice. I regard both current issues as well as historical information, especially family-of-origin history, important in assessment and treatment planning. I believe that working with the whole person is extremely important and therefore will discuss feelings, thoughts, and behaviors, and explore any spiritual connection you may have. Relationship issues are given primary attention. We may focus on different dimensions of time — past, present, future — in working toward solutions. After gathering information, I generally take an active role in your therapy as a "coach" or "consultant" — sharing observations, giving feedback, supporting, challenging behaviors or ideas, offering suggestions, assigning homework and readings when I believe it will be useful.

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Each course of treatment is unique to those who participate in it. Thus, your experience in psychotherapy is a blend of what you and I do together. I don't work in exactly the same manner with each person. Each person is unique and each story is different, though there may be many similarities between people. Together we are responsible developing and implementing a course of treatment that will most effectively help you reach your goals. I value being in a partnership with you and with great honor take this journey with you. I welcome feedback and suggestions as part of this partnership. Whether or not counseling is successful depends on a number of factors such as willingness to change, the nature of the desired

change, the level of trust between the client and counselor, the “fit” between the client and counselor, and outside influences.
I ascribe and adhere to the American Mental Health Counselor’s Association Code of Ethics as well as the American Psychological Association.

**QUALITY OF SERVICE**

If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel this does not resolve the issue, you may contact the following agency: Department of Health, P.O. Box 47857, Olympia, WA 98504-7857. Phone number 360-236-4700.

**CLIENT AGREEMENT**

By signing the “Client Consent to Treatment” form, I acknowledge that I have read the above statements and have been given an opportunity to ask questions about anything contained in these statements. I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above and understand that I have the right to terminate counseling at any time. I also understand that Elizabeth Bellmer requests notice at the beginning of a regularly scheduled session so that the reasons for termination may be discussed.

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## CLIENT CONSENT TO TREATMENT

I have read, or have had satisfactorily explained to me, Elizabeth Bellmer's "Disclosure of Information, Policies and Client Agreement" and I understand it. I have been given an opportunity to ask questions about statements regarding fees and payment policies. I understand and agree to the description of confidentiality. I consent to therapy with Elizabeth Bellmer and I understand that I have the right to terminate my therapy at any time. I also understand that Elizabeth Bellmer requests notice of termination at the beginning of a regularly scheduled session so that reasons for termination may be discussed.

My signature below indicates that I have read and received a copy of the "Disclosure of Information, Policies and Client Agreement."

_____

**Signature** **Date**

_____

**Print Name**