A Meaningful Path Counseling, PLLC
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Bothell, WA 98021
206-203-9007
amanda@ameaningfulpath.com

Welcome! *In order to make our first session as focused on why you are here as we can, I ask that you fill out as this packet ahead of time.* If you have questions I am happy to answer them via email, phone or during our first session.

Identifying Information

Date: _____ form completed by: _____

Last Name:_____ First Name: _____ MI: _____

DOB (MM/DD/YEAR) : ____/_____/_____ Age:_____

Parent or Guardian's Name (if client is a minor): _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H)(_____) _____(W)(_____) _____(Cell) (_____) _____

Email address: _____

Emergency Contact: _____ Relationship to client:_____

Emergency Contact Ph #: (_____) _____

Referred By: _____

Payment Information:

Pick one: Self Pay:_____ Insurance:_____

Full Name of Person Responsible for Charges (if different from primary subscriber):

Last:_____ First:_____ MI:_____

Insurance Information:

Insurance Company & Plan Name: _____

ID#:_____ Policy#:_____ Group#/Name: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

DOB (MM/DD/YEAR): ____/_____/_____

Street Address: _____

City: _____. State: _____ Zip Code: _____

Primary Insured's Telephone Number: (_____) _____ -_____

Secondary Insurance Information (if applicable):

Insurance Company and Plan Name: _____

ID#: _____ Group#: _____ Policy#: _____

Secondary Subscriber:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Employer: _____

Address:_____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Relationship to Client: _____

Medical Information:

Primary Physician: _____ Last Exam: _____

Physician Phone #: (____) _____

Any chronic health concerns that might affect therapy:_____
_____

Medications: (Please list dosages, frequency, and for what conditions):

_____
_____
_____

Any known allergies: _____
_____

Have you experienced any changes or concerns in (place an X next to):

Sleep? _____ Nightmares ? _____ Sexual Desire? _____ Weight? _____

Eating/Appetite? _____ Exercise/Energy Level? _____ Motivation? _____

How would you rate your overall health?

Poor _____ Fair _____ Good _____ Excellent _____

Describe any current health concerns:

What do you do to contribute to your health?

Do you consume:
Alcohol _____ Frequency _____ What kind? _____
Describe your history of alcohol use:

Do you currently use any stress drugs or misuse prescription drugs?
Names of drugs: _____ Amount and Frequency: _____
_____

Describe any history of drug use or abuse:

Please note any history of abuse or violence:

Please note the nature and extent of any other traumatic events in your life:

Treatment History:

Have you ever received counseling or inpatient psychiatric treatment? _____
When? _____
Provider Name: _____
Purpose: _____. Outcome: _____

Please list any previous or current mental health diagnoses: _____
_____

Have you ever been prescribed medication for a psychiatric condition? _____
When? _____
Prescribing Clinician: _____Name of medication(s): _____
_____
Purpose: _____ Outcome: _____

Have you ever been hospitalized for a psychiatric or emotional reason? _____
When: _____ Where: _____
Purpose: _____ Outcome: _____

Have you ever been in treatment for substance abuse? _____
When: _____ Where: _____ How Long?_____
Outcome: _____

What brings you here?

What are your main concerns or problems that you would like to address in therapy?

How long have you experienced these problems? Have the problems gotten worse or remains about the same over time?

What would you like to be changed when counseling is completed?

List your strengths, skills and resources that will help you make the changes that you want:

What challenges might get in the way of making the changes you want?

Please list the names and ages of family members you live with or are part of your social network:

What family information and history is related to your current concerns?

Describe your social support network and how will they help or get in the way of what you would like to change:

Do you have any concerns regarding your safety or harm? Do you have access to firearms?

Do you have any history of self-harm or suicidal ideation?

Do you have any history of assault or aggression towards others?

Are you currently working? Is this a job that you enjoy? Why or why not?

Do you have any current legal involvement?

Please describe any cultural, religious or philosophical beliefs that are meaningful to you:

Please indicate if you have had the following stressors in the last year:
Serious Illness/Injury to self or someone you love: _____
Divorce, separation, break-up: _____ Death of family/friend/person close to you: _____ New family member: _____ Job changes: _____
Other (please indicate):_____

Please let me know if there is anything else you think I should be aware of:

Disclosure and Informed Consent

My Services

My services are designed to help my clients create healthy fulfilling lives. I assist my clients in overcoming personal, relational, and family difficulties that might be holding back from the life they desire.

In my work with clients I emphasize strengths seen in each individual and ask that clients try on new perspectives and actions that might better help them reach their goals. I encourage clients to draw on experiences from their past in order to help them better understand their current choices, feelings, and relationships. I often teach my clients skills that can immediately make a difference in their lives.

The nature and course of therapy is determined by each client's unique needs, requests, and the nature and history of the presenting problem. I tailor my services to the individual needs of each person and their situation. I work together with clients as partners in our initial consultation and throughout the process to determine the most suitable course and type of services to meet each client's individual needs.

Confidentiality:

Communication with my clients is held in the strictest of confidence to meet client privacy needs. Counseling records and information pertaining to anyone 13 years of age or older are held confidential except as outlined below. Records or information pertaining to individuals younger than 13 years of age require the person's written consent to be released except as outlined below. I will not disclose the written acknowledgement of this disclosure statement, nor any information acquired from clients during consultation in a professional capacity when the information is necessary to enable me to render professional services to clients except:

(1) With the written authorization of my client or, in the case of death or disability, the clients' personal representative;
(2) If the client waives the privilege by bringing charges against the therapist.
(3) In response to a subpoena. The subpoena will pertain only to records related to a complaint or report under RCW 18.130.050 (regulatory investigation);
(4) When I have reasonable cause to believe that child or adult dependent or developmentally disabled person has suffered abuse or neglect, I *must* reports such incident within 24 hours to the proper law enforcement agency or to the Department of Social and Health Services.
(5) To any individual if I reasonably believe that disclosure will avoid or minimize and imminent danger to the health or safety of the individual or any other individual; however there is no obligation on my part to so disclose.

I keep a record of health care services I provide you. You may ask to see and copy the record that pertains to you. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so our unless the law authorizes or compels me to.

As an individual practitioner I practice while occasionally engaging in professional consultation with other mental health professionals, per best practices. In some cases, I share minimal information with these individuals for clinical reasons but they are bound by the same rules of confidentiality. All members of my consultation group have been given training about protecting your privacy and have agreed not to release any information outside of the consultation room according to confidentiality laws.

Electronic Records, Communication, and Storage:

I keep and store records or each client in record keeps system produced and maintained by Office Ally. The system is cloud based, meaning that the records are stored on servers which are not connected to the internet. I have entered into HIPAA Business Associate Agreement with Office Ally. Because of this agreement, Office Ally is obligated by federal law to protect these records from unauthorized use or disclosure. The computer on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons. Office Ally employs various technical security measures to maintain the protection of these records from unauthorized use or discloser Office ally keeps a log of my transactions with the system for various purposes, including maintaining the integrity of the record and allowing for security audits. These transactions are kept for seven years.

I also use Gmail for transmission and storage of client-related email communications, together with an email encryption program called Virtu. I also use a program called Spruce, which is HIPAA compliant to receive and make phone calls, as well as send messages through a secure system if clients wish to use this program. Therefore with a mobile device I use the aforementioned security processes and programs to protect the security of the information, the device and prevent unauthorized persons from using it and accessing communication.

Fee Structure:

Fees for the services provided are based Usual and Customary Rates, or Allowable Amounts in this area and are assessed periodically. Different insurance companies and benefit plans have diverse cost responsibilities for services provided. Please check your benefits prior to services to confirm the amount for which you will be responsible.

Insurance Reimbursement:

I have several insurance companies that I am "in network" with and several that I am in the process of becoming a network provider. In these instances I bill the insurance company for services provided. If I am not paneled with your insurance company I may be also able to submit out of network claims to some insurers. If not, you are welcome to seek this reimbursement for the maximum allowable benefit for psychotherapy sessions from your insurance carrier. This usually requires the submission of a claim form and receipt for services. Let me know if you decide to seek reimbursement from your carrier and require receipts to do so. Note that insurance companies often require a mental heath diagnosis in order to pay for services.

Client rights:

Clients have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits their needs. I am providing you with contact information for the department of health so that you may obtain a list or copy of the law regarding acts of unprofessional conduct:

Health Professions Quality Assurance, Customer Service Center
PO Box 47865 Olympia, WA 98504
Email: hpqa.csc@doh.wa.gov Phone: (360) 236-4700 Fax: (360) 236-4818

Your signature below indicates that you have read and understand the information in this document, authorize treatment, have been provided a coy of this disclosure information (if requested), and agree to abide by it's terms during our professional relationship.

_____

Signature of Client (or Parent/Guardian- please specify). Date

_____

Signature of Therapist Date

Notice of Privacy Practices:

As part of my professional practice, I maintain personal information about you and your health. State and federal law protects your privacy by limiting how I may use and disclose such information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present and future physical or mental health condition, the provisions of health care services, or the past, present, or future payment for the provision of health care.

Your rights regarding your PHI: maintained by my practice are:

Right to access and inspect a copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and receive a copy of the PHI that I maintain. I may charge a reasonable, cost based fee for the copying process. Your copy request may also include transmittal directions to a third party.

Right to Amend. If you feel the PHI I maintain about you is incorrect or incomplete, you may request in writing to amend the information although I am not required to agree to the amendment. You may write a statement of disagreement if your request is denied. The statement will be maintained as part of your PHI and will be included with any disclosure.

Right to accounting of disclosures. I maintain a record of disclosure I have made of your PHI. You have the right to request a copy of such an accounting.

Right to request Restrictions. You have the right to request in writing a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am generally not required to agree to such a request. If I have been paid in full for all of the services covered by such a request, then I will honor a request to restrict disclosure to your insurance.

Right to request confidential communication. You have the right to request that I communicate with you in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a copy of this notice. You have the right to obtain a paper copy of this notice upon request.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you belief I have violated your privacy rights. *I will not retaliate against you for filing a complaint.*

Uses and Disclosures of PHI for treatment, payment and Health Care Operations

Treatment. I may use your PHI, with your written authorization, for the purpose of providing you with health care treatment, including management, coordination, and continuity of care with other of your current providers.

Payment. I may use your PHI in connection with billing statements sent to you. I may use your PHI for the purpose of tracking charges and credits to your account. Unless you have requested and I have specifically agreed to restrict disclosure of your PHI to you health plan, I may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability as well as submit claims for payment.

Health Care Operations. I may use or disclose your PHI for the health care operations of professional practice in support of the functions of treatment and payment. Such disclosures would be to Business Associates for health care education, or to provide, planning, quality assurance, peer review, administrative, legal, or financial services to assist me in the delivery of your health care.

Appointment Reminders: With your agreement, I may use your PHI to contact you regarding your appointments.

Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object:

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigations of deaths. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose your PHI to a health oversight agency for activities authorized by law, such as or professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me, such as third party payers.
Threat to Health and Safety. I may disclose your PHI when necessary to minimize an imminent danger to the health or safety of you or any other individual.
Disaster or Emergency Relief Purposes. In situations of your absence, incapacity, or emergency and in accordance with good professional practice, I may disclose your PHI minimally necessary to a public or private entity authorized by labor by its charter to assist in disaster relief efforts, which are directly relevant to your identification and care.
Business Associates. I may disclose your PHI to the extent minimally necessary to Business Associates that are assisting me with to perform health care operations or payment activities on behalf of my practice, which may involve their collection use, or disclosure of your PHI. To safeguard the privacy of your PHI, such disclosures are regulated by the Department of Health and Human Services and must contain provisions to limit the use of and re-disclosure of your PHI, to require compliance by the Business Associate with your individual rights, to subject the Business Associate to security obligations, and to require the Business Associate to require such obligations to a subcontractor.
Compulsory Process. I will disclose your PHI if a court issues an appropriate order. I will also disclose your PHI if 1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order myst be obtained to avoid compliance, 2) no qualified judicial or administrative protective order has been obtained, 3) I have received satisfactory assurances that you received notice of your right to seek a protective order, and 4) the time for your doing so has elapsed.

Uses and Disclosures of your PHI With Your Written Authorization
I will make the uses and disclosures of your PHI old with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claims for payment.
This Notice
This Notice of Privacy Practices informs you how I may use and disclose your PHI and your rights regarding your PHI. I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and piracy practices with respect to PHI, and to notify you following a breach of unsecured PHI related to you. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the therms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available to you a revised Notice of Privacy Practices by providing a copy upon your request.

Acknowledgment:
I hereby acknowledge receiving a copy of this notice.

_____		_____	
Client signature	Date	Therapist Signature	Date

Cancellation and Missed Appointment Policy

When we make an appointment for services, *I reserve that time specifically for you,* and in doing so tell other clients asking for that appointment time that it's not available to them.

Cancellations and Rescheduling:
If you need to cancel or reschedule an appointment please contact me *at least 24 hours prior to the appointment* so that I have the opportunity to provide services for another client during that time. You can leave a confidential voicemail for me at 206-203-9007, any time 24 hours a day, 7 days a week. I will make an effort to reschedule your appointment for a mutually convenient time when provided sufficient notification.

Missed Appointments:
If you do not contact me to cancel or reschedule 24 hours prior to the session or you do not show up, you will be charged a $100 fee for the missed session (a charge which is not covered by your insurance company).
Missed appointments include but are not limited to , the unfortunate experience of forgetting an appointment or having something else important come up that conflicts with our appointment.
If you can reschedule with me within a reasonable amount of time, within a week of your missed appointment (if I have availability), I am willing to waive the fee. If this becomes a regular occurrence the aforementioned policy will determine charges.
I do my best to make myself available to my clients and *would rather have a regular session and continue care than charge a fee.*

Exceptions:
Emergency medical situations. If the sudden onset of a significant health or medical situation or unexpected emergency results in a late cancellation or missed appointment, the missed appointment charge will be waived at your request regarding the such a situation. *I ask that you reserve this request for circumstances that truly prevent you from getting to your appointment or notify me a day in adva*nce. Please call me as soon as you can in such situations so we can reschedule and/or verify our next appointment time.
Severe weather. If the driving conditions are such that you do not feel safe driving to my office, please call as soon as possible. If you do not call, regardless of weather conditions, you will be charged for the missed appointment.

I have read and understood the above information. I also understand that I will be charged in accordance with this policy in the event I miss or late cancel a scheduled appointment.*

Full name of person(s) responsible for any missed appointment fees:

Last Name: _____ First Name: _____

*Signature: _____
Date

Client Payment Agreement:

Regarding (Client Name): _____

I value the relationship with my clients. In order to best provide services for you, A Meaningful Path Counseling, PLLC (AMPC) recognizes the following client payment agreement.
Please read each item below to ensure your understanding. If you need further clarification please contact me at 206-203-9007 or amanda@ameanignfulpath.com.

-A credit or debit card is required on file to secure payment for services. Please complete the Credit/Debit Card Authorization for with your card information. **For your protection and peace of mind, your credit card information will be secured in an encrypted system.**

-Copayment and self-pay client fees can be paid by cash, check, or credit card. If paying by cash or check (made out to A Meaningful Path Counseling, PLLC) please provide this *at the time of each session.* If paying by credit card, your fee will be processed to your card *following* your session.
**Please note if can take up to a week for your copay to be processed and my reject a transaction at a later date than your session date. **

-Coinsurance and deductible fees are processed on your credit/debit card *following receipt* of your insurance Explanation Of Benefits (EOB). The EOB is sent to both you and AMPC, PLLC, serving as a mutual record of insurance claims processing. **If there is a remaining balance, you will be sent a statement to the email provided below.**

-Missed appointment fees will be charged to your credit/debit card in accordance with the Cancellation and Missed Appointment Policy.

**Please note that receipts and statements are sent by regular unsecured email. AMPC, PLLC will be identified in your receipt. Please know that all standard email transmission poses some risk or third-party interception.

Email Address for statements: _____

***I have read and understood the Payment Agreement. Please process my credit card on file for my copays or self-pay fees (not otherwise paid by cash or check at the time of service), coinsurance, insurance deductibles, and/or missed appointment fees. ***
Print Name of Person Responsible for Charges: _____

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