Mental Health Services for Children & Families

2110 Iron Street
Bellingham, WA 98225
phone: 360.734.2664
fax: 360.671.8006
www.freedman-associates.com

Freedman & Associates

Authorization for Disclosure of Healthcare Information

Client Name: _____ Birth date: _____/_____/_____ SS#:_____

Previous Name(s): _____ Address: _____

Freedman & Associates Treating Provider: _____

Information is to be disclosed to ☐ and/or received from ☐:

Name of Person/Agency: _____

Address: _____ Phone: (_____)_____Fax: (_____)_____

For purposes of: _____evaluation _____treatment _____forensic assistance _____other: _____

I authorize Freedman & Associates to release my:

_____ General Mental Health Record

_____ Information related to chemical dependency/substance abuse

_____ Psychotherapy Notes (the private content of your conversations with your therapist)

_____ Information related to HIV/AIDS and/or sexually transmitted diseases

_____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 12 months after the last dated signature.

_____ _____
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

[12 Month Signature Updates]

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date

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CHILD AND FAMILY INTAKE FORM

Please complete all pages of form.

Today's Date:_____

Child's Full Name:_____ Social Security#: _____

Date of Birth: _____ Gender: ☐ MALE ☐ FEMALE

Referred by: _____ Primary Care Physician: _____

Child lives with: ☐ Both ☐ Mother ☐ Father ☐ Other: _____

Mother's Name: _____ Social Security#: _____

Father's Name: _____ Social Security#: _____

Child's Address: _____

_____

Home Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

Work Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

Cell Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

PRIMARY INSURANCE INFORMATION
(information found on insurance card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to client: _____

Subscriber's Address: _____

ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION
(information found on insurance card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to client: _____

Subscriber's Address: _____

ID#: _____ Group/Plan #: _____

COUNSELOR'S NOTES (for office use only)

Date	Dx code	Dx	Provider Signature

CHILD'S MEDICAL HISTORY

How is your child's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your primary concerns and why you have brought your child to the office:

_____

_____

When was your child's last comprehensive medical evaluation? _____

Has your child ever been hospitalized for psychological reasons? ☐ Yes ☐ No
If yes, when and where? _____

Please check whether your child currently has, or has ever had any of the following:

__drug/alcohol abuse
__running away
__disturbing thoughts
__memory problems
__irritability
__bowel problems
__suicidal ideations/attempts
__sexual concerns
__chronic illnesses
__phobias:_____
__physical abuse or neglect
__racing thoughts
__broken bones
__problems with coordination

__sleeping problems
__frequent headaches
__lack of interest
__low self-esteem
__emotional abuse
__irregular heartbeat
__feelings of hopelessness
__difficulty managing anger
__family/relationship issues
__hormone disorder
__panic attacks
__frequent stomachaches
__school/work difficulties
__frequent or uncontrolled crying

__changes in appetite
__epilepsy or seizures
__sexual abuse
__speech problems
__hearing problems
__visual problems
__homicidal thoughts
__asthma
__communication problems
__difficulty concentrating
__serious infection
__feelings or paranoia
__blood pressure concerns
__self-destructive or self-injurious behavior

__flashbacks
__ulcers
__depression
__confusion
__stress
__bedwetting
__weight loss
__head trauma
__mood swings
__anxiety
__allergies

__Other physical or emotional issues (please describe):

_____

_____

Is your child currently taking medication? ☐ Yes ☐ No
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____

List any serious illnesses for which the child required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has your child ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

FAMILY SITUATION

Relationship/Marital Status of parents: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating
☐ Remarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Names and ages of other adults & children residing in the home:

Name	Age	Relationship to Client

Mother's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Father's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____

Employer: _____ For how long? _____

Are there any family members experiencing significant medical problems or substance abuse?
(Please indicate relationship to child):

Medical Problems-
Past: _____
Present: _____

Alcohol Use-
Past: _____
Present: _____

Drug Use-
Past: _____
Present: _____

Tobacco Use-
Past: _____
Present: _____

Caffeine Use-
Past: _____
Present: _____

Has your child had previous counseling? ☐ Yes ☐ No

If yes, with whom? _____ When? _____

Would it help to contact the previous counselor(s)? ☐ Yes ☐ No

GOALS FOR THERAPY

What are the goals and outcomes you would like to achieve for your self/child with therapy?

_____

_____

_____

_____

Mark Lazich, MS, LMHC

2110 Iron Street, Bellingham, WA 98225
360.734.2664 ext. 17
Licensed Mental Health Counselor # LH8481

Terms of Service / Professional Disclosure Statement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions at our next meeting. When you sign this document, it will represent an agreement between us.

Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

Education:
1999 M.S. Counseling Psychology, Professional Counselor Preparation, Southern Oregon University
1989 B.S. Marketing/International Business, University of Colorado
1989 B.A. Communication – Small Group/Interpersonal, University of Colorado

Philosophy and Approach:
As a student of the human condition, I continue to develop my professional theoretical philosophy. I approach most cases with a cognitive-behavioral perspective which is influenced by my existential-humanistic and multicultural orientations.

I view the psychotherapy process as a collaborative effort between the client and myself. Understanding the client's worldview and their presenting issue is my initial step in the psychotherapy process. Establishing a desired goal with the client and working towards that goal together is inherent in my collaborative counseling style. The presenting concern may be trauma, relationship, developmental, existential, career etc. I believe self-acceptance and responsibility are essential to a healthy existence. Particularly in today's post-modern world, creating a balance between self, family, community, and spirituality is a constant challenge. My goal as a psychotherapist is to assist the client with any immediate concerns and enable self growth as a result.

Confidentiality and Privacy:
I will keep confidential anything you say to me, with a few exceptions as required by law-RCW 18.19.180(1) through (6).

Freedman and Associates is a consultative group of experienced therapists. Good clinical practice requires occasional peer review and consultation within this group. Please be aware that your case may be clinically reviewed in this or other consult settings.

I have been provided a copy of Mark Lazich's professional profile, the "Terms of Service / Professional Disclosure Statement" and the "Notice of Practices Regarding Protected Health Information" and read and understand the information provided.

Initial here to acknowledge receipt_____

↓ Please turn over

Office Policies, Procedures and Fees

Appointments/Cancellations:

_____

Your appointment times are reserved for you alone. I try very hard to begin and end on time, out of respect to both of our schedules. If you need to cancel your appointment for any reason, appointments must be cancelled 24 hours in advance. Otherwise **you, not your insurance company**, will be charged a cancellation fee equal to **the full fee** for the session missed. No shows for appointments will also be charged at full fee. Telephone therapy time is prorated at the same rate as in-office therapy. Please initial in the box provided to acknowledge you have read and understand the Appointment and Cancellation/No Show Fee Policy.

Attendance:

_____

Attending scheduled appointments is critical to the success of counseling. If missed appointments become a concern, I will initiate a conversation about how to remain engaged in services. I may request that an attendance contract be discussed and signed. Please initial in the box provided to acknowledge that you have read and understand the Attendance Policy.

Billing practices:

Payment for services will be due at the end of each session. My basic rate is $100.00 per individual 50-minute session, $150.00 per 75-minute individual session and $125 per 50-minute family session. In some cases, your insurance company may pay a percentage of the cost of your therapy per session. In this case, your co-pay becomes your fee, while I collect the remainder of your fee from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company. In addition I hold a certain number of spaces for Adjusted Fee situations on a "space available" basis. The adjusted fee will be determined between the two of us at the intake session. My sliding fee scale ranges from 25 to 85 dollars. Costs per session will be determined at the first session and will remain at that level for six months, when it will be renegotiated. If you cannot make it to a session, please phone 24 hours in advance.

Emergencies: If there is an emergency between sessions, I can be reached by phone at (360)734-2664, ext 17. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If you are unable to reach me when you feel the need for some emergency help, Volunteers of America have a 24 hour on call crisis line at **1-800-584-3578** or please call **911.**

Treatment consent:

I have been informed of the type of counseling I will receive from Mark Lazich, the methods and techniques used, his education, training and experience and the cost of counseling services. Furthermore, I have received this information in writing.

Counselors practicing for a fee must be registered or certified with the Department of Health for protection of the public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

_____ _____

Client's Signature Mark Lazich, MS, LMHC

_____ _____

Date Date

Mark Lazich, MS, LMHC

2110 Iron Street, Bellingham, WA 98225

360.734.2664 ext. 17

Licensed Mental Health Counselor # LH8481

Notice of Privacy Practices Regarding Protected Health Information

effective April 14, 2003

To our clients: *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By initialing on the "Terms of Service" agreement, you are indicating that you received and reviewed this form, and you are giving consent for us to "***use***" your PHI within our practice group, or "***disclose***" your PHI to an outside entity for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

- ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations*****:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your "***Psychotherapy Notes***"—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has suffered abuse or neglect, she/he is required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, she/he must immediately report it to the appropriate authorities.

- **Health Oversight:** If the State Department of Health subpoenas your therapist as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)

- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If you file a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

V. Therapist's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way we have handled your privacy rights, you may contact please contact me at the above address or you may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. Our office can provide you with the appropriate address upon request.