Sally Dullum, LICSW

Revised 2/9/18

Background Information

Today's Date _____

I. Primary Client Name (If couple, family, or group, the one person who will be the identified client):

First Name _____MI_____ Last Name_____M___F___

Home Phone # ( ) _____ Work Phone # ( ) _____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Drivers license #_____Date of Birth (DOB) _____ SS# _____

Employer _____ Client E-mail _____

II, Spouses's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):

Relationship to primary client: Spouse_____ Parent _____ Legal Guardian _____ Child _____ Other_____

First Name _____MI_____Last Name_____M___F___

Home Phone # ( )_____ Work Phone# ( )_____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Driver's license # _____ Date of Birth (DOB) _____ SS # _____

Employer _____ Client E-mail _____

If we are billing your insurance please fill out the following information completely:

Are you using an Employee Assistance Program (EAP)? _____ yes _____ no If yes, who do we bill? _____

EAP Phone# ( )_____ How many sessions? _____ Authorization # _____

Primary Ins. Co _____ *Grp #* _____ *ID#* _____

Ins. Billing Address _____Ins. Phone # _____

City_____State_____Zip_____

Name of Subscriber _____ Relationship to client _____

Subscriber's Address (if not above)_____ DOB _____

City_____State_____Zip_____ SS# _____

Subscriber's Employer _____ Phone # _____

*Any secondary insurance?(please give complete information)*_____

_____

_____

Signature of person financially responsible for bill: (Include address and Phone # if not above) _____

_____

Have you (or any member of your family) previously been a client of Pearl Counseling Associates, LLC? □ Yes □ No
If yes, is your (or family members) portion of the account with that counselor clear and/or current? □ Yes □ No

PERSON TO NOTIFY IF EMERGENCY:
Relative: _____ Phone: ( ) _____
Name and address of person, organization, or ad that referred you:

Sally Dullum, LICSW
Pearl Counseling Associates, LLC
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860, FAX: (253) 752-1890

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE CLAIMS PROCESSING

TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Sally Dullum and/or her billing representative** to use and/or disclose the following protected health information: **Please initial.**

- ❑ _____ Information required to process manual claims
- ❑ _____ Information required to process electronic claims

ASSIGNMENT OF BENEFITS (Please initial)

- ❑ _____ I authorize my insurance benefits to be paid directly to the provider.

INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name_____

Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

DURATION

If not previously revoked, this authorization will expire one (1) year from date signed below.

***Specific Limitation**:* Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

SIGNATURE

This Authorization covers protected health information pertaining to *(client)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature: _____ Date: _____

Patient/Parent/Guardian/Other legal representative for health care decisions: _____

Renewal Signature: _____ Date: _____

Witness: _____ Date: _____

Client Information and Disclosure Statement
Sally Dullum, LICSW
LICSW Certification #LW60070761
PROFESSIONAL PROFILE

I am a Licensed Independent Clinical Social Worker in the State of Washington (License # LW60070761) and ESA School Counselor. I earned a Bachelors of Arts degree in Sociology from Washington State University and a Masters of Arts in Social Work from Florida State University. I have over 20 years of extensive experience working with children, individuals and families in crisis. I lived and worked as a counselor in China and Poland, have served as a school counselor/social worker at the elementary, middle and high school level, worked as a hospital therapist and travelled with the military as a Military Family Life Consultant. I have experience in therapy with individuals of all ages, faiths, and ethnic/cultural backgrounds.
My specialties include: children, adolescents, adult and family therapy, domestic violence, divorce recovery, infidelity, life transitions, grief/loss, trauma, depression, and anxiety.
I am not a physician and cannot prescribe or provide medications. If a client is under current medical treatment, I will work in cooperation with the doctor. If medical treatment is needed, I will recommend competent medical personnel and work in cooperation with them toward the client's best interest.
I am an independent private practitioner. My work as a therapist is solely my responsibility and does not necessarily reflect the views of other independent therapists at Pearl Counseling Associates, LLC. You are a client of Sally Dullum, LICSW and not a client of Pearl Counseling Associates, LLC.

COUNSELING PROCESS

My therapeutic orientations are systems, cognitive/behavioral and solution focused. Recognizing and building on existing strengths, a treatment plan will be collaboratively implemented to address your/the client's identified issues. Depending on the age and needs of the client, I use play therapy, sand tray work, games, art and homework to facilitate the therapy process. When appropriate, I will bring in her therapeutic dog Lola.

I personally adhere to a Christian belief system, but I respect and appreciate your right to address your spiritual
growth in whatever manner you have chosen. I view the counseling process as an alliance with you: identifying the problem, identifying possible solutions and supporting healing and growth.

FEES

My hourly fee is $130.00 except for the first session, which is $150.00. However, if you pay in full on the day
of service, I will reduce my fee to $110.00. Charges for extended appointments will be assessed according to
your hourly rate. This also includes between session telephone calls lasting over 10 minutes. In addition, if we
believe that it would be helpful for me to consult with another paid professional regarding your situation; you
will be responsible for all fees, including my time. If you believe your health insurance will cover my services,

please supply me with all the necessary information to process your claims. Our office manager will bill the
insurance company for you. (All insurance claims will be billed at the $150.00/$120.00 rate). In the event that I
am called to testify in any court proceeding in regards to your case a $190.00/ hour rate will be charged for any
and all time spent. A charge for mileage of 36.5 cents per mile and any parking fees will also be assessed.
Appointments are generally made on a regularly scheduled basis. In the event that you are unable to keep an
appointment, a 24-hour notice is required for cancellations. Except for unforeseen circumstances, you will be
charged full fee for a "no show" and a late cancel fee of $55 for a cancellation without 24 hours notice.
Financial considerations are a necessary part of counseling. Openness and flexibility are needed when
determining a client's financial obligation. It is also my policy to not let a client accrue a balance of more than
$250.00 in personal debt (excludes amount owed by insurance). If at such time your balance goes beyond that
amount, I can no longer continue to see you in counseling until reasonable efforts have been made to reduce
your balance. I reserve the right to determine what a reasonable effort is. Bills for which no payment has been
made for 60 days will be considered delinquent and may be instituted for collection. The fact of our counselorclient
relationship may be released to appropriate persons for collection of overdue accounts. Any billing
disputes must be brought to my attention within 6 months of the date of service, or they will not be considered
valid.

CONFIDENTIALITY

As a professional counselor, there is a legal privilege in this state protecting the confidentiality of the
information that you share with me, and I assure you that I strive to maintain the strictest ethical standards of
confidentiality.

- State law requires suspected child abuse (physical or sexual) to be reported to Child Protective Services or law enforcement officials.
- Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement professionals.
- Case record and testimony may be subpoenaed by court order.

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information that you share with me, and I assure you that I strive to maintain the strictest ethical standards of
confidentiality.
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 Case record and testimony may be subpoenaed by court order.

ETHICS AND PROFESSOINAL STANDARDS

I subscribe to the ethical and professional standards of the Washington State Licensing Law. If you have
questions about our work together, please talk with me about this so that we can come to an understanding
about your specific needs and the direction of our work together. In the event that you feel I have acted in an
unethical manner, please discuss the situation with me so that we can come to a resolution. If you find that our
negotiation has not been satisfactory, you may contact directly the US Secretary of Health and Human Services.

CLIENT RIGHTS AND RESPONSIBILITIES

The goals and course of therapy are mutually determined. You are encouraged to ask any questions you may
have regarding my educational or professional background, therapeutic approach, and the specific therapy plan
in progress. It is your responsibility to determine whether the services offered are appropriate and ultimately
helpful. Counselors practicing counseling for a fee must be registered or certified with the Department of
Licensing for the protection of a person's health and safety. Registration of an individual with the Department
does not include recognition of any practice standards nor necessarily implies the effectiveness of any
treatment.
You
may seek a second opinion from another therapist at any time. You have the right to end therapy at any time
without additional obligation other than those already accrued.

DISCLAIMER REGARDING CHILDREN

Unless children are part of the therapy session it is recommended that they not be brought to the office. I am
unable to guarantee their safety if left unattended in the waiting room or group room. Also, our receptionist, if
present cannot be responsible for keeping an eye on them.

I acknowledge that I have read and understand this information.

counseling as

SALLY DULLUM, LICSW
Child, Adolescent, Adult & Family Therapy

CLIENT DISCLOSURE INFORMATION

BACKGROUND

I earned a Bachelor of Arts degree in Sociology from Washington State University and a Master of Arts in Social Work from Florida State University. I have over 20 years of extensive experience working with children, individuals and families in crisis. I lived and worked as a counselor in China and Poland, have served as a school counselor/social worker at the elementary, middle and high school level, worked as a hospital therapist and travelled with the military as a MFLC. I have experience in therapy with individuals of all ages, faiths, and ethnic/cultural backgrounds. My specialties include children, adolescents, adult and family therapy, domestic violence, divorce recovery, infidelity, life transitions, grief/loss, trauma, depression, and anxiety.

DESCRIPTION

Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.
I am a Licensed Independent Clinical Social Worker in the State of Washington (License # LW60070761) and ESA School Counselor. I am not a physician and cannot prescribe or provide medications. If a client is under current medical treatment, I will work in cooperation with the doctor. If medical treatment is needed, I will recommend competent medical personnel and work in cooperation with them toward the client's best interest.
I am an independent private practitioner. My work as a therapist is solely my responsibility and does not necessarily reflect the views of other independent therapists at Pearl Counseling Associates, LLC. You are a client of Sally Dullum, LICSW and not a client of Pearl Counseling Associates, LLC.

THERAPEUTIC METHODS

My therapeutic orientations are systems, cognitive/behavioral and solution focused. Recognizing and building on existing strengths, a treatment plan will be collaboratively implemented to address your/the client's identified issues. Depending on the age and needs of the client, I use play therapy, sand tray work, games, art and homework to facilitate the therapy process. When appropriate, I will bring in my therapeutic dog Lola.
I personally adhere to a Christian belief system, but I respect and appreciate your right to address your spiritual growth in whatever manner you have chosen. I view the counseling process as an alliance with you: identifying the problem, identifying possible solutions and supporting healing and growth. As your therapist, I will write and safely maintain confidential notes about our therapy sessions. These notes are available for you to review.

THERAPEUTIC PROCESS

Therapy is a joint responsibility, with the therapist and clients mutually working towards client goals. As your therapist, I will listen to your concerns, clarify your issues, encourage independence and offer professional insights into possible resolutions. For therapy to be most effective, I believe it is necessary for you to communicate honestly your thoughts, feelings, and behaviors, be willing to change, consistently attend therapy sessions and participate in between-session tasks.
Therapy involves change, with the potential for both risks and benefits. Risks may include dealing with other people's negative reactions to your behavioral changes. Benefits may include learning more effective ways of

interacting with others. The length of the therapeutic process varies depending on the needs and issues of the individual client. The progress and treatment plan will be reviewed and modified, if necessary, on an ongoing basis. Clients have the right to choose counselors who best suit their needs and purposes. As therapy is voluntary, you may terminate at any time, with the option of requesting a referral to another counselor.

SCHEDULED SESSIONS

Typically, sessions are scheduled for weekly 55-minute segments. Frequent cancellations or missing two sessions in a row warrant a discussion about whether to continue with therapy. If I am unable to keep our scheduled appointment, I will notify you.

In the case of an emergency, and I am not readily available, call the 24-hour crisis line: (253) 798-4333.

FINANCIAL ARRANGEMENTS

My fee is $130.00 per 55-minute session for billed services except for the initial session, which is $150.00. Appointments are generally made on a regularly scheduled basis. In the event that you are unable to keep an appointment, a 24-hour notice is required for cancellations. Except for unforeseen circumstances, you will be charged full fee of $130 for a "no show" and a late cancel fee of $65 for a cancellation without 24 hours notice. Charges for extended appointments will be assessed according to your hourly rate. This also includes between session telephone calls lasting over 10 minutes. In addition, if we believe that it would be helpful for me to consult with another paid professional regarding your situation; you will be responsible for all fees, including my time when asked to write up evaluations and summaries of treatment. In the event that I am called to testify in any court proceeding in regards to your case a $190.00/ hour rate will be charged for any and all time spent. A charge for mileage of 36.5 cents per mile and any parking fees will also be assessed.

If you believe your health insurance will cover my services, please supply me with all the necessary information to process your claims. Our office manager will bill the insurance company for you. (All insurance claims will be billed at the $150.00/$130.00 rate).

Financial considerations are a necessary part of counseling. Openness and flexibility are needed when determining a client's financial obligation. It is also my policy to not let a client accrue a balance of more than $250.00 in personal debt (excludes amount owed by insurance). If at such time your balance goes beyond that amount, I can no longer continue to see you in counseling until reasonable efforts have been made to reduce your balance. I reserve the right to determine what a reasonable effort is. Bills for which no payment has been made for 60 days will be considered delinquent and may be instituted for collection. The fact of our counselor client relationship may be released to appropriate persons for collection of overdue accounts. Any billing disputes must be brought to my attention within 6 months of the date of service, or they will not be considered valid.

CONFIDENTIALITY

As a professional counselor, there is a legal privilege in this state protecting the confidentiality of the information that you share with me, and I assure you that I strive to maintain the strictest ethical standards of confidentiality.

- State law requires suspected child abuse (physical or sexual) to be reported to Child Protective Services or law enforcement officials.
- Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement professionals.
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present cannot be responsible for keeping an eye on them.

ASSURANCE OF PROFESSIONAL CONDUCT

The State has determined a number of acts that constitute unprofessional conduct. Following are acts or conditions that give you a general idea of the kinds of behaviors that could be considered a violation of the law. If you feel that any of the following have occurred during your treatment, you can file a complaint with me as my own privacy officer or the U.S. Secretary of Health and Human Services

- Acts of unprofessional conduct
- Abuse of a client or sexual contact with a client
- Incompetence, negligence or malpractice that harms a client or creates an unreasonable risk or harm to a client
- Willful betrayal of the counselor-client privileges as recognized by law
- The commission of any act involving moral turpitude, dishonesty or corruption relating to the practice of counseling. The act does not have to be a crime to be a violation of the law regulating counselors
- Practicing counseling while suffering from a contagious or infectious disease in a way that would pose a serious risk to the public
- Aiding a client to obtain an abortion through illegal means
- Possession, use or distribution of drugs except for a legitimate purpose, addiction to drugs or violation of any drug law
- Habitual use or impairment from the use of alcohol. Misrepresentation or fraud in any aspect of the conduct of the profession
- Advertising that is false, fraudulent or misleading
- Offering to treat clients by a secret method, procedure or treatment
- Promotion for personal gain of any drug, device, treatment procedure or service that is unnecessary or has no acceptable benefit to the client
- Conviction of any gross misdemeanor or felony relating to the practice of counseling
- Violation of the rebating laws which includes payment for referral of clients
- Interference with an investigation by use of threats or harassment against a client or witness to prevent them from providing evidence in a disciplinary proceeding or other legal action

In the event, that you feel I have acted in an unethical manner, please discuss the situation with me so that we can come to a resolution. If you find that our negotiation has not been satisfactory, you may contact directly the US Secretary of Health and Human Services.

I have read the Disclosure Statement and am satisfied with my rights as stated above and agree to act in accordance with my responsibilities also outlined above.

_____ Date_____

Client Signature

_____ Date _____

Sally Dullum, LICSW

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected Health Information," (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters 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 a paper copy of this notice.

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 believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Initials _____

USES AND DISCLOSURES OF PHI WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

THIS NOTICE

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your right regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *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 a revised *Notice of Privacy Practices* by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

CONTACT INFORMATION

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Sally Dullum, LICSW
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this *Notice*. I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this notice is April 14, 2003

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of this notice.

_____

Client's Signature *Date*

_____

Client Signature *Date*

Date of first appointment _____

CHILD/ADOLESCENT INTAKE FORM

Name of child as on insurance card_____ Date of Birth _____
Address of Child _____ City/State_____
Zip _____ Phone of Mother _____ Phone of Father _____
Parent(s) Email: _____
Mother's Name _____ Father's Name _____
Child Resides with _____, who is Mother __ Father __ Guardian __
Address of Mother or Father if different from Child's address
_____

If school age, what school is child attending? _____, City _____
Grade ____ Teacher _____

Insurance: Coverage is through _____ insurance company, under which parent? Name on card is _____ Subscriber's I.D. # _____
Group # _____ Subscriber's Date of Birth _____

Secondary insurance coverage through _____ insurance company, under
Name on card _____ Subscriber I.D. # _____
Group # _____ Subscriber's Date of Birth _____

Social Security number of financially responsible parent or guardian _____

Parent did receive Notice of Privacy Practices (please initial) _____

Referred to me by whom? _____

Child's Physician _____, City of _____
Physician phone number _____ Fax number _____

Which week of the pregnancy was the child delivered _____ Vaginal ___ Caesarean ___
Were there complications in the pregnancy? If so, what _____
_____
Were there complications in the delivery? _____
_____

When did child do the following: Roll over_____crawl_____stand up holding onto furniture _____
Walk _____ Say first words _____ Speak in a short sentence _____
Did the child have any illnesses of great concern? _____
Disabilities? _____
Developmental delay? _____
Has child been diagnosed with a disorder such as anxiety, depression, ADD/ADHD or other _____
_____
_____

SCHOOL: How are your child's progress reports/grades in school? _____

Does the school or teacher have any concerns? _____

_____

_____

What is your main concern? _____

_____

Underline the ones that apply: Is your child shy, quiet, outgoing, adventurous, "dare-devil", oppositional, passive, assertive, aggressive, cooperative, affectionate, stand-off-ish, overly curious Willing to follow rules, doesn't remember simple commands, follow commands

naturally adept at fine motor (holding a pencil, paintbrush and staying within an outline when coloring or painting, walking a balance beam), adept at large motor (running, climbing, tumbling, kicking, throwing and catching a ball),

Very sensitive Not sensitive enough Kind Impulsive Respectful Well behaved
_____

FAMILY
Does your child have siblings? Indicate if half or step sibling. Names/ages _____

_____

_____
Does a brother or sister have a disorder or illness or disability? _____

FATHER/MOTHER
If married, how long? _____ How long married before child was born? _____
Was this a planned pregnancy? _____ Adoption?__ From where/whom?_____
And at what age adopted? ____. Adjustment issues from adoption? _____
If not living with both parents, does child see the other biological parent? _____
How often? _____

Does child have a step-mother or step-father? _____
How does child get along with that step-parent? _____

_____

What was the most recent incident that caused you to think your child needed counseling? Use back side if necessary.

Sally Dullum, LICSW
1919 N. Pearl St., Ste. C-1
Tacoma WA 98406
Phone: (253)752-1860x355 • Fax: (253)752-1890

Release of Information Form

I hereby authorize_____
(Name of Counselor)

to disclose to □ and/or obtain from □:

_____
(Name of person or organization)

_____
(address) (City) (State) (Zip)

the following information from my records or those of my dependent:

_____ **Number and period of appointments**

_____ **Overall summary of interview content**

_____ **Detailed interview content**

_____ **Results from diagnostic assessment**

_____ **Copy of hospitalization records**

_____ **Hospitalization summary**

or

_____ **All information necessary for the coordination of services.**

This consent may be revoked by me, in writing, at any time but may not be revoked with respect to information provided prior to that time. I understand that if not revoked, my consent will automatically expire 90 days from the date of my signature.

Client Name (please print): _____

Client Signature (parent/or guardian if minor):_____

Date: _____ **Date of Birth of client** _____

Witness: _____ **Date:** _____