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:
____Phone: ( ) _________________________

Intake Questionnaire
Shonna Porter, LMHC

Name: ____________________________ Date: ______________ Email (optional): _______________________

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
________Yes ________ No If yes, from whom, where and for how long? __________________________
____

Have you had previous psychotherapy? ______ Yes ______No If yes, when? ____________________________
Previous therapist's name: ____
What did you find helpful/not helpful about your previous therapist? ______________________________
____

Are you currently taking prescribed psychiatric medication (i.e. antidepressants, etc.)? _____ Yes ____ No
If yes, please list: ____
If no, have you previously taken psychiatric medication? ______ Yes _______ No
If yes, please list – Name: _________________________ Dosage: ____________ Duration: __________________

Please list any additional supplements or over the counter medications you are taking: ____________
____

Health and Social Information:

1. How is your physical health at present?
________ Poor ________ Unsatisfactory ______ Satisfactory _______ Good _________ Very Good

2. Please list any previous or current persistent physical symptoms, conditions, surgeries or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): ______________________________
____

3. Are you having any problems with your sleep habits? ______Yes _______ No
If yes, check where applicable:
_____ Sleeping too little _____Sleeping too much _____ Poor quality sleep _____ Disturbing dreams
For how long? ______________________ How often? ____

4. How many times per week do you exercise? _____________ For how long each time? __________

5. Are you having any difficulty with appetite or eating habits? __________ Yes __________ No

6. Do you regularly use alcohol? _____________ Yes __________ No
In a typical month, how often do you have 4 or more drinks in a 24-hour period? ___________

7. Do you engage in recreational drug use? _________ Yes __________ No If yes, how often?
_________ Daily ________ Weekly ________ Monthly ________ Rarely

8. Have you had suicidal thoughts recently? _____ Frequently ____ Sometimes ____ Rarely ____ Never
Have you had them in the past? _____ Frequently ____Sometimes ____Rarely ____ Never

9. Are you currently in a romantic relationship? ____ Yes ____ No
If yes, how long have you been in this relationship? ____________________
On a scale of 1-10, how would you rate the quality of your current relationship? __________

10. Please list your greatest concerns/issues/stressors: ____________________
____
____

Are you currently or have you ever experienced any of the following:

			Approximate date of onset and duration:
Extreme depressed mood:	Y	N	____________
Wild mood swings:	Y	N	____________
Rapid speech:	Y	N	____________
Extreme anxiety:	Y	N	____________
Panic attacks:	Y	N	____________
Phobias:	Y	N	____________
Sleep disturbances:	Y	N	____________
Hallucinations:	Y	N	____________
Unexplained losses of time:	Y	N	____________
Unexplained memory lapses:	Y	N	____________
Alcohol/substance abuse:	Y	N	____________
Frequent body complaints:	Y	N	____________
Eating disorder:	Y	N	____________
Body image problems:	Y	N	____________
Repetitive thoughts (obsessions):	Y	N	____________
Repetitive behaviors (hand-washing):	Y	N	____________
Homicidal thoughts:	Y	N	____________
Suicide attempt:	Y	N	____________

Occupational Information:

Are you currently employed? ______ Yes ______ No
If yes, who is your current employer/position? ______________________________
If yes, are you happy at your current position? ______________________________
Please list any work-related stressors: ______________________________
____
____

Religious/Spiritual Information:

Do you attend church regularly? _______ Yes _______ No
If yes, what is your faith? ______________________________
If not do you consider yourself to be spiritual? ______ Yes ______ No

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulty with any of the following? Please check any that apply and who it applies to (e.g. sibling, parent, uncle, etc.):

Difficulty		Family Member
Depression	________	______________________________
Bipolar Disorder	________	______________________________
Anxiety Disorder	________	______________________________
Panic Attacks	________	______________________________
Schizophrenia	________	______________________________
Alcohol Abuse	________	______________________________
Drug Abuse	________	______________________________
Eating Disorders	________	______________________________
Learning Disability	________	______________________________
Trauma History	________	______________________________
Suicide Attempts	________	______________________________

Other Information:

What do you consider to be true about you? In summary, who are you? “I am….”

____

____

____

What do you consider to be your greatest strengths? Weaknesses?

____

____

____

What are your greatest personal challenges?

____

____

____

What do you hope to address and accomplish in therapy?

____

____

____

What is the best way I can care for you?

____

____

____

What do you need from a therapist?

____

____

____

Client Information and Disclosure

Shonna@pearlcounseling.com
www.shonnaporter.com

Training and Degrees: I received my Bachelor of Arts in Exercise Physiology from Western Washington University in May 1995 and a Masters of Arts in Counseling Psychology from Mars Hill Graduate School in May 2007. I am a trained Lifespan Integration Counselor and a member of the ACA (American Counseling Association). In addition to counseling I am certified through NASM (National Academy of Sports Medicine), ACE (American Council on Exercise) and have been a fitness, health and wellness consultant for over 20 years.

Counseling Orientation, Techniques and Methods: My training is primarily Object Relations Therapy, meaning I am a relational therapist who uses relational patterns, attachment patterns, family of origin and emotional relatedness to explore where there may be "dis-ease" in your life. According to my theory many of our deepest issues are rooted in relationship. In addition to Lifespan Integration and talk therapy, I use a variety of other tools depending on the presenting problems and in some cases homework is required. It is also important to note that therapy can be very disrupting and you may feel things are getting worse before they get better. This is very common during the process of change and transformation. However, there are no guarantees regarding the outcome of treatment, desired change and outcomes of therapy are inevitably up to you. Our time together will be 45-55 minutes in length for a general session and 90 minutes in length for Lifespan Integration work or unless otherwise scheduled. Group sessions are typically 90 minutes.

Billing and Insurance: I am a Licensed Mental Health Counseling with the state of WA, #LH60498106. I am an in network provider for some insurance plans. Please check with your insurance to determine whether or not I am a preferred provider and what your mental health benefit will be. Should we choose to work together, our first intake session is 45-60 minutes in length and is $150.00. Subsequent sessions will be billed at my standard fee of $130.00 per 45-55-minute session ($165.00 per 90 minute session). If you are not using insurance and agree to make full payment at the time of service, the fee can be discounted to $130 for the intake session and $110 for subsequent sessions.

Payment can be made by credit card (Visa, MasterCard), debit card (Visa, MasterCard), cash, or check. All checks should be made out to **Shonna Porter Counseling**. Fees may increase periodically, and are subject to change with prior notification. I require 24-hours notice if you need to cancel or reschedule an appointment. Should you miss a session or cancel a session without 24-hours notice, you will be billed for that session and are expected to pay for your missed time. (Insurance does not cover missed sessions) If payments or cancellations become problematic you may have the option to pre-pay each session in order to hold your time slot open. Any outstanding monies owed will be sent to a collection agency after 90 days.

Confidentiality: There is a legal privilege in the state of Washington protecting the confidentiality of any information you share with me. As a professional I can assure you I strive to maintain the strictest standards of confidentiality. Your information will not be released to outside sources without your written permission unless the law requires me to do so. The only exception to this is if you are planning to harm yourself or someone else. (Detailed information about these exceptions can be read in the Washington Notice Form (HIPPA)).

Confidentiality and Technology: Some clients may choose to use technology in our counseling relationship. This includes but is not limited to online counseling via Skype, telephone, email, text. Due to the nature of electronic communication, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur.

Please be advised to take precautions with regard to authorized and unauthorized access to any technology that is used. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology.

Contacting by phone: To schedule, reschedule, or cancel an appointment, please utilize my online scheduling tool at http://shonnaportercounseling.fullslate.com. You may also reach me at Pearl Counseling 253-752-1860 x323. I check my messages on a regular basis and will usually return your call within 24-hours on any business day.

Contacting by email: I do allow clients to contact me through email at shonna@pearlcounseling.com. However, this is not a forum for discussing serious issues, staying "in touch" through lengthy updates, or for counseling of any sort. Email is for the sole purpose of initial contact, appropriate brief inquiries, or in the event alternative communication is not possible. Should you send me an email, you can expect brief responses from me until we can talk on the phone or at your next session.

Social Media: My goal is to protect each client's privacy and autonomy; therefore I do not accept friend requests on social media.

Scheduling via text: Once the therapeutic relationship is initiated, texting may become a preferred, or at times a more efficient medium with which to schedule an appointment. Should we agree to this, texts should be brief and professional. Please do not use texting for any other purpose. Once our therapeutic relationship has been terminated, your information will be deleted from any and all technological devices.

Emergencies:
In the event of an emergency call 911.
You can also call the Crisis Line in Tacoma at 253-798-4333.
The Domestic Violence Hotline is 1-800-562-6025.

I have read, understand and agree with all of the information, policies and procedures presented in this form.

***Client Signature*____________________________________**

***Date*_________________________**

***Counselor Signature*_________________________________**

***Date*_________________________**

Financial Policy
Pearl Counseling Associates, LLC

Private Pay (not using Insurance)

Payment is due at time of service unless you make other arrangements with your counselor. If you do have an alternate agreement with your counselor, please make sure the Office Manager is aware of it.

We accept as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders, Cash, or online banking service. Make checks or money orders payable to your counselor (not to Pearl Counseling). Checks returned for non-sufficient funds (NSF) will be charged back to your account with an additional $18.00 service charge. If you prefer, you can use EASY PAY for billing. In that case, we will maintain your credit or debit card number on file to satisfy all fees charged, including late cancels, no shows, co pays, deductibles, coinsurances or other balances.

Insurance & Insurance Collection

Insurances doing business in the state of Washington have 30 to 90 days to pay or deny a claim. They normally respond in 2-3 weeks' time. If you have paid your account in full and insurance pays at a later date, or you pay more than is owed, you may choose either to receive a refund from your counselor or apply the credit toward future sessions.

It is your responsibility to know what your mental health benefits and financial obligations are with your insurance company. As a courtesy, we will also check on your benefits. Be aware that most insurance plans require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information. This information becomes part of the insurance company files.

We will bill your insurance for you. Co-pays, if applicable, are due at time of service. If you have a coinsurance (vs a co-pay) you will be billed after we receive the explanation of benefits from your insurer. If your counselor is out of network for your insurance, you may need to pay for the session in full, and then receive reimbursement directly from your insurance company. Note: Having more than one insurer does not necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays.

Late/Missed Sessions: Insurance does not pay for missed sessions, nor for missed time during a session. If you are late or miss a session, insurance will not pay for the lost minutes, and we will need to bill you for the missed time.

Minor Clients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment requires that charges be authorized to a Visa/MasterCard/Bank Card, or payment by cash or check at time of service has been verified, or we have the signature on file of the person(s) financially responsible for the bill and they have read and signed this policy.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibility for minors rests with the accompanying adult. An exception may be made if we have a written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

Collections / Rebilling Fees: We may charge a rebilling fee of $10.00 per bill on past due accounts (over 30 days). If it becomes necessary to send your account to collections., you will be responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collections process. Non-emergency counseling sessions will be suspended until your account is paid in full.

On Call Counseling: Pearl Counseling Associates, LLC offers "on call" counseling when crisis or emergency counseling is needed during your counselor's absence. If you meet with an "on call" counselor, payment is due at the time of service, at the counselor's rate. If the "on call" counselor is in network with your insurance and you fill out their intake form, your insurance can be billed.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Client or Responsible Party: ______________________________ **Date**____________

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 _____________

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

OTHER 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 and law enforcement reports. 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 PHI to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of the public or another person.

Criminal Activity on My Business Premises/Against My Staff or Me. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against my staff or me.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

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:

Shonna Porter, MA
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860x323

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's Signature *Date*

Shonna Porter, LMHC
Pearl Counseling Associates
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860 x **323**, 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 **Shonna Porter and/or his 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: ________________