Rosemary Crawford MA, LMHCA

State Licensed Mental Health Counselor Associate
Northwest Family Life Affiliate

Today's Date:	Therapist: Rosemary Crawford	Diagnosis (Code and Description):

CLIENT INFORMATION

Client's last name:	First:	Middle:	☐ Mr. ☐ Miss☐ Ms .☐Mrs.	Social Security no.:

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
☐ Yes	☐ No					

Street address:	Home Phone no.: ( ) Ok to leave a msg: □yes □no	Work Phone no.: ( ) Ok to leave a msg: □yes □no
City: State: Zip Code:	Cell Phone no.: ( ) Ok to leave a msg: □yes □no	Alternate no.: ( ) Ok to leave a msg: □yes □no

P.O. box:	City:	State:	County:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Email Address:	

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Is this person a client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this client covered by insurance?	☐ Yes	☐ No	

Please indicate primary insurance:	EAP Authorization#:

Subscriber's name:	Subscriber's ID#.:	Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

11320 Roosevelt Way NE, Seattle, WA 98125 | 2606 1/2 3rd Ave, Seattle, WA 98121 | rcrawford@nwfamilylife.org
rosemary@mycounselingseattle.com | ph: 256.648.1730 | fax: 206.363.9639

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Partner Status
1 ☐ Single
2 ☐ Married
3 ☐ Separated
4 ☐ Divorced
5 ☐ Widow
6 ☐ Cohabited

Ethnicity
1 ☐ Hispanic/Latino
2 ☐ African American
3 ☐ Asian/Pacific Islander
4 ☐ European Descent
5 ☐ Alaskan Native or Native American
6 ☐ Multi-racial: _____

Household Income/Month
1 ☐ $0 - $1,499
2 ☐ $1,500 - $2,499
3 ☐ $2,500 - $3,499
4 ☐ $3,500+

Sexual Orientation
1 ☐ Heterosexual
2 ☐ Gay /Lesbian
3 ☐ Bi-Sexual
4 ☐ Transgender
5 ☐ _____

Do you have a disability, which qualifies you for special accommodation or compensation?

_____

Referral Source (Please check the box or boxes that best describe how you chose us as your service provider.)

1 ☐ Relative
2 ☐ Friend
3 ☐ Counselor
4 ☐ Court
5 ☐ Attorney
6 ☐ Church
7 ☐ NWFL Client
8 ☐ Doctor
9 ☐ Radio Ad
10 ☐ Radio Show
11 ☐ Yellow Pages
12 ☐ Dept. of Corrections
13 ☐ NWFL Website
14 ☐ Internet Search
15 ☐ CPS
16 ☐ Insurance Company
17 ☐ Other

Name of referral person, church or agency_____

FAMILY MEMBERS

Names of Family Members Living w/you	**Age**	**Ethnicity**	**Any Disability or Health Concerns?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I give my permission for the above information to be used in aggregate form for research, required reporting and funding purposes. I understand that my name, the names of my children and any other identifying information will be kept confidential. Please talk with your therapist if you have a concern with the statement.

Signature_____**Date**_____

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IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**
		( )	( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to NWFL. I understand that I am financially responsible for any balance. I also authorize NWFL or insurance company to release any information required to process my claims.			
Patient/Guardian signature		**Date**	

Disclosure Statement

Welcome! Before we start counseling, it is both my desire and a requirement of Washington State law to provide you with the following information. Signing this form establishes our contract for therapy services.

The Washington State Counselor Credentialing Act (WAC 246-810) requires that any counselor practicing counseling for a fee must be registered or certified with the Department of Health. This law was designed for the protection of the public health and safety, and to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. However, registration of an individual with the Department does *not* include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment (WAC 246-810-031**).** ***It is every individual's right and responsibility to choose the provider and treatment modality which best suits their needs.***

My credentials and work experience

- I am licensed as a Mental Health Counseling Associate within the state of Washington (MC 60303339)
- I have a Masters Degree in Counseling Psychology from the Seattle School of Theology and Psychology
- I completed a one year internship at the Salvation Army
- I am an affiliate of Northwest Family Life Learning and Counseling Center
- I completed a one year externship at the Seattle Therapy Alliance
- **I am supervised by Nancy Murphy, DMin., LMHC (LH00004217)**
- I have completed training to become a state certified DV Treatment Program Provider

My counseling approach:

My work is relationally focused, exploration and strength based counseling. I am influenced heavily in theories that place the relational aspects of being human at the forefront. This means that your specific reason for coming to counseling will be addressed, as well as looking at the

relationships you have had with important people in your life. These theories help me to work you to integrate your past experiences with their present reality. Based on your unique self, and the way that we work together within sessions, I seek to interact with and be sensitive to your personhood, and your story.

Some of the most central ideas in the way I work include:

- The ways we interact within the office can inform us of the many different ways in which you interact with yourself and others outside of our therapeutic relationship.
- Working together to identify the patterns of behavior, engrained messages, experiences and responses that have occurred throughout your life and the affect they may have had on your past, continuing up to today.
- Focus on self-awareness, mindfulness, self- agency and personal meaning.
- Parsing out what ways of thinking, and being that are healthy and helpful, and those that are harmful by looking into past stories and how they manifest in your life.
- My hope for you is to be able to live more fully into your personal, truths, desires, dreams, and freedom while creatively and intentionally interacting within your relationship with yourself and others within the world around you.

Please tell me about you:

Medical Information:

Are you under the care of a physician? Yes - No
Name and Phone Number: _____

Most recent physical exam date: _____

Are you under the care of a psychiatrist? _____
Name and Phone Number: _____

Have you had a formal psychological assessment? _____

Are you currently in other counseling? _____ Have you had prior counseling? _____

Name(s) of counselor(s) _____

Please list any current medications and what they are prescribed for:

Medication: Prescribed for:

_____

_____

_____

_____

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I have been diagnosed with:

_____ Anxiety Disorder
_____ Borderline Personality Disorder
_____ Obsessive/Compulsive Disorder
_____ Bipolar Disorder
_____ PTSD
_____ Anorexia
_____ Bulimia
_____ Sexual Dysfunction
_____Schizophrenia
_____ Anger Issues
_____ Alcoholism
_____ Chemical Dependency
_____ Depression
_____ Seasonal Affective Disorder
_____ Dissociative Identity Disorder
_____ Other: _____

Please Explain: _____

Addictions: _____

Have you ever been suicidal? _____ If so, when? _____

Have you ever been homicidal?_____ If so, when? _____

Would you sign a release form to obtain information from medical/psychological professionals you have worked with? Yes - No

Have you ever served in the armed forces? _____ Years: _____

Do you have any current legal problems? _____

If so, please explain: _____

Do you consume alcohol regularly? _____ How often? _____

Do you take non-prescribed drugs? _____ How often? _____

Other information that you believe is important for your counselor to know of which may impact therapy:

_____

_____

_____

_____

What are primary concerns, issues, or problems that you would like to work on in counseling?

_____

_____

_____

_____

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At this time how would you state your personal dreams and goals?

_____

_____

_____

_____

Confidentiality: I am bound by professional ethics to protect client rights to confidential communications in regards to their involvement in counseling. *All issues discussed in the course of counseling are strictly confidential.* By law, health care information pertaining to you may be released only with your written consent or the consent of a parent or guardian. For this reason, if you want me to release information about your participation in therapy, I will require a signed "Release of Information" from you. A release is legally valid for ninety (90) days from the date of signature. However, the law (RCW 18.19.180) provides **exceptions to client confidentiality** where *information may be released without your consent*:

1. In the event of a medical emergency information deemed necessary for treatment *may* be released.
2. In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individuals *must* be contacted. This may include the individual against whom a threat is made.
3. In the event of suspected abuse of a child, dependent adult or elder, the proper authorities *must* be contacted. The abuse does not have to be personally witnessed by the counselor.
4. If you register a complaint with the Washington State Department of Health, information will be released as requested or required by the State to resolve the issue.
5. If ordered by a judge or other judicial officers, information regarding your treatment *must* be disclosed.
6. If an attorney in the state of Washington duly subpoenas your records, they will be released unless you file a protection order within 14 days of the subpoena.
7. In the event of a client's death or disability, information will be released as authorized by the client's personal representative or beneficiary.
8. A counselor is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act.
9. Evidence that a minor client was a victim of a crime *may* be released to the proper authorities.

Initial here: _____

Records Review & Correction: I keep a record of the health care services that I provide to you. You have a right, by law (RCW 70.02.070), to see and copy that record. Also, you may ask to make corrections to your record. A reasonable fee will be charged for reviewing and/or photocopying any portion of your record.

Initial here: _____

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Case Consultation: I advocate and practice professional consultations for the purposes of professional training, accountability and providing the best counseling service possible to clients. I may at times discuss your situation with other professionals within a confidential case conference. Please speak with me if you have concerns regarding this practice. Use of data derived from counseling for purposes of training, research, or publication are confined to content that is disguised to ensure the anonymity of the individuals involved.

Initial here: _____

Phone Calls, Texts and Emails: I do not handle emergencies. If you have an emergency it is essential for you to dial 911. If you decide to call or email me between sessions wanting to discuss something, my typical practice is to address that topic in the next session. If you do feel a need to talk in between sessions, any calls over 10 minutes, I pro-rate by 15-minute increments based on my standard fee of 90.00. My preference of interaction is first telephone, and then email. Please note I consider your choice to interact with me via these mediums includes your awareness of confidentiality risks that are present due to the nature of the before mentioned technologies.

Initial here: _____

Security and Confidentiality: It is imperative that you keep the outer lock and key code the Vine Court offices kept confidential. By signing this contract you are committing to keeping this code safe and private.

Initial here: _____

Unprofessional Conduct & Complaint Process: A handout is provided listing legally recognized acts of unprofessional conduct (RCW 18-130-180). If you have any concerns about the course of your treatment I ask that you attempt to resolve them with me individually. If resolution is still not reached you have the right to file a complaint with the Dept. of Health (Dept. of Health, Health Professions Quality Assurance Division, Counselor Registration/Certification, 310 Israel RD PO Box 47860 Tumwater, WA 98501-7860 (360) 236-4700.)

Initial here: _____

Termination: It is every client's right to disengage from counseling with or without notice to the treatment provider. However, I request notification of termination of therapy. I find it helpful to arrange a final session(s) to explore termination, and review counseling goals and progress.

Initial here: _____

Formal Evaluations: I do not do custody or visitation evaluations or recommendations. I specifically do not do retroactive, retrospective or after-the-fact evaluations or recommendations. For an opinion of whether or not you need treatment, are competent to stand trial or wish to contest your referral here I can assist you in locating a licensed clinical psychologist who can perform a psychological evaluation. That evaluation will be at your expense. The question of whether or not you were appropriately referred here should not be a treatment issue and should be addressed with the referral source or the clinical psychologist, not in treatment.

Initial here: _____

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Fees & Payment: Payment of fees are expected at the beginning of our appointment. Sessions will begin at the scheduled time. My standard individual (45-50 minute) session fee is $90. Representation of a case in court is billed at $150/hr beginning from the time the therapist leaves the office and ending when the therapist returns to the office. In the case of a sliding scale fee, the amount will be decided on between us during the first session and added to the contract. The following amount displays the agreed upon sliding scale fee of _____ for a period of _____.

Initial here: _____

Cancellation of Appointments: If you need to cancel your appointment, please let me know at least 24 hours in advance. Missed sessions or cancellations within 24 hours of a scheduled appointment will be charged at your hourly fee. Charges for missed sessions cannot be billed to insurance.

Initial here: _____

Insurance Coverage & Payments: Insurance company carriers, plans, coverage and provider contracts are so varied in regards to mental health benefits that *there is no way of guaranteeing that your insurance plan will cover my services for your diagnosis and counseling*. Although I automatically bill insurance for all my clients unless requested to do otherwise, I *STRONGLY* advise each client to call their insurance company to *estimate* what coverage *may* apply *before* entering into therapy. Insurance companies require a formal diagnosis to determine eligibility for payment. Also, be aware that insurance company contracts with both clients and providers include authorizations to review actual counseling case notes if they request to do so. Insurance benefits are received directly to my office.

I, _____, authorize Rosemary Crawford, MA, LMHCA to engage in counseling services with me. I have read and understood the preceding disclosure and policy statements. I have also read and understood the Unprofessional Conduct handout. I understand I may have copies of both this contract and the Unprofessional Conduct form. I agree to the conditions of this therapy contract.

_____ _____

Client's Signature **Date** **Parent/Guardian's Signature (if applicable)** **Date**

_____

Therapist/Counselor's Signature **Date**

Last revised 3/31/14

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Notice of Privacy Practices

This notice describes how your medical records information may be used and disclosed, and how you can get access to this information.

The law protects the privacy of information we create and obtain in providing our care and services to you. Your protected health information includes your diagnoses, treatment, information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. Domestic Violence Treatment Laws do require me to give some specific information to victims and authorities, which is explained at the time of admission.

Your Health Information Rights

The healthcare and billing records I create and store are the property of Rosemary Crawford Counseling. The protected health information in it belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us.
- Request and receive from me a paper copy of the most current Notice of Privacy Practices.
- Request that you be allowed to see and get a copy of your records.
- Have me review a denial of access to your records.
- Ask me to change something in your records. Please give me this request in writing. If your request is denied you may write a statement of disagreement. It will be stored in your medical record and included with any release of your records.
- You may request a list of disclosures of your records without charge once every 12 months. Requests made more frequently will require a fee to process. Please sign, date, and give me your request in writing. The list may not include disclosures for treatment, payment or health care operations.
- You may ask that your records be given to you by another means or at another location.
- Cancel prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before I have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain payment.

For help with these rights or to report a problem about your medical records during normal business hours, contact Rosemary Crawford at 256.648.1730 or write to Rosemary Crawford, 11320 Roosevelt Way NE, Seattle, WA 98125.

If you believe your privacy rights have been violated, you may discuss your concerns with Rosemary Crawford. You may also deliver a written complaint addressed to Rosemary Crawford. You may also file a complaint with the U.S. Secretary of Health and Human Services. I respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, I will not retaliate against you.

Rosemary Crawford MA, LMHCA

State Licensed Mental Health Counseling Associate (MC 60303339)
Northwest Family Life Affiliate

My Responsibilities

I am required to:

- keep your protected health information private unless authorized to give it out.
- allow you to read this Notice and give you a copy if you want one.
- update this Notice if we make changes. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.
- notify Family and Others for Public Health and Safety Purposes as Required by Law:
  - to prevent or reduce a serious, immediate threat to someone's health or safety
  - to public health or legal authorities to prevent or control disease, injury, or disability
  - if you are hospitalized we may tell your family or the authorities so that you may receive proper care
- ask your permission to share information of a personal nature for researchers' purposes.
- give Coroners information consistent with applicable law to allow them to carry out their duties.
- report Suspected Abuse or Neglect to public authorities.
- give Correctional Institutions information for health and safety purposes if you are in jail or prison.
- give information for Law Enforcement Purposes or in the course of Judicial Proceedings such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- give information for Specialized Government Functions for national security purposes.
- get your written authorization for other uses and disclosures not in this Notice.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations:

For treatment:

- Information obtained by me will be recorded in your medical record and used to help create a treatment plan for you. Other Northwest Family Life Learning & Counseling Center Affiliate members may be involved in helping to develop the treatment plan.
- Northwest Family Life Affiliate members discuss cases in a peer review format to assure the best approach for your treatment.

For payment:

- Insurance plans require information from us about your diagnosis, treatment and recommendations.

For health care operations:

- I use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the performance of Northwest Family Life Affiliates.
- I may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- I may use and disclose your information for medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs.

I _____ verify that I have received, read and understand this Notice of Privacy Practices.

_____ _____

Client's Signature Date Therapist/Counselor's Signature Date

Last revised 5/8/14

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