Joanne Jones, MSW, M.A.
Licensed Marriage & Family Therapist

EAP CLIENT INTAKE FORM

Today's Date: _____

Client (Last Name) (First Name) Date of Birth

Spouse (Last Name) (First Name) Date of Birth

Client Address Street City State Zip Code

Client Cell Phone # Client Work # Client Home Number #

Spouse Cell Phone # Spouse Work # Spouse Home Number #

Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ In a Relationship ☐ Single

Name of Insurance Name of Subscriber or Policy Holder Date of Birth of Subscriber

Subscriber ID# Social Security # Authorization # # of Sessions Authorized

Note: If your EAP provider is different than your mental health insurance provider, you must include your social security number above in order for me to bill your EAP.

Please check if it is okay to contact you on: ☐ Home Phone ☐ Work Phone ☐ Cell Phone
Is it okay to send mail to your home? ☐ Yes ☐ No

Name and contact information of Primary Care Physician:

_____

Are you taking psychotropic medication(s)? ☐ Yes ☐ No

If Yes, please describe: ☐ Anti-depressant ☐ Mood Stabilizer ☐ Anti-Anxiety ☐ Psychostimulant ☐ Anti-psychotic ☐ Other ☐ Don't Know

Medications monitored by: ☐ Psychiatrist ☐ Primary Care Physician ☐ ARNP ☐ Other

Describe why you are seeking help:

_____

_____

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When were you last examined by a physician? _____

List any major health problems for which you currently receive treatment:

_____

_____

List any medications you are now taking:

Medication Name	Dosage	Start Date	End Date

Describe your reason(s) for seeking treatment at this time. Include when the problem started:

_____

_____

Have you ever received mental health or substance abuse treatment of any kind before?
☐ No ☐ Yes (please provide additional information below)

Provider Name	Reason for seeking help	Start Date	End Date

Please indicate past problems with a "P" and current problems with a "C."

___ Depression	___ Chronic Illness	___ Marriage/Relationship Issues
___ Anxiety	___ Chronic Pain	___ Sexuality/Sexuality Issues
___ Stress	___ Loneliness	___ Family Conflict
___ Grief/Loss	___ Eating or Weight Problem	___ Behavioral Problems
___ ADHD	___ Abuse/Victimization	___ Schizophrenia/Psychosis
___ Anger	___ Domestic Violence	___ Phobias/Fears
___ Obsessions/Compulsions	___ Manic Episodes	___ Eliminating a drug/alcohol habit
___ Trauma	___ Legal Matters	___ Eliminating another habit (i.e. overspending, gambling)

Please indicate how the problems are affecting the following areas of your life:

	No Effect 1	Little Effect 2	Some Effect 3	Much Effect 4	Significant Effect 5	Not Applicable N/A
Marriage/Relationship	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐
Job/School Performance	☐	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐	☐
Financial Situation	☐	☐	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐	☐	☐

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EAP CLIENT DISCLOSURE STATEMENT

Washington Licensed MFT Number: LF00001118

Counselor's Name: Joanne Jones

Type of Counseling Provided: Individual, Couples, and Family Therapy

Methods and Techniques Used: Family Systems Therapy, Structural, and Solution- Focused Therapy

Education, Training, Experience:

- Licensed Marriage and Family Therapist
- Chemical Dependency Professional
- Clinical Member of AAMFT and WAMFT
- Family and Adolescent Therapist, Starting Over
- Master of Arts, Marriage & Family Therapy, Pacific Lutheran University
- Montlake Family Therapy Training
- Master of Social Work, University of Washington
- Bachelor of Arts in Psychology with Addiction Studies Specialty

FEES

Your Employee Assistance Program has authorized _____ sessions. These sessions will be billed to your EAP. At the end of the sessions you may negotiate with me for additional sessions or request additional sessions from your insurance carrier depending upon your plan.

If you do not obtain proper authorization or if for any reason the EAP does not cover these sessions, you will be responsible.

Appointments cancelled with less than 24 hours notice will be billed to your EAP. **(INITIAL_____)**

CONFIDENTIALITY

All information discussed in therapy is **CONFIDENTIAL**. No information is communicated to others outside of the session without your signed consent. However, I am required by Washington State law to release confidential information in selected situations. If I believe you may be physically or sexually abusing or neglecting a minor child or vulnerable adult or developmentally disabled person, or if you report information to me about the possible abuse or neglect of such a person, I am required by law to report it. If I believe you are likely to do harm to yourself or to another person, I must also take steps to protect you and/or the other person. Written records of your sessions are kept in a locked file cabinet.

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EAP CLIENT DISCLOSURE STATEMENT

Client Disclosure Statement
"Counselors practicing counseling for a fee must be licensed or registered with the Department of Health 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."

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is: (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

I am not qualified to do parenting evaluations nor am I an expert witness. Should you be involved in legal matters, I will not go to court. However, I can refer you to a qualified professional to assist you if needed.

CONSENT TO TREATMENT

I/we have read, understand and agree to the information above.

_____ _____
Client Signature **Date**

_____ _____
Client Signature **Date**

_____ _____
Joanne Jones, LMFT **Date**

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EAP / INSURANCE RELEASE OF INFORMATION

I, _____, authorize ***Joanne Jones*** to release and obtain information pertaining to my client records to insurance provider to bill insurance for mental health benefits for me.

Name and address of insurance provider with whom information is to be exchanged:

_____

_____

_____

_____

Specific type of information to be disclosed: participation in therapy, billing for services and clinical updates as required by insurance carrier.

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**

_____ _____

Joanne Jones, LMFT **Date**

The information which is being disclosed from records whose confidentiality is protected by law prohibits disclosure without the specific consent of the person to whom it pertains.

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EMAIL & TEXT MESSAGE AUTHORIZATION FORM

Email Address(es) to Send Appointment Reminders to: _____

_____

OR

Phone Number(s) to Text Message Appointment Reminders to: _____

_____

Email Address(es) to Send Statements to: _____

_____

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Please notify me if you decide to avoid or limit, in any way, the use of email. Unless I hear from you otherwise, I will continue to communicate with you via email when necessary or appropriate.

Statements will be sent from jessica@joannestherapy.com by my Administrative Assistant, Jessica Barrett.

By signing below I authorize ***Joanne Jones*** and ***Jessica Barrett*** to email my statements and appointment reminders. I also authorize ***Joanne Jones*** to send appointment reminders by text message.

I understand that appointments cancelled with less than 24 hours notice will be billed directly to me.

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**

_____ _____

Joanne Jones, LMFT **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices from Joanne Jones.

_____ _____

Client/Parent/Guardian Signature **Date**

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

_____ _____

Personal Representative's Name **Relationship to Client**

For Office Use Only

I attempted to obtain written acknowledgment of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented me from obtaining acknowledgement.

☐ Other (please specify)

_____

_____

This form will be retained in your medical record. This form is educational only, does not constitute legal advice, and covers only federal, not state law.