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

KAISER PERMANENTE 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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KAISER PERMANENTE 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
- Family and Adolescent Therapist, Starting Over, 1991-1999
- 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

The fee for the first session (intake) is $150.00 and thereafter each individual session is $110.00, each couple or family session is $125.00.

Your co-pay is _____ per session payable at the time of the session.

Please refer to your letter of authorization for detailed information about the number of sessions authorized. You are also responsible for meeting any deductible required by your Kaiser Permanente Health Plan.

It is your responsibility to follow-up with Kaiser Permanente promptly after today's session to inform them you are attending therapy with Joanne Jones, LMFT to obtain authorization for the sessions. If you do not call promptly, you will be responsible for the session fee(s). **(INITIAL_____)**

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

Unpaid accounts 90 days past due are turned over to Collections. **(INITIAL_____)**

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KAISER PERMANENTE CLIENT DISCLOSURE STATEMENT

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.

Client Disclosure Statement
"Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include a 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

We have read, understand and agree to the information above.

_____ _____
Client Signature **Date**

_____ _____
Client Signature **Date**

_____ _____
Joanne Jones, LMFT **Date**

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PRIMARY CARE PHYSICIAN RELEASE OF INFORMATION

I, _____, do hereby authorize ***Joanne Jones*** to release information pertaining to my client records and exchange information with the following person:

_____

_____

_____

_____

Purpose of this release is to allow contact with the above named person and Joanne Jones to release my medical information which includes: treatment plan, dates of attendance in therapy, progress in treatment, and recommendations.

This consent is subject to our revocation at any time and will expire 6 months after treatment is completed.

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**

_____ _____

Joanne Jones, LMFT **Date**

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

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KAISER PERMANENTE / INSURANCE INFORMATION

Client's Name_____ Date of Birth _____

Client's Insurance ID_____

Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

(Client) Are You: ☐ Employed ☐ Student ☐ Unemployed

Name of Insurance_____

Group or Policy #_____

Claims Address:_____

Is authorization required prior to attending therapy? ☐ **Yes** ☐ **No**

You may need to call and let the insurance company know that you are seeing me to get the sessions authorized.

Authorization # (if required):_____ # of sessions covered _____

If you are not the insured policy holder fill out the following information:

Name of Subscriber _____

Subscriber ID_____ Subscriber's Date of Birth _____

Subscriber's Address_____

Subscriber's Employer _____

If there is a secondary insurance fill out the following information:

Name of the Insured Person _____

Name of Secondary Insurance _____Group or Policy #_____

Insured Person's ID #_____ Insured Person's Date of Birth_____

Address of Insured Person _____

Employer of Insured Person _____

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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:

Kaiser Permanente
P.O. Box 34585
Seattle, WA 98124

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.