



Joanne Jones, MSW, M.A.

Licensed Marriage & Family Therapist

SELF-PAY 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

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."

<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Marriage/Relationship Issues
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Sexuality/Sexuality Issues
<input type="checkbox"/> Stress	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Family Conflict
<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> Eating or Weight Problem	<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> ADHD	<input type="checkbox"/> Abuse/Victimization	<input type="checkbox"/> Schizophrenia/Psychosis
<input type="checkbox"/> Anger	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Phobias/Fears
<input type="checkbox"/> Obsessions/Compulsions	<input type="checkbox"/> Manic Episodes	<input type="checkbox"/> Eliminating a drug/alcohol habit
<input type="checkbox"/> Trauma	<input type="checkbox"/> Legal Matters	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job/School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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SELF-PAY 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

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.

Intervention sessions are \$175.00 per session.

Payment is to be made at the beginning of each session in the form of cash, check, or credit card. If you are unable to pay at the time of your session, we will discuss possible payment options. If you pay by check and your check is returned from the bank, I require cash or money order payment for the unpaid session and any bank fees to be made prior to any subsequent sessions.

<i>Appointments cancelled with less than 24 hours notice will be billed to you.</i>	(INITIAL _____)
<i>Unpaid accounts 90 days past due are turned over to Collections.</i>	(INITIAL _____)



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SELF-PAY 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 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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SELF-PAY 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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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 for 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 acknowledgment 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.