

## INTAKE SHEET

Date: \_\_\_\_\_ Form completed by  self  parent  guardian  spouse

**Client Name:** \_\_\_\_\_

Personal Pronoun [optional] \_\_\_\_\_ Referred by \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Can we leave you a phone message? Circle Yes or No

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Yes  No

Yes  No

Yes  No

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Marital Status:  single  married  partnered  divorced  widowed

Education: highest grade completed \_\_\_\_\_ degree \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

full-time  part-time  retired

### Person responsible for copayments, coinsurance, deductibles, and/or payment in full:

(if different than client's)

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please provide Insurance card(s) at first appointment.

### PRIMARY INSURANCE COMPANY \_\_\_\_\_

Member's #ID: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Social Security \_\_\_\_\_

(if different than client's)

Subscriber's Address \_\_\_\_\_ Employer \_\_\_\_\_

### SECONDARY INSURANCE COMPANY \_\_\_\_\_

Member's #ID: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Social Security \_\_\_\_\_

(if different than client's)

Subscriber's Address \_\_\_\_\_ Employer \_\_\_\_\_

**Therapist Use Only: ICD-10:** \_\_\_\_\_ **Date Submitted:** \_\_\_\_\_

**Provider Initials** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**If client is a student:**

Grade: \_\_\_\_\_ School: \_\_\_\_\_

School Counselor \_\_\_\_\_ Teacher(s) \_\_\_\_\_

**Please list any other persons residing in home**

Name	Age	Relationship to client

**If client is a minor, please list any Parent(s) or sibling(s) not residing with client**

Name	Age	Relationship to client

**Payment and Insurance billing:**

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company previously noted. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company.

I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

**Client or Authorized Person's Signature:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**For your information,** your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes in order to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately, to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.

### MEDICAL HISTORY

Client Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Form completed by:  self  parent  guardian  spouse/equivalent

Primary Care Physician: \_\_\_\_\_

Please list all doctors or medical specialists the client sees now or has seen in the past year:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date of client's last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Examiner's Name: \_\_\_\_\_

Client's Height: \_\_\_\_\_ Client's Weight: \_\_\_\_\_ Is client gaining/losing weight?  yes  no  
If yes, amount of gain  \_\_\_\_\_ loss  \_\_\_\_\_ Date gain/loss began: \_\_\_\_\_

List any prior hospitalizations:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How is client's appetite?  good  fair  poor. How well does client sleep?  good  fair  poor.

How is client's energy level?  good  fair  poor.

Rate client's general health: \_\_\_\_\_

Describe any current medical problems or recent changes in client's physical condition: \_\_\_\_\_

List all medications client is taking. Include non-prescription drugs and health supplements:

Drug Name	Dosage	# Per Day	Drug Name	Dosage	# Per Day

Do you have any allergies to medication?  yes  no. If yes, which ones? \_\_\_\_\_

Check any of the following which you use/have used and how much/often:

Substance	Past	Now	How Much/Often	Substance	Past	Now	How Much/Often
Hard Liquor				Barbiturates			
Beer/Wine				Cocaine			
Cannabis				Tobacco			
Amphetamines				Coffee			
Heroin				Soft Drinks			
LSD				Other			

Further comments on alcohol or drug use including problem use/abuse: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has client had any previous mental health or counseling?**  yes  no. If yes, describe below:

Location/Therapist	Dates	Reason

Further comments on mental health care results and/or reasons for termination: \_\_\_\_\_  
 \_\_\_\_\_

**Check any of the following symptoms you (the client) have had in the past three months:**

- Vision  Weakness in arms or legs  Constipation  Diarrhea  Stomach aches  Unusual bleeding  Abnormal Growth or Lump  Memory Loss  Chronic Pain  Back Pain  Menstrual Irregularities  Hearing loss  Convulsion/Seizures  Headaches  Nausea or Vomiting  Fainting  Shortness of Breath  Dizziness  Chest Pains or Tightness  Head Injury  Loss of Consciousness

**Dates for above:** \_\_\_\_\_

**Check any of the following conditions you (the client) have had and give dates of onset:**

Condition	Date	Condition	Date	Condition	Date
<input type="checkbox"/> Allergies		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Learning Disability	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Angina		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Parkinson's	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Gonorrhrea		<input type="checkbox"/> Polio	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Gout		<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Attention Deficit		<input type="checkbox"/> Head Trauma		<input type="checkbox"/> Stomach Ulcers	
<input type="checkbox"/> Autism		<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Bladder Problems		<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Bowel Problems		<input type="checkbox"/> Huntington's Chorea		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Hyperactivity		<input type="checkbox"/> AIDS/HIV	
<input type="checkbox"/> Cerebral Palsy		<input type="checkbox"/> Hypoglycemia		Other	Date
<input type="checkbox"/> Chronic Fatigue		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/>	
<input type="checkbox"/> Circulation Problems		<input type="checkbox"/> Jaundice		<input type="checkbox"/>	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney Problems		<input type="checkbox"/>	

**Please indicate which/whom if any of the client's blood relatives (mother, father, grandparent, sister, brother, etc.) have had any of the above conditions:** \_\_\_\_\_  
 \_\_\_\_\_

**Have any of the client's blood relatives had any of the following conditions?**

- Alcohol/drug abuse  Anxiety or Panic Disorder  Attention Deficit/Hyperactivity Disorder  Bipolar Disorder  Depression  Dementia  Nervous breakdown  Obsessive/Compulsive Disorder  Psychiatric Hospitalization  Schizophrenia  Seizure Disorder  Suicide

**Indicate which/whom:** \_\_\_\_\_  
 \_\_\_\_\_

**Additional comments on client's health or client's family health history:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## *Treatment Goals*

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**I. Please list issues to discuss in therapy which are of primary concern to you at present:**


**II: Please list any specific goals or changes you would like to accomplish:**


**WASHINGTON NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT**

I keep a record of the health care services I provide you. The Washington Notice Form describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge:

Receipt of the Washington Notice Form of Privacy Practices that went into effect April 14, 2003: \_\_\_\_\_  
(initials)

I chose not to receive a copy of the Washington Notice Form of Privacy Practices that went into effect on April 14, 2003: \_\_\_\_\_  
(initials)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or legally authorized individual Date

\_\_\_\_\_  
Relationship (self, parent, legal guardian, personal representative)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
(Notation, if any, by staff)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Staff Signature Date

***THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD***

## WASHINGTON NOTICE FORM

### Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### I. Examples of Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

*The providers of Associates in Mental Health may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions.*

**PHI** refers to information in your health record that could identify you.

**Treatment** is when a provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when a provider consults with another health care provider, such as your family physician or another mental health provider.

**Payment** is when provider obtains reimbursement for your healthcare. Examples of payment are when provider discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

**Health Care Operations** are activities that relate to the performance and operation of provider's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

**Use** applies only to activities within a provider's office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

**Disclosure** applies to activities outside of provider's office, such as releasing, transferring, or providing access to information about you to other parties.

#### II. Uses and Disclosures Requiring Authorization

Provider may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when a provider is asked for information for purposes outside of treatment, payment and health care operations, provider will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) the provider has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

#### III. Uses and Disclosures with Neither Consent nor Authorization

Provider may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse.** If provider has reasonable cause to believe that a child has suffered abuse or neglect, provider is required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

**Adult and Domestic Abuse.** If provider has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, provider must immediately report the abuse to the Washington Department of Social and Health Services.

**Sexual or Physical Assault.** If provider has reason to suspect that sexual or physical assault has occurred, provider must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

**Health Oversight.** If the Washington Licensing Board subpoenas provider as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of State licensed providers, provider must comply with its orders. This could include disclosing your relevant mental health information.

**Judicial or Administrative Proceedings.** If you are involved in a court proceeding and a request is made for information about the professional services that provider has provided to you and the records thereof, such information is privileged under state law, and provider will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform provider that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety.** Provider may disclose your confidential mental health information to any person without authorization if provider reasonably believes that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

**Worker's Compensation.** If you file a worker's compensation claim, with certain exceptions, provider must make available, at any stage of the proceedings, all mental health information in their possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

#### IV. Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization. Regarding all other uses and disclosures for which an authorization or opportunity to agree or object is not required, including specialized government functions, please see HIPAA 164.512.

#### V. Patient's Rights

*Receive, read, and ask questions about this Notice.* You have the right to request and receive a paper copy of the most current Notice of Privacy Practices for Protected Health Information (Washington Notice Form) from your provider.

*Right to Request Restrictions.* You have the right to request restrictions on certain uses and disclosures of protected health information about you. You must deliver this request in writing to your provider. However, your provider is not required to agree to a restriction you request but will comply with any request granted.

*Cancel prior authorizations.* You have the right to cancel prior authorizations to use or disclose health information by giving written revocation to your provider. Your revocation does not affect information that has already been released. It also does not affect any action taken before your provider has your revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are receiving treatment. Upon your written request, your provider will send your PHI to another address.

*Right to Inspect and Copy.* You have the right to inspect or obtain a copy (or both) of PHI in your provider's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. Upon your request, your provider will discuss with you the details of the request and denial process.

*Right to Amend.* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your provider may deny your request. On your request, your provider will discuss with you the details of the amendment process. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.



*Right to an Accounting.* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). This will not include disclosures to third-party payers. You may obtain this information without charge once every 12 months. Your provider will notify you of the cost involved if you request this information more than once in 12 months.

The following patient rights are required by the Omnibus HIPPA Final Rule, which was published in January, 2013.

*Right to Request Non-disclosure.* You have the right to request that AMH *not* disclose information to your insurance company regarding your treatment *for sessions that you pay for privately.*

*Right to be Notified.* You have the right to be notified by AMH in the event that there are any breaches of you PHI.

VI. Provider's Duties

Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

Your provider reserves the right to change the privacy policies and practices described in this Notice. Unless your provider notifies you of such changes, however, your provider is required to abide by the terms currently in effect.

Your provider has the right to change his/her practices regarding the protected health information he/she maintains. If your provider makes changes and you are an active patient in his/her practice, he/she will provide you with a copy of the updated Notice at your first visit after the change. You may always receive the most recent copy of this Notice by calling your provider and asking for it or by visiting your provider's office to pick one up.

VII. To ask for Help or Report a Grievance

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Letisha Stokes, Office Manager, Associates in Mental Health, 1116 Key Street Suite 204, Bellingham, WA 98225, (360) 715-2488

If you believe your privacy rights have been violated, you may discuss your concerns with your provider or the above noted person. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VIII. Website

Associates in Mental Health has a website that provides information about your provider. For your benefit, this Notice is available on the website at this address: [www.amhinfo.com](http://www.amhinfo.com).

IV. Effective Date

This notice went into effect on April 14, 2003.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or legally authorized individual Date

\_\_\_\_\_  
Relationship (self, parent, legal guardian, personal representative)

\_\_\_\_\_  
Printed Name

**Bridget M. Gordon, LICSW**  
**2209 Elm St., Ste 201**  
**Bellingham, WA 98225**  
**(360) 647-2616**

**AGREEMENT FOR THERAPEUTIC SERVICES**

**APPOINTMENTS:** Therapy sessions are generally scheduled for 50 minutes (unless alternative session lengths are arranged and scheduled by you and I). It is important that you arrive on time, as sessions can not be extended to compensate for late arrival.

**CANCELLATIONS:** If you must cancel an appointment, please do so at least 24 hours prior to your scheduled time. Unless you have experienced an emergency, you will be billed for the fee of one session for either not notifying me to cancel, or not canceling within 24 hours of your scheduled time.

**TELEPHONE MESSAGES:** You may call 360-647-2616 at any time and leave a message on my voice mail. Because I am often in session, I may be unable to take your call directly, but I check my messages frequently. If I am out of town, I will have another professional cover for emergencies. If you need immediate attention, contact Care Crisis Response Service (1-800-584-3578) or St. Joseph Hospital Emergency Room (360-734-5400).

**CONFIDENTIALITY:** Washington State Law insures the confidentiality of our therapy relationship with the following exceptions: (1) suspected child abuse; (2) serious risk of harm to self or others. In certain situations, the court does have the right to subpoena treatment records. In the event of a potential subpoena, this process will be discussed with you.

**REQUIRED STATEMENT:** Washington State requires the following additional statement and information: Counselors practicing for a fee must be registered or certified with the Department of Health (Professional Licensing Services) for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the law RCW 18.9 regulating counselors 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 (see attached brochure). You may have the right to discipline recourse under this statute and may direct correspondence to the Department of Health, Counselor Program, PO Box 47869, Olympia, WA 98504-7869, (360) 236-4902.

**FEES AND PAYMENTS:** Fees will be discussed with you at the time of your first appointment. The fee is due at the time of service, unless other arrangements are agreed upon in advance. The standard fee for individual therapy is \$120.00, and \$130.00 for couples or family therapy. The initial appointment/assessment is \$150.00. Please plan to pay required fees, such as co-payments, at the time of each session. You need to assume responsibility for charges not covered by your insurance company, including any necessary legal fees for collections on your account.

Your signature below signifies that you have read, understood, and received a copy of this disclosure statement. Your signature does not obligate you to continue services, nor does it incur any financial responsibility, except for services already rendered. The objective of this disclosure statement is to clarify both your responsibility, and the responsibility of the therapist in the provision of therapy services. I thank you for your cooperation in this process and welcome the opportunity to work with you.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Bridget M. Gordon, LICSW  
License # 020704 LW00006873

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

BRIDGET M. GORDON, LICSW  
2209 Elm St., Ste 201  
Bellingham, WA 98225  
(360) 647-2616

**SUMMARY OF QUALIFICATIONS:**

Licensed Clinical Social Worker

Thirty-two years post Master's degree experience in Social Work, including two years of supervisory experience

Experience in individual, couples, family, and group therapy for acutely and chronically mentally ill and dually diagnosed adolescents, adults, and geriatric clients in inpatient, partial hospitalization, and residential placements

19 years in private practice providing outpatient psychotherapy

**EDUCATION:**

Virginia Commonwealth University, Master of Social Work, 1989

George Mason University, Bachelor of Arts in Psychology, 1981

**PROFESSIONAL EXPERIENCE:**

Private Practice in Psychotherapy, Associates In Mental Health, Bellingham, WA, 2002-present

Clinical Social Worker, Dominion Hospital, Falls Church, VA, 1997-2002

Field Case Manager, MAXIMUS Referral and Monitoring Agency, Leesburg, VA, 1996-1997

Mental Health Utilization Management Coordinator, Health Management Strategies, Inc., Alexandria, VA, 1994-1996

Clinical Social Worker, Northern Virginia Mental Health Institute, Falls Church, VA, 1989-1994

Clinical Social Work Intern, George Washington University Hospital, Psychiatric Unit, Washington, D.C., 1988-1989

Clinical Social Work Intern, Arlington County Department of Social Services, Foster Care, Arlington, VA, 1986-1987

**AREAS OF SPECIALIZATION:**

Individual, Couples, Family, and Group Therapy. Experienced in working with Mood Disorders, Anxiety, Dual Diagnosis (Mental Health/Substance Abuse), Adult Survivors of Childhood Abuse, and Relationship Issues.

**PROFESSIONAL AFFILIATIONS**

National Association of Social Workers

Northwest Behavioral Health Independent Provider Association

Client's Copy

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**Worker's Compensation.** If you file a worker's compensation claim, with certain exceptions, provider must make available, at any stage of the proceedings, all mental health information in their possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

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*Right to be Notified.* You have the right to be notified by AMH in the event that there are any breaches of you PHI.

VI. Provider's Duties

Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

Your provider reserves the right to change the privacy policies and practices described in this Notice. Unless your provider notifies you of such changes, however, your provider is required to abide by the terms currently in effect.

Your provider has the right to change his/her practices regarding the protected health information he/she maintains. If your provider makes changes and you are an active patient in his/her practice, he/she will provide you with a copy of the updated Notice at your first visit after the change. You may always receive the most recent copy of this Notice by calling your provider and asking for it or by visiting your provider's office to pick one up.

VII. To ask for Help or Report a Grievance

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Letisha Stokes, Office Manager, Associates in Mental Health, 1116 Key Street Suite 204, Bellingham, WA 98225, (360) 715-2488

If you believe your privacy rights have been violated, you may discuss your concerns with your provider or the above noted person. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VIII. Website

Associates in Mental Health has a website that provides information about your provider. For your benefit, this Notice is available on the website at this address: [www.amhinfo.com](http://www.amhinfo.com).

IV. Effective Date

This notice went into effect on April 14, 2003.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or legally authorized individual Date

\_\_\_\_\_  
Relationship (self, parent, legal guardian, personal representative)

\_\_\_\_\_  
Printed Name

*Client's Copy*

**Bridget M. Gordon, LICSW**  
2209 Elm St., Ste 201  
Bellingham, WA 98225  
(360) 647-2616

**AGREEMENT FOR THERAPEUTIC SERVICES**

**APPOINTMENTS:** Therapy sessions are generally scheduled for 50 minutes (unless alternative session lengths are arranged and scheduled by you and I). It is important that you arrive on time, as sessions can not be extended to compensate for late arrival.

**CANCELLATIONS:** If you must cancel an appointment, please do so at least 24 hours prior to your scheduled time. Unless you have experienced an emergency, you will be billed for the fee of one session for either not notifying me to cancel, or not canceling within 24 hours of your scheduled time.

**TELEPHONE MESSAGES:** You may call 360-647-2616 at any time and leave a message on my voice mail. Because I am often in session, I may be unable to take your call directly, but I check my messages frequently. If I am out of town, I will have another professional cover for emergencies. If you need immediate attention, contact Care Crisis Response Service (1-800-584-3578) or St. Joseph Hospital Emergency Room (360-734-5400).

**CONFIDENTIALITY:** Washington State Law insures the confidentiality of our therapy relationship with the following exceptions: (1) suspected child abuse; (2) serious risk of harm to self or others. In certain situations, the court does have the right to subpoena treatment records. In the event of a potential subpoena, this process will be discussed with you.

**REQUIRED STATEMENT:** Washington State requires the following additional statement and information: Counselors practicing for a fee must be registered or certified with the Department of Health (Professional Licensing Services) for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the law RCW 18.9 regulating counselors 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 (see attached brochure). You may have the right to discipline recourse under this statute and may direct correspondence to the Department of Health, Counselor Program, PO Box 47869, Olympia, WA 98504-7869, (360) 236-4902.

**FEES AND PAYMENTS:** Fees will be discussed with you at the time of your first appointment. The fee is due at the time of service, unless other arrangements are agreed upon in advance. The standard fee for individual therapy is \$120.00, and \$130.00 for couples or family therapy. The initial appointment/assessment is \$150.00. Please plan to pay required fees, such as co-payments, at the time of each session. You need to assume responsibility for charges not covered by your insurance company, including any necessary legal fees for collections on your account.

Your signature below signifies that you have read, understood, and received a copy of this disclosure statement. Your signature does not obligate you to continue services, nor does it incur any financial responsibility, except for services already rendered. The objective of this disclosure statement is to clarify both your responsibility, and the responsibility of the therapist in the provision of therapy services. I thank you for your cooperation in this process and welcome the opportunity to work with you.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Bridget M. Gordon, LICSW  
License # 020704 LW00006873

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date