Tara J. Platz, MEd, LMHC, CMHS

1229 Cornwall Avenue, Suite 303, Bellingham, WA, 98225, (360) 676-7342

Professional Disclosure and Financial Policy Statement

I received my undergraduate degree in psychology from Western Washington University in 2002 and my Master of Education in School Counseling from Western Washington University in 2005. I am a Licensed Mental Health Counselor (LH 00011061) and a Child Mental Health Specialist. I have been licensed in the State of Washington since 2005.

I see children, adolescents, families and adults in my practice. I strive to create a safe, supportive and collaborative working relationship in which individuals are motivated to achieve their identified goals. My overarching theoretical orientation is cognitive behavioral therapy, though other interventions such as emotion coaching, motivational interviewing and parent education and support will be employed as needed. If I cannot effectively meet your treatment needs, I will refer you to an appropriate provider.

As a client, you have a right to complete privacy except in the instances mentioned below. All information you reveal will be kept confidential. This includes information from written records. Texting and email are not appropriate forms of confidential communication and should not be used to contact me. Should exchange of information be needed, a written consent must be signed by you. In certain situations, the law requires that information be disclosed without your permission. If you threaten grave bodily harm or death to yourself or another person, the law states that certain people or agencies must be informed. If there is reason to believe that child abuse or neglect or abuse of someone who is unable to protect himself/herself is occurring, that information must be reported. If the court issues a legitimate subpoena, it is required that the information required be released.

I regularly participate in professional, confidential consultation with other mental health professionals. In the case of consultation, non-clinical identifying information including client names, are not disclosed without written consent of the client.

My fees for psychotherapy are $140.00 for a 53-60 minute session and $120.00 for a 38-52 minute session. I bill hourly at these rates, excluding the initial intake session at $160.00. The same rates will apply for Telehealth sessions. I will bill insurance companies as requested, however, authorizations and deductibles and non-payment by insurance are the responsibility of the client. You will be billed every month and are expected to pay a co-pay at the time of each session. Court and legal services are billed at $200.00 per hour. Court appearances include all preparation, consultation, travel and lost work time at a minimum retainer of $1500.00. Letters, treatment summaries and extended phone calls will be billed at my hourly rate. I refer unpaid accounts to the Physicians and Dentists Credit Bureau. If an appointment is cancelled without 24 hours notice or you do not show for your scheduled appointment, I will charge $140.00 for the missed session.

Washington State Law provides a complaint procedure through the Department of Health. Should you believe your mental health professional to have acted unprofessionally you can write to P.O. Box 47857, Olympia, WA 98504-7857 or phone (360) 236-4700.

Emergencies: You can reach me by calling my business phone at (360) 676-7342. I am not in the office every day and will return calls on the days I am in the office. **If you have an urgent situation, please call my answering service at (360) 715-2470 and they will attempt to connect me with you as soon as possible. The 24 hour Crisis Line is also available at 1-800-584-3578. If it is a life threatening emergency, please call 911 or go to the nearest hospital emergency room.**

I HAVE BEEN OFFERED A COPY OF, AND UNDERSTAND MY CLINICIAN'S DISCLOSURE INFORMATION.

Client Signature_____ Date_____

Associates in Mental Health
Administrative Office: (360) 715-2488

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 _____

- Please complete other side -

Associates in Mental Health
Administrative Office: (360) 715-2488

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.

Associates In Mental Health Administrative Office *(360) 715 - 2488 Phone*
1116 Key St Ste 204 Bellingham, WA 98225 *(360) 671 - 1842 Fax*

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

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: _____
_____
_____

Adult History

Behavioral/Trauma History (please mark yes if it was past and/or current)

Suicidal Behavior	Yes	No	Sleep Issues	Yes	No
Self-injurious Behavior (i.e. head hitting, cutting)	Yes	No	Weight Loss/Gain Issues	Yes	No
Aggressiveness/Delinquency	Yes	No	Disturbing Thoughts	Yes	No
Drug/Alcohol Issues/Concerns	Yes	No	Panic/Anxiety Attacks	Yes	No
Runaway Behavior	Yes	No	Hallucinations/Delusions	Yes	No
Acting Out Sexually	Yes	No	Past Psychiatric Hospitalization(s)	Yes	No
Other Behavioral Concerns	Yes	No	Other Emotional Concerns	Yes	No

If Yes, please explain:

_____

_____

_____

_____

Witness to Violence	Yes	No	Deaths/Losses (including pets)	Yes	No
Firearms in the Home	Yes	No	Multiple Moves/Loss of Housing	Yes	No
History of Physical Abuse	Yes	No	Extreme Financial Difficulty	Yes	No
History of Sexual Abuse	Yes	No	Multiple Job Losses in Family	Yes	No
History of Peer Abuse	Yes	No			

If Yes, please explain:

_____

_____

_____

_____

School/Work History

Easily Motivated	Yes	No	Specialized Services	Yes	No
Gets Along with Teachers/Coworkers	Yes	No	Attentional Difficulties	Yes	No
Peer Conflicts/Concerns	Yes	No	Other	Yes	No
Academic/Work Challenges	Yes	No			

Family History

Biological Mother

Abuse/Neglect History	Yes	No	Not sure	Suicidal History	Yes	No	Not sure
Sexual Abuse History	Yes	No	Not sure	Learning Disabilities	Yes	No	Not sure
Alcohol/Drug Abuse History	Yes	No	Not sure	Divorces/Separations	Yes	No	Not sure
Mental Health History	Yes	No	Not sure	Other (Medical/Social/Legal)	Yes	No	Not sure

If Yes, please explain:

_____

_____

_____

_____

Biological Father

Abuse/Neglect History	Yes	No	Not sure	Suicidal History	Yes	No	Not sure
Sexual Abuse History	Yes	No	Not sure	Learning Disabilities	Yes	No	Not sure
Alcohol/Drug Abuse History	Yes	No	Not sure	Divorces/Separations	Yes	No	Not sure
Mental Health History	Yes	No	Not sure	Other (Medical/Social/Legal)	Yes	No	Not sure

If Yes, please explain:

_____

_____

_____

_____

Please list support systems (family, friends, church, clubs, etc.)

What are some of your strengths?

Cultural/Ethnic/Spiritual Influences

What does a typical day look like for you during the week? On the weekend?

What does your sleep schedule look like during the week? On the weekend?

How many hours a day are you plugged in? What are you doing? Using?

Is there anything else that you can think of that would be helpful for me to know about?

Associates In Mental Health Administrative Office *(360) 715-2488 Phone*
1116 Key St Ste 204 Bellingham, WA 98225 *(360) 671-1842 Fax*

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:

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

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1116 Key St Ste 204 Bellingham, WA 98225 *(360) 671-1842 Fax*

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.

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

Associates In Mental Health Administrative Office
1116 Key St Ste 204 Bellingham, WA 98225
(360) 715-2488 Phone
(360) 671-1842 Fax

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