

INTAKE

PATIENT: First: _____ Middle: _____ Last: _____

Street Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Phone Number:(Home) _____ (Cell) _____ (Work) _____

May we leave a message? Yes No SS#: _____ Birth Date: _____ Age: _____ M / F

Employer: _____ Occupation: _____ For how long: _____

Driver License #: _____ or Identification #: _____ Married Single Divorced Separated Widowed

Email Address: _____ Does your email push to your phone? Yes / No

Student- Status: F/T or P/T Lives with: _____

Spouse's Name: _____ Years Together: _____ # of Children: _____

Medications I am taking: _____

Primary Doctor(s): _____ Phone #: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

RESPONSIBLE PARTY: NAME: First _____ Middle: _____ Last: _____

Mailing Address: _____ City: _____ Zip: _____

Phone Number:(Home) _____ (Cell) _____ (Work) _____ May we leave a message? Yes No

SS#: _____ Birth Date: _____ Employer: _____

INSURANCE: YES / NO PLEASE GIVE A COPY OF YOUR INSURANCE CARD TO THE FRONT DESK

Company: _____ ID#: _____ Group #: _____

How did you hear about us? Website / Yellow Pages / Google / Psychology Today / Advertising: Where: _____

Who may we thank for your referral? _____

Shipowick-Smith Counseling assessments meet legal criteria as set out by 388-805-310. A statement regarding HIV/AIDS brief risk intervention and referrals if necessary and evidence the patient was notified of the assessment results and treatment options were provided. All reports required by the courts, dept. of correction, dept. of licensing and dept. of social health services will be submitted in a timely manner. A referral will be made to the county designated specialist in the event involuntary treatment is required. COUNSELORS: April Shipowick-Smith, A.S., CDPT CO60106994, LH 00006835, DBHR 04 1459, Michael Abbott, M.A., CDP CP 00006414, DBHR 04 1459, Wayne Hersel, W.L.H., CDP CD00005627, DBHR 04 1459, Cheryl French, C.F., LW00008707, CDPT CO60209801, DBHR 04 1459 meets the education, training and experience requirements of the Department of Health, the Divisional of Behavioral Health/Recovery, Department of Social and Health Services, in WAC 388-805. PO Box 47869, Olympia, WA 98504-7869. These counselors are responsible for the overall treatment plan for each patient as required by WAC 388-805-315(1). The purpose of the health and safety registration of an individual with the department does not include recognition of practice standards, nor guarantees the effectiveness of treatment. Patient disclosure: Counseling credentialing act RCW 18-19 provides protection for public health and safety and provides a complaint process against those who commit unprofessional conduct. I have received a fee schedule if requested, setting forth the full terms of anticipated cost and length of treatment. I have the right to choose the counselor that best suits my needs. Unprofessional conduct includes false or fraudulent or misleading advertising, the commission of any act involving moral turpitude, dishonesty or corruption relating to the practice of counseling, incompetence, negligence or malpractice resulting in injury or unreasonable risk of harm, continuing to practice when a certification has been suspended, revoked, or restricted, the possession, use, prescription for use or distribution of controlled substances or legend drugs in any way except for legitimate therapeutic purposes, violation of any federal, state law or rules of any health agency, aiding or abetting an unregistered or uncertified person to engage in the practice of counseling, unless exempt by law, misrepresenting or fraud in any aspect of counseling, involving contact with public while suffering from contagious or infectious disease, promotion for personal gain of any unnecessary or useless drug, device, treatment procedure or service, conviction of any gross misdemeanor or felony relating to the practice of counseling, procuring, aiding or abetting in procuring a criminal abortion, the offering or undertaking or agreeing to cure by secret method, procedure or treatment, the willful betrayal of a counselor/client privilege as recognized by law, violation of the rebation laws which includes payment to referral of clients, the use of threats or harassment against clients or witnesses to prevent them from providing evidence in a disciplinary proceeding or legal action, drunkenness or habitual intemperance in the use of alcohol or addiction to alcohol, and abuse of a client or sexual contact with a client. In the event of agency closure, you shall be given thirty days notice, assisted with relocation, given refunds to which you are entitled and advised how to access records to which you are entitled. Other than the close of this agency, there will be no refunds of any kind whatever. This agency shall obtain your consent for each release of information to another person or entity which includes name of consenting patient, name of provider, name of person or organization to whom information is being released, nature of information, purpose of disclosure, specification of the date or event on which the consent expires, statement that consent can be revoked any time unless action has been taken in reliance on it, signature of patient, parent, guardian, or authorized representative, date, statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains. I have received HIV/AIDS information, Federal Confidential Requirements, Patient Rights, Counselor Disclosure and this agreement. I have received the results of this assessment or I have agreed to receive them later upon receipt of required background information. I have been advised of my rights to be referred to another approved alcohol/drug treatment facility and been given contact information for such referrals. I received a copy of notice of privacy regarding my health information. I have been asked if I am under DOC supervision or have been court ordered for a mental health or chemical dependency treatment or I have provided this agency with a court order exempting me from reporting requirements. Copies of this evaluation may cost me \$1.05 per page for the first thirty pages, \$.79 per page thereafter plus \$22 handling fee.

I understand my rights and the information in this Disclosure

Name _____ Date _____