EVAN FREEDMAN PhD, ABPP
Licensed Psychologist #2306

CLIENT INTAKE FORM
Please complete both sides of form.

Today's Date: _____

Name:_____ Social Security#: _____

Address: _____ Email:_____

Home Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

Work Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

Cell Phone: _____ ☐ day ☐ evening OK to leave msg? YES NO

Date of Birth: _____ Gender: _____

Referred by: _____ Primary Care Physician: _____

PRIMARY INSURANCE INFORMATION (on card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to you: _____

ID#: _____ Group/Plan #: _____

SECONDARY INSURANCE INFORMATION (on card)

Insurance Company: _____ Phone#: _____

Insurance Company Address: _____

Subscriber's Name: _____ Relationship to you: _____

ID#: _____ Group/Plan #: _____

PERSONAL INFORMATION

Where were you born/raised? _____

Religion (optional): _____ Important in up-bringing? YES NO Still? YES NO

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: _____ Employer: _____ For how long? _____

Emergency Contact: _____ Relation: _____

Phone #(s): (1) _____ (2) _____

COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

2110 Iron Street, Bellingham, WA 98225 • p: 360.734.2664 • f: 360.671.8006
evan@drevanfreedman.com • www.drevanfreedman.com

MEDICAL HISTORY

(All current medications-including herbal and over-the-counter)

Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____
Medication: _____ Dosage: _____ Date Started: _____

Significant Medical Problems-
Past: _____
Present: _____
Allergies: _____
Alcohol Use-
Past: _____
Present: _____
Drug Use-
Past: _____
Present: _____
Tobacco Use-
Past: _____
Present: _____
Caffeine Use-
Past: _____
Present: _____

Have you had previous counseling? ☐ Yes ☐ No
If yes, with whom? _____ When? _____
Would it help to contact your previous counselor (s)? ☐ Yes ☐ No

FAMILY SITUATION

Relationship/Marital Status: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Marriages, Significant relationships, and children:

Partner/Spouse	From (Year)	To (Year)	Names & ages of children from relationship	Where/with whom do they live?

GOALS FOR THERAPY

What would you like to see happen as a result of your work here?

_____
_____
_____

12/15/14

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Billing Practices / Financial Agreement

Client name: _____ Date of birth: _____

Financially Responsible Party (e.g. self or parent): _____

As the Financially Responsible Party for the client please carefully review this information and sign below:

Session fees:
Payment for services will be due at the end of each session. My basic rates are:

$290.00 for an initial intake session	$185.00 per family counseling session
$225.00 per 53+ minute individual counseling session	$265.50 per 90-minute session
$155.00 per 38-52 minute individual counseling session	$150 per each hour of psychological testing

For those with insurance, your insurance company may pay a portion of the cost of your therapy per session. In this case, your patient responsibility (e.g. co-pay, coinsurance, etc.) becomes your fee, while I collect the remainder of your fee from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company. In addition, I hold a certain number of spaces for Sliding Fee situations on a "space available" basis. The sliding fee will be determined between the two of us before or at the intake session. The fee per session will remain at that level for six months, when it will be renegotiated.

Changes in insurance coverage:
As a reminder, it is the client's/responsible party's responsibility to inform service providers of any changes in insurance coverage. Your insurance company will only inform service providers about any changes in insurance coverage **after** a bill for services has been submitted to the insurance company.

"No show" and cancelled appointments:
If appointments are missed without notification, **you, not your insurance company**, will be charged a no show fee of $100. If left unpaid no-show fees increase each month. If you need to cancel your appointment for any reason, please do your best to cancel 24 hours in advance. Appointments canceled within 24 hours of the appointment time may be subject to the no show fee.

Fees for unpaid bills:
To offset the cost of paper, printing, and administrative time needed to resend unpaid billing statements, bills that need to be resent due to non-payment will be charged a $3.00 administrative fee. In addition, there will be a 1.5% interest fee per month added to balances that have received no payment for over 30 days. Bills that remain unpaid for over 90 days are subject to being sent to a collections agency.

Non-Sufficient Funds (NSF) check returns:
Checks that are returned as NSF will incur a reprocessing fee of $10.00 per occurrence.

_____ _____
Signature of Responsible Party Evan B. Freedman, Ph.D.

_____ _____
Date Date

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EVAN FREEDMAN PhD, ABPP
Licensed Psychologist #2306

Notice of Privacy Practices Regarding Protected Health Information
effective April 14, 2003

To our clients: *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By initialing on the "Terms of Service" agreement, you are indicating that you received and reviewed this form, and you are giving consent for us to "***use***" your PHI within our practice group, or "***disclose***" your PHI to an outside entity for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

- ***Payment***: obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations***: activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization
Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your "***Psychotherapy Notes***"—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based 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
We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has suffered abuse or neglect, she/he is required by law to report it to the proper law enforcement authorities.

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- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, she/he must immediately report it to the appropriate authorities.

- **Health Oversight:** If the State Department of Health subpoenas your therapist as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)

- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe 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, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

V. Therapist's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way we have handled your privacy rights, you may contact please contact me at the above address or you may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. Our office can provide you with the appropriate address upon request.

EVAN FREEDMAN PhD, ABPP
Licensed Psychologist #2306

Terms of Service / Therapist Disclosure Statement

Welcome to my practice. Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our work together.

Education:
Board Certified Board Certified in Forensic Psychology, American Board of Professional Psychology, 2014.
Ph.D., Clinical Psychology. California School of Professional Psychology, Berkeley, CA, 1996.
MA, Clinical Psychology. California School of Professional Psychology, Berkeley, CA, 1993.
MA, Theological Studies. Harvard University, Harvard Divinity School, Cambridge, MA, 1990.
BA, with Honors in Psychology. Marlboro College, Marlboro, VT., 1987.

Approach to Therapy:
I view the therapeutic relationship as a collaboration in which we work with your strengths, culture, and life experience to reach goals we establish together. I utilize a variety of integrated theoretical approaches for treatment, including emotionally focused, cognitive-behavioral, existential, family systems, and mindfulness. It is my hope to inspire change through support, gentle confrontation and humor. Therapy may be offered in individual, couples, or family format, depending on what is assessed to be most helpful, effective and ethical. My intent is to provide a safe and comfortable mental and emotional space to explore and create change.

If you or I ever feel that our therapeutic relationship does not suit your needs, a referral to another appropriate mental health professional will be happily provided. You also have the right to refuse treatment and the right to a confidential relationship to the extent described in RCW 18.19.180(1) through (6).

Our Relationship:
Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the sessions you have with me. Please do not invite me to social gatherings, contact me via social networking, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Given the size of our small community, we may
encounter each other in public. As part of the intake process we will discuss how to make any chance meetings most comfortable for you.

Consultation and Peer Training:
Good clinical practice requires occasional peer review of my work and consultation with other professionals. Please be aware that I may anonymously review your case to improve my ability to treat effectively and my competency as a clinician. In the course training I provide to other professionals, I may use vignettes from my clinical work. Any personal information will be disguised to completely protect the identities of my clients unless written permission is first granted.

Confidentiality and Privacy:
I have been provided a copy of Dr. Freedman's "Notice of Practices Regarding Protected Health Information" and read and understand the information provided.

_____ **Initial here to acknowledge receipt**

Billing Practices:
Billing practices are explained in detail on a separate "Billing Practices / Financial Agreement" page. By initialing below, I acknowledge that that the Financially Responsible Party (e.g. self or parent) has read and understood the information provided.

_____ **Initial here**

Attendance:
Attending scheduled appointments is critical to the success of counseling. Repeatedly missing appointments can be detrimental to the counseling process and potentially costly when no show fees accumulate. If missing scheduled appointments becomes a concern, I will initiate a conversation about how to remain engaged in services. At that time, I may request that an attendance contract be discussed and signed.

Emergencies: If there is an emergency between sessions, I can be reached by phone at 360.734.2664 ext. 11. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. In an emergency I will make all efforts possible to schedule a session as soon as possible. If you are unable to reach me when you feel the need for some emergency help, emergency Volunteers of America have a 24 hour on call crisis line at **1-800-584-3578**. In the case of a life-threatening or please call **911.**

Treatment consent:
I consent to receiving mental health services from Evan Freedman, PhD, ABPP. I have been informed of the type of counseling I will receive from Dr. Freedman, the methods and techniques used, his education, training and experience and the cost of counseling services. Furthermore, I have received this information in writing.

Mental health professionals practicing for a fee must be registered or certified with the Department of Health for protection of the public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

_____ _____
Client's Signature Evan B. Freedman, Ph.D.

_____ _____
Date Date

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Authorization for Disclosure of Healthcare Information

Client Name: _____ Birth date: _____/_____/_____ SS#:_____

Previous Name(s): _____ Address: _____

Information is to be disclosed to ☐ and/or received from ☐:

Name of Person/Agency: _____

Address: _____ Phone: (____)_____Fax: (____)_____

For purposes of: ____evaluation ____treatment ____forensic assistance ____other: _____

I authorize Dr. Evan Freedman to release my:

____ General Mental Health Record
____ Information related to chemical dependency/substance abuse
____ Psychotherapy Notes (the private content of your conversations with your therapist)
____ Information related to HIV/AIDS and/or sexually transmitted diseases
____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 12 months after the last dated signature.

_____ _____
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

12 Month Signature Updates:

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date

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