Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105

NEW CLIENT INTAKE FORM

GENERAL INFORMATION

Full Name: _____

Name you prefer: _____Age: _____ Date of Birth: _____

Race: □ White □ Black □ Hispanic □ Asian □ Other: _____

Gender Identity: □ Male □ Female □ Genderqueer □ Trans □ Other: _____

Sexual Orientation: □ Gay □ Lesbian □ Bisexual □ Hetero □ Queer □ Other: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May I send mail here? □ Yes □ No

Email Address: _____ May I send a message here? □ Yes □ No

Home Phone: (____)_____ May I leave a message here? □ Yes □ No

Cell Phone: (____)_____ May I leave a message here? □ Yes □ No

Work Phone: (____)_____ May I leave a message here? □ Yes □ No

EDUCATION/EMPLOYMENT INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ AA □ BA/BS □ Post-Grad

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____

Annual Salary: _____

RELATIONAL INFORMATION

Current Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Are You Content with Your Current Status? □ Yes □ No. If No, Briefly Explain: _____

_____

If Partnered/Married, How Long: _____ If Separated or Divorced, How Long: _____

With Whom Do You Currently Live? *(Check all that apply)*

□ Alone □ Spouse/Partner □ Children (#___) □ Parent(s) □ Sibling(s) □ Boyfriend/girlfriend

□ Other: _____

PRESENTING ISSUES

Please tell me why you are seeking counseling: _____

_____

_____

_____

How long have these concerns been causing you distress? _____

Please check the boxes below if you've had problems or concerns with any of the following:

Aggressiveness	□ Past □ Present	Loneliness	□ Past □ Present
Alcohol Abuse	□ Past □ Present	Loss of Control	□ Past □ Present
Anger	□ Past □ Present	Making Decisions	□ Past □ Present
Anxiety	□ Past □ Present	Memory	□ Past □ Present
Apathy	□ Past □ Present	Nervousness	□ Past □ Present
Bad Dreams	□ Past □ Present	Pain	□ Past □ Present
Change in Appetite	□ Past □ Present	Panic	□ Past □ Present
Compulsivity	□ Past □ Present	Physical Abuse	□ Past □ Present
Depression	□ Past □ Present	Racing Thoughts	□ Past □ Present
Difficulty Breathing	□ Past □ Present	Rapid Heart Rate	□ Past □ Present
Digestive Upset	□ Past □ Present	Seeing Things	□ Past □ Present
Dizziness	□ Past □ Present	Serious Illness	□ Past □ Present
Drug Abuse	□ Past □ Present	Sexual Abuse	□ Past □ Present
Eating Problems	□ Past □ Present	Sexual Problems	□ Past □ Present
Emotional Abuse	□ Past □ Present	Sleep Trouble	□ Past □ Present
Emotional Instability	□ Past □ Present	Social Anxiety	□ Past □ Present
Fatigue	□ Past □ Present	Stress	□ Past □ Present
Fears	□ Past □ Present	Trauma	□ Past □ Present
Finances	□ Past □ Present	Trouble Focusing	□ Past □ Present
Grief/Loss	□ Past □ Present	Trouble Relaxing	□ Past □ Present
Guilt	□ Past □ Present	Unhappiness	□ Past □ Present
Headaches	□ Past □ Present	Unwanted Thoughts	□ Past □ Present
Hearing Noises/Voices	□ Past □ Present	Verbal Abuse	□ Past □ Present
Hopelessness	□ Past □ Present	Withdraws/Isolates	□ Past □ Present
Impulsive Behavior	□ Past □ Present	Weakness	□ Past □ Present
Legal Matters	□ Past □ Present	Work Problems	□ Past □ Present

Have you been previously diagnosed with a mental health/psychiatric condition? □ Yes □ No

If Yes, please list: _____

Are you currently having suicidal thoughts? □ Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

If Yes, when and how: _____

Have you had any previous psychiatric hospitalizations? □ Yes □ No

If Yes, when and where: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____)_____

Address: _____ City: _____ Zip: _____

Are You Currently Receiving Medical Treatment? □ Yes □ No

If Yes, Please Specify: _____

List any Previous Conditions, Illnesses, Surgeries, Hospitalizations, or Injuries you've had:

_____

Current Medications: Dosage: Taking for:

_____

_____

_____

SOCIAL SUPPORTS

Do you have a personal support system? □ Yes □ No

If Yes, Who: _____

Do you regularly attend a place of worship? □ Yes □ No

If Yes, Where: _____

How important are spiritual matters to you? □ Not at all □ Somewhat □ Very much

Would you like your spiritual/religious beliefs to be included in your counseling? □ Yes □ No

REFERRAL SOURCE

How were you referred to me? □ Online Directory □ Website □ Friend/Family □ Other

Name of person/directory/other: _____

May I have your permission to thank this person for the referral? □ Yes □ No

INSURANCE

Provider: _____

Policy Number: _____

Subscriber's Name/Date of Birth: _____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105
meghanwhitlockcounseling.com

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or "PHI"). I must follow the privacy practices described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal and State of Washington law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in supervision and consultation so that I may provide high quality services for your benefit. My Supervisor/Consultant contact information is available upon request.

2. Health care operations: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing or credentialing activities. I will notify you in advance of any such disclosure.

3. Required or permitted by law: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.

e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.

f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization:

1. Marketing communications: I will not use your health information for marketing communications without your written authorization.
2. Payment: I may not disclose PHI to your insurance company for payment purposes without your written authorization.
3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I-A. Above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, to your attorney, or to your health care providers. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within 15 days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years of age or older, please note that certain portions of the minor's medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.

B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction writing address to me, the "Privacy Officer," as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. It is my obligation to you to inform you if there are any unauthorized releases of your PHI by me. If a breach of your PHI has been made I will explain the possible scope of the disclosure, the risks associated, and the steps I have taken/will take to deal with the breach.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a "Statement of Disagreement," based upon your proposed amendment, must be added to your record.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to me, the Privacy Officer, at any time.

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Meghan Whitlock, MA LMHC, by telephone at (206) 707-5105, or in writing at 600 N. 36th St. Suite 406, Seattle WA 98103. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360)

236-4900, P.O. Box 47869, Olympia, WA 98504. I will not retaliate against you if you file a complaint with me or the Department of Health.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on September 1, 2015.

B. Changes to this Notice: I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will inform you, and you may obtain any revised notice by contacting me.

Acknowledgement of Receipt of Notice of Privacy Practices

Meghan Whitlock, MA LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for Meghan Whitlock, MA LMHC.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

The Notice of Privacy Practices also describes my individual rights and responsibilities, and the duties of Meghan Whitlock, MA LMHC with respect to my protected health information.

_____ _____
Signature of Client Date

This form will be retained in the mental health record.

* * * FOR OFFICE USE ONLY * * *

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the Acknowledgment
☐ An emergency situation prevented me from obtaining Acknowledgment
☐ Other: _____

_____

THERAPIST DISCLOSURE STATEMENT & CLIENT INFORMED CONSENT

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105
meghanwhitlockcounseling.com

You have the right to choose a counselor who best suits your needs and purposes. With that in mind, the following disclosure is provided to you. Please read each section carefully and initial each page.

I. THERAPIST DISCLOSURE TO CLIENT

- **Credentials**: I am a Licensed Mental Health Counselor in Washington State (#LH60436315)
- **Education, Training, and Experience:** I received a Bachelor of Arts in Psychology from the University of Montana, with a minor in Human and Family Development. I completed my Master of Arts in in Applied Psychology at Seattle University. I completed my internship hours at Compass Health working with individuals, children and families, and couples. After graduation, I worked as the lead therapist for an Intensive Special Learning Program and in outpatient settings with children and families. I have had experience with children, adolescents, adults, and families in various accredited agencies since 2005.
- **Professional Memberships:** I am a member of the Seattle Counselors Association, Washington Association for Play Therapy, Seattle Play=Peace Pop-Up Adventure Play, and the American Mental Health Counselors Association.
- **Services Provided:** I provide psychotherapy for individuals (children and adults), families, and couples.

II. WORKING RELATIONSHIP

- Confidentiality: The privacy of your personal information is of utmost importance. I am compliant with current Federal and State of Washington laws, including the Health Insurance Portability and Accountability Act of 1996. Federal and State laws set the limits on confidentiality.

I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:

a) Duty to warn: Your PHI may be disclosed if I determine a need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.

b) Danger to self: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.

c) Child or elder abuse or neglect: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Children's Protective Services (CPS).

d) Court order: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.

e) Crime against me or within office premises: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.

f) Other disclosures: Your PHI may be disclosed for public health activities, health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties involved if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

■ Health Care Coordination: It is important to make sure that the problems you present are not related to a physical health difficulty. Since I am not a medical provider, I cannot determine if you have physical conditions that might be related to your health and our work. Therefore, you should get a physical examination from a physician as soon as possible. It would be best to tell your medical provider that you will be working with me so we might begin to coordinate your health care. With your written authorization, I may obtain your medical records so I have a better understanding of your overall health.

■ Risks and Benefits: During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Counseling is intended to alleviate problems, but sometimes as you get to the root of some issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in the future.

■ Free Introductory Session: I offer a free introductory session for all new clients. We can schedule this session by phone or email. I will ask that you complete the following paperwork prior to our meeting: Informed Consent, Notice of Privacy Practices, and the New Client Intake. During the first session, we can review your paperwork, discuss the reasons why you are seeking counseling, and talk about your goals. Additionally, I can answer any questions you might have about therapy. If we decide we might be a good fit, we will then schedule another appointment. Participating in an introductory session does not obligate you to continue counseling with me. Please note that this is for *new clients only;* returning or prior clients are not eligible.

■ Appointments: We will schedule our appointments either via email/phone or in person at the end of a session. Please notify me via phone, at (206) 707-5105, as soon as possible if you have any schedule conflicts or emergencies which would require you to cancel our appointment. Likewise, I will notify you via phone if I should need to cancel our appointment.

When you arrive for an appointment, please remain in the waiting room and I will promptly meet you. Our sessions will be 45-50 minutes long, and we will need to end on time. I charge the full session fee for any sessions that are shortened due to your late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

I will have to charge you the full session fee if you do not give me 24 hours notice of any cancellations. You will not be charged if I cancel our appointment. Please be prepared to pay the full session fee from your appointment that was either missed or cancelled late (not within 24 hours) when you attend your next scheduled appointment.

■ Fee for Services: My standard fee is $125.00 per 45-50 minute session. This is the same fee charged for any missed or late canceled appointments. If you are paying the full fee out of pocket with cash the session will be charged at $115.00 per 45-50 minute session. Phone calls made or received on behalf of the client will be billed in 15 minute increments at a prorated rate of $25/hour. I will not charge for one hour of phone time used per month. Additional fees might include: preparation of requested documents (e.g. letters to lawyers, government agencies, etc.)

and copying and sending records. I will discuss any fees with you at the time of a request. Periodically I raise my fees to adjust to the increase in the cost of living and doing business, and I will give you one month's notice of any fee increase. Please be aware that in all cases, payment for my services is always your responsibility.

■ Payment for Services: I accept cash, credit card, or personal check payments made payable to **Meghan Whitlock** or **Meghan Whitlock Counseling**. Payments are due directly to me at the time of service (at the end of each session). If paying by cash or check is a barrier, I can arrange to have you pay by debit/credit card using Square (though this will incur a small fee). If payments are not made at the time of service or in a timely manner that we have agreed upon, then I may notify debt collectors. I will charge a $36 fee for any returned checks.

■ Insurance: I am a preferred provider for Premera, Regence, LifeWise, and First Choice Health insurance plans. I do accept certain insurance plans and I am an out-of-network provider for others. Please ask me about whether I accept your particular plan. If I am an out-of-network provider for your insurance plan, I am happy to provide you with a receipt and you can submit it to your insurance company for possible reimbursement. However, I cannot guarantee reimbursement and you remain ultimately responsible for all costs and fees.

■ Emergency, Urgent, or Other Contacts: You may call me anytime and leave a message on my voicemail, and I will get back to you as soon as I can. I retrieve my messages daily, and whenever possible, I will get back to you within 24 hours.

You may also email me with your message; however, if you need to cancel an appointment within 48 hours of the scheduled time, I need to be contacted by phone. Please remember that anything you send over email is not confidential.

I am not able to provide on-call crisis or emergency services. If you have a physically or psychologically life-threatening emergency, please immediately call 911, and/or the Seattle Crisis Clinic at (206) 461-3222. The Crisis Clinic has 24-hour availability to offer crisis counseling, community resources, and emergency assistance. Do not use email to communicate emergent or crisis information.

If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with alternate contact information should you need support during my absence.

■ Therapy Relationship and Professional Boundaries: It is my intention to maintain a warm, safe, and professional environment where I consider your best interests my priority. Because I have the utmost respect for you and our therapeutic relationship, professional boundaries are essential so that no harm or damage is done. I uphold the following practices regarding professional relationship boundaries:

1) I will not, at any time, have a social relationship with you outside of my office, even after we have ended our therapeutic relationship; this includes contact on social networking sites, like Facebook. I will not accept social or family event invitations from you, and I will not offer them to you. This is not for a lack of interest or care.
2) I will not, at any time, have physical or sexual contact with you, aside from shaking your hand as a greeting or parting.
3) I will not, at any time, accept any gifts from you. I may accept a card or note from you.
4) If I were to see you in public at any time, I will not initiate any contact or familiarity with you. This is to ensure your confidentiality as my client. If you choose to initiate a visible or audible greeting, I will reciprocate, but I will not attempt further communication unless you request it.
5) I will not, at any time, have a relationship with you beyond my range of psychotherapy, counseling, and referrals, and the collection of fees for these professional services. While this includes not having any social or sexual relationships with you, it also

includes any business and financial relationships. Additionally, I will not provide any services beyond my expertise, including legal or medical advisement.

6) I will only provide appropriate referrals to other health professionals, with your consent. I do not make referrals to lawyers, accountants, financial planners, credit counselors, or other non-healthcare related individuals and agencies. I do not accept payments for giving referrals.

7) I will uphold confidentiality standards pertaining to Federal and State of Washington law during the course of therapy and thereafter. By law, our sessions are considered "privileged." Neither your death nor mine terminates your confidentiality rights.

■ Therapeutic Work, Duration, and Termination: You have the freedom to make decisions as you please. You may engage in therapy for as long as you like. You may, at any time, change your goals for therapy, and/or you may choose to end our relationship, no matter where you are in the process of goal achievement. I respect and promote your right to make your own decisions. If you would like to end therapy, I would only ask that we first discuss this in person.

If more than 30 days have passed since our last contact, and I have not received any word from you, I will accept that as your notice that you no longer wish to continue counseling and that our therapeutic relationship is terminated.

■ Complaints: If you have a complaint or inquiry about my professional service that cannot be resolved with me directly, please contact the Washington State Department of Health. Complaints or inquiries can be sent to: The Department of Health, Health Professions Quality and Assurance Division, P.O. Box 47869, Olympia, WA 98504-7869.

Confirmation of Informed Consent

Meghan Whitlock, MA, LMHC
Meghan Whitlock Counseling, LLC
3417 Evanston Ave. N. Suite 212
Seattle, WA 98103
206-707-5105

Please initial each statement, and sign below:

_____ I have read the Disclosure Statement for Meghan Whitlock, MA LMHC and I understand it.

_____ I have had the opportunity to ask questions and be provided further explanation pertaining to the Disclosure Statement.

_____ I agree to follow the terms in the Disclosure Statement.

_____ I give my consent for treatment as outlined in this Disclosure Statement.

_____ I will receive a copy of this Disclosure Statement with my signature.

_____ I understand that my therapeutic relationship with Meghan Whitlock, MA LMHC may be discontinued if the terms in this agreement are not fulfilled by either of us.

_____
Client Name (please print)

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date

This form will be retained in the mental health record.