Kitsap Counseling and Hypnotherapy Center

CLIENT INFORMATION

Welcome to Kitsap Counseling and Hypnotherapy Center. I look forward to providing you with excellent and efficient counseling services. Please take a moment to fill out this form. The information will help me to better understand your current situation and life challenges. This information is confidential and will not be released to anyone without your written permission unless I am compelled to in accordance with Washington State law.

Today's Date: _____

Type of Services Being Sought [*Check all that applies*]:
____Individual Adult, ____Individual Minor, ____Marital/Couple, ____Family/Family-of-Origin

Referral Source: ____School, ____Other Client, ____Ad, ____Friend/Relative, ____Legal System, ____Self, ____Other (please list): _____.

Primary Client Name: _____ DOB: _____ Ethnicity: _____

Age: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer/School: _____

Person filling out form: _____ Relationship to client: _____

Emergency contact: _____ Emer. Contact Phone: _____

If the client is a child, is he/she the subject of custody proceedings? ___Yes ___No

Financial Guarantor (for fees/other charges in arrears):
Name: _____ SSN or DL#: _____

Names of individuals living in your primary household (Check any who are attending counseling)

A	Last, First Name	Relation	DOB	Employment/School & Grade	Ethnicity

Additional Household Members / Second Household /Children Outside the Home

	Last, First Name	Relation	DOB	Employment/School & Grade	Ethnicity

CLIENT COFIDENTIAL COMMUNICATIONS

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that KHC staff communicate financial and/or medical information to you in confidence by a particular methods or to certain locations. **Please list ONLY the methods by which you want to be contacted:**

Voice Communication

____Home Phone: _____ Can a message be left? ____Yes____No
____Work Phone: _____ Can a message be left? ____Yes____No
____Cell Phone: _____ Can a message be left? ____Yes____No

If Voice Messages can be left, Check One :

____Messages can contain medical information **OR** ___Leave message with name/call-back # only.
____Messages can be left with a specific person(s) [*list names*] _____
____Messages left with a specific person can discuss: _____

Written Communication

___Do NOT sent written medical information to me
___Mail information to my home address on file
___Mail to my work/office address on file
___Mail information to other address:
List_____
___Fax to the following number: _____
___I do not want to communicate by E-mail
___You can communicate via E-mail with me at: _____

Follow-Up Communication

___It is okay for me to be contacted after completion of services for purpose of follow-up.
___It is NOT okay for me to be contacted after completion of services for purpose of follow-up

Sources of Stress: What are the primary concerns that bring you here for counseling?

1._____

2._____

3._____

When did the problem(s) start?

_____

_____

_____

What is the most important thing your counselor should know about these concerns?

_____

_____

_____

What do you hope to accomplish through the use of my services?

_____

_____

_____

How did you hear about my services?

_____

Hypnotherapy Clients Only: Have you ever been hypnotized before? ____Yes ____No

If yes, by whom: _____ Where: _____ When: _____

Reason: _____

Outcome: _____

----------*for office use only*----------

Medical/Mental health releases on file:

_____*address:*_____*phone:*_____

_____*address:*_____*phone:*_____

Other:

_____*address:*_____*phone:*_____

Parental Release/Parenting Plan on File/Notes:

_____

_____

_____

AGREEMENT OF PARENTS/GUARDIANS IN CASES OF CUSTODY PROCEEDINGS

Therapy can be a very important resource for children experiencing separation and divorce. The counselor can provide a neutral setting where children can explore their thoughts and feelings about these issues. In this case, a child cannot be seen unless both parents agree to the child receiving therapy. An exception to this is if one parent has legal documentation (e.g., a legally signed parenting plan) stating they have sole decision making for mental health and medical treatment for the child. The parent would be required to provide a copy of this document to the therapist. However, the usefulness of therapy is extremely limited when therapy itself becomes simply another area of conflict between parents. Any matter that is brought to the therapist's attention by either parent regarding the child may be revealed to the other parent unless otherwise stated in the parenting plan. It is best if all parents/guardians stay in frequent communication with the therapist regarding the child's emotional well-being.

As a therapist I do not choose sides and do not render forensic opinions. The parent must understand completely that I as the therapist am providing treatment NOT acting as an evaluator. The parent must also understand that I as a therapist am not conducting a custody, visitation, or parenting evaluation. I want you to understand the reasons why I do not provide your records for custody disputes. I may not possess the professional competency to make a decision about issues besides those I deal with in therapy. Therapy often involves full disclosure of information that you might not want revealed in a court of law. In testifying or making a deposition often changes the therapeutic relationship, and I hold the therapeutic relationship as the most important priority. In those cases where you are seeking custody evaluations and recommendations, I will be happy to refer you to those who specialize in that field.

INFORMED CONSENT OF PARENT/GUARDIANS REGARDING CUSTODY PROCEEDINGS

I, the parent/guardian(s) am aware that requesting the release of treatment notes, plans, or evaluations for forensic purposes or therapist testimony about the content of my child's treatment will interfere with the therapeutic process. Therefore, I knowingly and freely waive my right to request the release of information (beyond attendance, dates, and length of our sessions) to my attorney. I understand that release of clinically significant information to any officer of the court shall only be in response to a court order or subpoena. I understand if records are requested by both parent and the parenting plan states both parents have medical decision making, then the policy is to send records to BOTH parents even if the other parent has not requested records.

I have read and understand the issues and points made above. I have discussed those points I do not understand and my questions have been answered satisfactorily. I agree to act in accordance to the aforementioned policies of James McCormack, MA-LMFTA, & Kitsap Hypnosis Center, LLC. I further state that I am the legal custodian of this child and have no court orders in effect that would prohibit me from consenting to the treatment of this child. I also understand that my therapist/counselor can rely on my representation that I am authorized to consent to health care for the minor patient as true without incurring any civil or criminal liability for such reliance, pursuant to RCW 70.02.130. My signature below indicates I agree to all these points and will follow fully to the best of my ability.

IF YOU DO NOT SIGN OR ALL LEGAL PARENTS/GUARDIANS DO NOT AGREE TO THIS AGREEMENT, THEN WE CANNOT PROVIDE THERAPY TO YOUR MINOR/CHILD.

_____ _____
Responsible Party/Client Signature Date

_____ _____
Additional Legal Parent/Guardian Signature Date

_____ _____
James McCormack, MA-LMFTA, Rht Date

____ Copy accepted by client _____ Copy accepted by additional person