

Koala Smiles Counseling, PLLC

Helping You Find Your Smile Again!

Shawnda Brese, MA, LMFT

*Child, Adolescent, Adult & Family Therapist
601 Valley Ave NE, Suite F, Puyallup, WA 98372
(253) 733-1975 www.koalasmiles.com*

CHILD INITIAL ASSESSMENT FORM Identifying Information

Today's Date: _____
Name of child _____ Age _____ Date of Birth _____
Race: _____ Religion _____, Sex: M F Present Address: _____
City: _____ State: _____ Zip: _____ Home phone: _____ Other phone: _____
SSN: _____ Email Address: _____ Preferred Contact Method: _____
Okay to Leave Voicemail: Y N Okay to Email: Y N Okay to identify as Mental Health Provider: Y N
Name of person completing form (if different than child): _____ Relation: _____
How did you hear about Koala Smiles Counseling, PLLC: _____
Who has current legal custody of child? (Please attach a copy of the current parenting plan) _____

Is there now, or has there been in the last 5 years, an Order For Protection or Restraining Order in place from any state on a member of this household? No __, Yes __ (please explain) _____

Is there any current or pending legal actions against any member of the household (including the child)?
No __, Yes __ (please explain) _____

Has there been mental health services involved with child before? No __, Yes __ (please explain) _____

Is the County Social Services involved with this child or family? No __, Yes __ (how?) _____

Family History

Parents

Parents are / were married __ years.

Are parents divorced? __Yes __No If yes, how old was the child at time of divorce: _____

Is there any significant information about the parents' relationship or treatment towards the child which might be beneficial in counseling: __Yes __No If yes, explain: _____

Client's Mother (Step-mother)

Name: _____ Age: _____ Phone: _____

__Natural parent __Step-parent __Adoptive parent __Foster parent Other: _____

Is there anything unusual or stressful about the child's relationship with the mother? __Yes __No

If yes, explain: _____

Client's Father (Step-father)

Name: _____ Age: _____ Phone: _____

__Natural parent __Step-parent __Adoptive parent __Foster parent Other: _____

Is there anything unusual or stressful about the child's relationship with the father? __Yes __No

If yes, explain: _____

Siblings and Others in Household

Names

Age

Gender

M F

Lives
Home AwayQuality of Relationship w/ Client
Poor Average Good

_____	____	____	____	____	____	____	____	____
_____	____	____	____	____	____	____	____	____
_____	____	____	____	____	____	____	____	____
_____	____	____	____	____	____	____	____	____

Others in child's life

Age

Gender

M F

Lives
Home AwayRelationship
to childQuality of Relation w/ Client
Poor Average Good

_____	____	____	____	____	____	____	____	____
_____	____	____	____	____	____	____	____	____
_____	____	____	____	____	____	____	____	____

Medical Information

Child's Physician's Name and/or Clinic: _____ Phone _____

Are there any physical or medical problems I should be aware of? No __, Yes __ (please explain) _____

Is the child currently taking any medication? No __, Yes __ (please state the medication and dosage) _____

Has there been any history of head trauma, seizures or loss of consciousness? No __, Yes __ (please explain) _____

Developmental / Social

Pregnancy, Labor and Delivery

Duration of Pregnancy _____

Did the mother smoke during this time? No __, Yes __ (if yes, how much per day?) _____

Was there any drinking or drug use by mother during this time? No __, Yes __ (please describe fully) _____

Were there any complications during pregnancy (i.e., illness, injuries, hospitalization, etc.)? No __, Yes __ (please describe) _____

Any complications during labor/delivery (i.e., premature, lack of oxygen, injuries to mother or child, incubator care, infections, etc.?) No __, Yes __ (please explain) _____

Infancy - Toddler Period (Birth to 2 years of age)

Primary caregiver(s) during this time: _____

Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No __, Yes __ (please explain) _____

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No __, Yes __ (please explain) _____

Early Childhood (3 to 5 years of age)

Primary Caregiver(s) during this time: _____

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No __, Yes __ (please explain) _____

Any changes in, or separations from, primary caregivers lasting more than 2 weeks? No __, Yes __ (please explain) _____

Were there any physical or emotional difficulties for either the child or the primary caregivers during this time? No __, Yes __ (please explain) _____

Please rate your opinion of the child's development (compared to others the same age) in the following areas:

	Below Average	Average	Above Average
Social			
Physical			
Language			
Intellectual			
Emotional			

For each type of development that you rated above as below average, please describe current areas of concern. Be specific.

List your child's three greatest strengths:

1. _____
2. _____
3. _____

List your child's three greatest weaknesses or needed areas of improvement:

1. _____
2. _____
3. _____

List your child's main difficulties in school:

1. _____
2. _____
3. _____

List your child's three main difficulties at home:

1. _____
2. _____
3. _____

Briefly describe the child's friendships: _____

Briefly describe the child's hobbies or interests: _____

What report card grades does the child usually receive? _____

Have these changed lately? ____Yes ____No If yes, how: _____

Briefly describe the child's way of expressing the following emotions or behaviors:

1. Anger: _____
2. Happiness: _____
3. Sadness: _____
4. Anxiety: _____

Current School Information

Present school and grade: _____ Class placement: ____ Mainstream; ____
Special Class (where) _____ Teacher or Advisors' name: _____ IEP in place?
No ____, Yes ____ Please rate the child in school on the following:

	Very Poor	Poor	Average	Good	Very Good
Writing Skills					
Arithmetic Skills					
Reading Skills					
Attendance					
Behavior Management					
Work Completion					
Social Interaction					

Counseling Goals

What goals or changes would you like to see your child work towards in their counseling experience?

1. _____
2. _____
3. _____
4. _____

Current Symptoms: Please rate the child on the following as occurring now or in the recent past:

Symptom	Frequently	Sometimes	Rarely	Never
Fails to give close attention to details or makes careless mistakes				
Has difficulty sustaining attention in tasks or play activities				
Doesn't seem to listen when spoken to directly				
Doesn't follow through on instructions and fails to finish tasks				
Has difficulty organizing tasks and activities				
Avoids, dislikes or is reluctant to engage in tasks that require sustained effort				
Loses things necessary for tasks or activities				
Is easily distracted by external stimuli				
Is forgetful in daily activities				
Fidgets with hands or feet or squirms in seat				
Leaves seat in situations in which remaining seated is expected				
Runs about or climbs excessively in situations in which it is inappropriate				
Has difficulty playing or engaging in leisure activities quietly				
Is "on the go" or acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before the questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others (e.g., butts into conversations or games)				
Symptom	Frequently	Sometimes	Rarely	Never
Loses temper				
Argues with adults				
Actively defies or refuses to comply with adults' requests or rules				
Deliberately annoys people				
Blames others for his or her mistakes or misbehavior				
Is touchy or easily annoyed by others				
Is angry or resentful				
Is spiteful or vindictive				
Symptom	Frequently	Sometimes	Rarely	Never
Bullies, threatens or intimidates others				
Initiates physical fights				
Has used a weapon that can cause serious physical harm to others				
Has been physically cruel to people				
Has been physically cruel to animals				
Has stolen while confronting a victim				
Has forced someone into sexual activity				
Has deliberately engaged in fire setting with intention of causing serious damage				
Has deliberately destroyed others' property (other than by fire setting)				
Has broken into someone else's house, building or cars				
Has stolen valuable items without confronting a victim (i.e., shoplifting)				
Stays out at night despite parental prohibitions				
Has run away from home overnight or longer				
Is truant from school				

Symptom	Frequently	Sometimes	Rarely	Never
Depressed or irritable mood most of the day				
Markedly diminished interest or pleasure in all or nearly all activities				
Weight loss when not dieting, or weight gain, or increase or decrease in appetite				
Insomnia (not sleeping) or Hypersomnia (sleeping too much)				
Overly agitated or slowed down in movements				
Fatigue or loss of energy				
Feelings of worthlessness or excessive or inappropriate guilt				
Diminished ability to think or concentrate, or indecisiveness				
Recurrent thoughts of death (not just fear of dying)				
Suicide thoughts without a plan for committing suicide				
Suicide attempts or planning of suicide				
Symptom	Frequently	Sometimes	Rarely	Never
Has experienced traumatic event(s)				
Has recurrent and intrusive distressing memories of traumatic event(s)				
Does repetitive play with themes or aspect of the traumatic event(s)				
Recurrent distressing dreams (with or without recognizable content)				
Acts or feels as if the traumatic event were recurring				
Psychological distress at internal or external reminders of the traumatic event(s)				
Physical reacting to internal or external reminder of the traumatic event(s)				
Tries to avoid thoughts, feelings or conversations associated with the event(s)				
Tries to avoid activities, places or people that arouse memories of the event(s)				
Inability to recall important aspects of the trauma(s)				
Markedly diminished interest of participation in significant activities				
Feeling of detachment or estrangement from others				
Restricted range of affect (i.e., unable to have loving feelings)				
Sense of foreshortened future				
Difficulty falling or staying asleep				
Irritability or outbursts of anger				
Difficulty concentrating				
Hypervigilance				
Exaggerated startle response				
Symptom	Frequently	Sometimes	Rarely	Never
Excessive distress when separation from home or loved ones is anticipated				
Excessive worry about losing, or harm happening to, a loved one				
Excessive worry that some bad event will lead to separation from loved ones				
Reluctance or refusal to go to school or elsewhere because of fear of separation				
Excessive fear to be alone at home or elsewhere without loved ones				
Reluctance or refusal to go to sleep without being near loved ones				
Nightmares involving themes of separation				
Complaints of physical symptoms when separation occurs or is anticipated				
Substance use resulting in a failure to fulfill major obligations at school or work				
Substance use in situations in which it is physically hazardous (i.e., driving)				
Substance use related to legal problems				
Substance use despite recurring social or interpersonal problems caused by use				

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OUTPATIENT SERVICES CONTRACT / INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies as well as the rights and responsibilities for our therapeutic relationship. Please read it thoroughly before you sign it and consent to treatment and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

CLINICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

QUALIFICATIONS/EDUCATION/EXPERIENCE

- Licensed Marriage and Family Therapist through the state of Washington, Licensure #LF60462717.
- Clinical Fellow Member of the American Association for Marriage and Family Therapy (AAMFT), Member # 151675.
- Master's Degree in Counseling Psychology with emphasis in Marriage and Family Therapy at Chapman University in 2011.

- Bachelor's Degree in Psychology at Saint Martin's University in 2008.
- Child Mental Health Provider with experience working with children, adolescents, adults, couples, and families with a wide range of issues from mild to severe, as well as previous experience in training and mentoring young adults / college students on job related skills and resume/career development skills.
- Experience working in school systems (Bonney Lake High School, Daffodil Elementary & Orting School District) providing counseling services for children and adolescents while coordinating with school officials and parents.
- I am committed to furthering my knowledge and expertise by regularly participating in specialized training and receiving ongoing clinical consultation.

TREATMENT ORIENTATION

My primary approach to counseling is client-centered and focuses on clients' strengths and abilities to make positive changes in their lives. I believe that one of the essential ingredients for therapeutic change is trust between the therapist and client. Clients are encouraged to set their own goals for therapy and to be full and active participants in their own approaches. Guided by the client's needs and issues, I use a variety of tools drawing from many therapeutic approaches, such as Psychoeducation, Client-Centered, Behavioral, Cognitive-Behavioral (including Trauma Focused Cognitive Behavioral Therapy), Mindfulness, Gottman Methods and Solution-Focused strategies. Together, we will explore your values and beliefs as well as those of your family. I am trained from a systemic perspective and believe that a person's role in their family of origin can be translated to their relationships, behaviors and beliefs. For this reason, I believe that family of origin exploration and family therapy can be helpful and is sometimes necessary to see change.

MEETINGS

During our initial sessions I will be gathering information as we formulate goals and a plan together. Sessions typically last 50-minutes. They are expected to begin promptly, and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. As your therapist, I am also expected to be on time, and will offer appropriate remedy if late, such as making the time up, prorating the fee, etc. Occasionally there is a need for sessions to go longer depending on the amount of processing a client needs. Longer sessions will be billed at a prorated amount based on my standard fee. The total number of sessions is dependent on several factors including your goals, timeframe, rate of progress, etc. I offer both short and long-term therapy. The therapeutic process is different for each person. On average, client sessions are at least once a week for the first 3 sessions and then can be tapered to weekly or every other week for at least 10-12 sessions. We will discuss your course of treatment at intake. All of this can be updated as needed by any of us at any time.

FEE POLICY

I charge \$160 for the initial session (intake session) as there is quite a bit of paperwork and information gathering required to set you up as a new client. Thereafter, fees are \$140 per 50-minute session. Fees are adjusted annually in January, and will not increase more than \$15 per year. Payments (cash, check or credit card) are to be made at the beginning of each session unless we have made other arrangements. A \$30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

I charge for other professional services you may need based on a prorated rate of my standard fee. I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations lasting more than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

For those who cannot afford my fees, I do offer a sliding scale fee on a limited basis for lower income individuals/families. Sliding scale fees are based on family income and number of dependents using the Federal Poverty, Sliding Scale Guidelines and are updated annually in February. If finances are a concern to you, please check with me to see if this is an option. Please note, this option is only available for private pay clients.

Insurance/Managed Care

If I am billing your insurance, your copayment is required at the time of service. If your insurance coverage requires you to pay a co-insurance, you may either pay at the time of service or you will be billed after insurance has paid. I will bill insurance companies directly, unless you request otherwise, and I will provide you with a monthly statement for any outstanding balances. Unpaid balances more than 90 days past due will be charged an 18% interest rate (1.5% monthly). Accounts more than 180 days past due may be referred to collections. Any collection legal fees or costs necessary to collect unpaid balance will be your responsibility.

It is your responsibility to follow any plan requirement that applies to you including co-pay amounts, co-insurance and deductibles. I recommend you clarify with your insurance company the specific benefits provided under your insurance plan and to follow any plan requirements that apply to you. For example, some plans require that you obtain an authorization/referral from your insurance/managed care company prior to your first session. Most plans limit the services for which they will reimburse. *If you request or agree to a service for which reimbursement is later denied by your insurance company or its agent (i.e. not pre-authorized, considered medically unnecessary, beyond the benefit limit, etc.) then you assume the responsibility for paying the entire fee.*

Out of Network Provider

I participate in many insurance plans, but not all. If I am not yet a preferred provider for your insurance carrier then I am considered an out of network provider. Most often, companies will provide reimbursement based on your specific reimbursement rate for out-of-network care. Usually, the amount returned is calculated as a percentage, so if you have financial concerns please check with your agency to learn more about its particular policies. I offer two options as an out of network provider:

- Option 1) You pay my fees up front and I will provide you with a SuperBill (Receipt) that can be submitted directly to your insurance company for reimbursement to you. If needed, I can help you figure out what forms need to be attached to this receipt and where to send them. Many clients choose this option to avoid receiving any bills later. Instead they are likely to receive a reimbursement check from their insurance provider (based on their out of network coverage) and will receive no further bills from me as services were paid for in advance.
- Option 2) You pay my fees up front and I will submit the claims to your insurance company electronically for you. Whatever amount of funds your insurance pays for this claim

will be reimbursed directly to you once the claim has been processed. I will do my best to verify your out of network insurance benefits and give you an estimate on how much you will be reimbursed for, but I cannot guarantee the exact amounts until your insurance company processes the claim. If your insurance company denies the claim, you will receive no reimbursements, as the full session fee was your responsibility.

APPOINTMENTS AND CANCELLATIONS

Regular psychotherapy typically promotes faster healing and progress, so it is important that you attend your scheduled therapy session consistently. My policies are outlined below.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone a minimum of two days (**48 hours**) in advance. E-mail and text messages are not adequate notice. Monday appointments require notification before 5:00pm the preceding Friday. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** Emergency needs are an exception, so please discuss this with me to avoid a charge. To change or cancel an appointment, please call (253) 733-1975. If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Two or more late cancellations or no shows will result in the requirement of non-refundable prepayment for sessions at the time of scheduling. A pattern of frequent rescheduling, even if a 48-hour notice is given, may result in a requirement of prepayment for sessions at the time of scheduling, unless due to extenuating circumstances and agreed upon by the therapist. As an alternative you may be limited to scheduling appointments at times in low demand (typically mornings and early afternoons).

CRISIS INFORMATION/TELEPHONE/MESSAGES

I do not provide ongoing crisis services. If you are experiencing an emergency or crisis situation that requires an immediate response, call the National Crisis Line at (800) 273-8255, the 24-hour crisis clinic at (800) 244-5767 for King County or (800) 576-7764 for Pierce County, call 911, or go to the nearest hospital emergency room.

Non-emergency messages may be left on my confidential voice mail at (253) 961-0552. I check my voicemail several times a day during business hours, Monday through Friday. Due to the nature of an outpatient practice, it may not be possible to respond immediately.

CONFIDENTIALITY

All issues discussed in the course of therapy will remain confidential except those for which you may choose to sign a release of confidential information (e.g., for your medical doctor, other treatment provider, or family member). Also, your insurance company or its agents may have the right to audit your records for the purposes that may include but not be limited to accuracy of claims, coverage of services, medical necessity, proper utilization and appropriateness of services, and appropriateness of billing.

I seek ongoing consultation from colleagues in order to provide you with the best services

possible. In the course of clinical consultation, your case information may be discussed with other professionals, in which case I will limit the information I disclose to the minimum amount necessary. I have an agreement with **Deonta Favors, Office Assistant**, to access my client files in order to make appropriate notification and referrals in case I am temporarily or permanently incapacitated. If you do not consent to **Deonta Favors** accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

Your participation in therapy, the content of our sessions, and any information you provide to me is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose this information:

- If you give me written consent to have the information released to another party;
- With your authorization, to effect billing of a third-party payor for the services I provide to you;
- In the case of your death or disability I may disclose information to your personal representative;
- If you waive confidentiality by bringing legal action against me;
- In response to a valid subpoena from a court or from the secretary of the Washington State Department of Health for records related to a complaint, report, or investigation;
- If I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other person;
- If, without prior written agreement, no payment for services has been received after 90 days, the account name and amount may be submitted to a collection agency.

As a mandated reporter, I am required by law to disclose certain confidential information including suspected abuse or neglect of children under RCW 26.44, suspected abuse or neglect of vulnerable adults under RCW 74.34, or as otherwise required in proceedings under RCW 71.05.

If you elect to communicate with me by email at some point in our work together, please be aware that I cannot guarantee the confidentiality of information sent via email. Emails may be retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be saved in your electronic treatment record.

TELEHEALTH

At your request and if it is therapeutically appropriate, I may make use of technology assisted telehealth tools such as telephone communications and internet enabled video and/or audio services as an adjunct to our in-person work together. It is important that you understand the benefits and limitations of such services.

- Telehealth services may improve your access to counseling, may reduce your costs associated with counseling, and may support more effective use of in-person counseling.
- If you are located outside of the State of Washington, the counseling services I am allowed to provide to you may be limited or prohibited. If you are located outside of the State of Washington, we will discuss what services I may be able to provide to you.

- Telehealth services are not appropriate for all clients and all situations. If you or I determine that telehealth services are not appropriate for you, I will assist you in obtaining appropriate alternative services.
- Successful use of telehealth services requires a reasonable level of access to computer hardware and software. If you do not have access to such resources, we can discuss available alternatives.
- At times it may become necessary for me to allow access to my computer hardware and software for purposes of system maintenance, repair, upgrades, or other similar purposes. In such cases, I will make reasonable efforts to protect your confidential information.
- Telehealth services are often not reimbursed by insurance. In such cases, payment for telehealth services remains your sole responsibility.
- In case of hardware, software or other system failure, you may reach me by phone to coordinate our continued work together.

At the beginning of each session I will ask you to provide me with the following information:

- Your physical location and address;
- A phone number I can use to contact you in case of technology failure or other loss of internet connection during our telehealth session;
- An email address I can use to contact you as an alternative if we cannot connect via phone.

At the initiation of our therapeutic relationship I will ask you to provide me to the following contact information if you and I are in different geographic locations:

- Your local hospital emergency room phone number;
- Your local crisis line phone number.
- The phone number of a local clinician who can provide you with appropriate alternative services in case you or I determine that my telehealth services are no longer appropriate for you.

SOCIAL MEDIA POLICY

Professional ethics standards do not permit me to communicate with clients via personal social media. For this reason, I cannot accept any client requests to connect on Facebook, or other similar social media platforms.

AGE OF CONSENT — OUTPATIENT TREATMENT OF MINORS

Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW [7.70.065](#), is required for outpatient treatment of a minor under the age of thirteen. Parents or guardians may not generally access the treatment record of a client aged 13 or older without that client's written permission.

COURT TESTIMONY

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$185 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child

custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

TERMINATION OF THERAPY

The client (or the parents if the client is a minor) has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that the client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering appropriate referral resources to the client. If, without having made prior arrangements, I have not heard from you in 30 days I will assume that you would like me to terminate our current episode of care and close your active clinical file. In such cases, we may re-open the file and initiate a new episode of care once we meet in person again.

STATE OF WASHINGTON DISCLOSURES

The State of Washington requires that I provide you with the following information.

As an individual, you have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs. A copy of the acts of unprofessional conduct can be found in RCW 18.130.180. Complaints about unprofessional conduct can be made to:

Health Systems Quality Assurance Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
E-mail: HSQAComplaintIntake@doh.wa.gov

YOUR AGREEMENT: I have read and understand all of this information, including my rights as a client. I agree to all of the above policies and procedures. If my fees are determined by a sliding scale, I agree to notify my therapist of changes in my income or household size that could affect my fee. I hereby agree, whether signing as an agent or as a patient, to be financially responsible for all charges not paid for by insurance. I hereby authorize Shawnda Brese, MA, LMFT, to render mental health services to (client's name):

ACKNOWLEDGEMENT OF KNOWLEDGE OF CONFIDENTIALITY AND PRIVACY PRACTICES:

I have received a copy of my HIPAA Notice of Privacy Practices.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Client printed name

Parent/Guardian printed name

Clinician Signature
Date

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COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER ELECTRONIC MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, can not be guaranteed as confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your therapist
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with me about ways to keep your communications safe and confidential.

****As a practice policy, I do not communicate with patients and/or their families via social media nor accept any "friend" requests. Therapists are required to ignore all such requests.**

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY ELECTRONIC MEANS

I, _____
(name of client)

REQUEST: Shawnda Brese, MA, LMFT

to use email and mobile phone text messaging to transmit to me the following protected health information to this email address(es): _____

[] Information related to the scheduling of meetings or other appointments. Initial here: _____

[] Information related to billing and payment for health care treatment. Initial here: _____

[] Information related to administrative matters such as sending forms, including forms that have been filled out and signed. Initial here: _____

[] Information directly related to therapy or other clinical matters. Initial here:____I have been informed of and understand the confidentiality risks inherent in sending therapeutic information by non-secure communication methods. Initial here:____
[] Other information. Describe here:_____ Initial:_____

BY THE FOLLOWING NON-SECURE MEDIA:

[] I request to receive text messages for the purpose of appointment reminders. I agree to not use texting for any other purposes other than to cancel or reschedule an appointment. If I need to share any other information regarding treatment I will contact my therapist by other means. Initial here: _____

I understand that Shawnda Brese, MA, LMFT does not receive or send text messages other than for scheduling and/or appointment reminders or use any other media form, such as Skype or Facebook to communicate my Protected Health Information.

I understand that emails are not a way to communicate crisis/safety information and that it may take up to 24 hours for my therapist to respond to my emails. If I have an emergency, I agree to pick up the phone and dial 911, go to the nearest hospital emergency room or call the 24-hour crisis clinic at (800) 244-5767 for King County or (800) 576-7764 for Pierce County.

I understand that this agreement can be revoked at any time at my request.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of signing this agreement. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that Shawnda Brese, MA, LMFT makes secure means of communication available to me, but I prefer to use the above non-secure means for the above purposes.

(Signature of client)

Date

(Signature of parent/guardian)

Date

Koala Smiles Counseling, PLLC

Helping You Find Your Smile Again!

Shawnda Brese, MA, LMFT

Child, Adolescent, Adult & Family Therapist

601 Valley Ave NE, Suite F, Puyallup, WA 98372

(253) 733-1975 www.koalasmiles.com

CLIENT EASY PAY CONSENT

(Optional payment plan for those paying by credit/debit card). This form is for those who wish me to keep your debit/credit card number on file and I will automatically deduct any payments owed from your debit/credit card. (Examples of payments deducted are copays, deductibles, coinsurances, late cancels, no- shows or full payment if not using insurance). Your payment information will be entered into an encrypted system and then blacked out on this form for security purposes.

I authorize **Koala Smiles Counseling, PLLC (Shawnda Brese)**, to charge my credit/debit card for fees charged (including late cancels and no shows) and if using insurance, copays, coinsurances, deductibles and the balance of charges not paid by insurance within 90 days.

Please charge my credit card:

☐ The amount of my copayment, coinsurance or other amounts due OR

☐ \$ _____ Each session

I authorize Koala Smiles Counseling, PLLC (Shawnda Brese) to charge my credit card for counseling services at the rate listed above. I understand that this form is valid for up to three months after I close out of counseling services unless I cancel the authorization through written notice to Koala Smiles Counseling, PLLC. I agree to update this information with my counselor if/when it changes.

Client Name		
Cardholder Name Exactly as it Appears on the Card		
Cardholder Address		
City	State	Zip
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discovery <input type="checkbox"/> American Express <input type="checkbox"/> Other		
Card Credit Card Number _____		
Date of Expiration ____/____		
V-code (3-digit Security code on back of card) _____		
Cardholder Signature _____		

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BEHAVIORAL HEALTH INSURANCE INFORMATION

Today's Date: _____

Client's full name: _____

Sex: _____ Age: _____ Date of Birth: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Family Physician: _____ Phone Number: _____

Person to contact in emergency: _____ Phone: _____

INSURED / RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage

Full Name of Insured: _____ Relationship: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

Insured's Primary Ins. Co.: _____ ID #: _____ Group #: _____

Secondary Ins. Co.: ____ No ____ Yes; Company: _____ Policy #: _____

Job Related Injury-Workmens Comp. Co.: ____ No ____ Yes; Company: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name: _____ ID #: _____

Insurance Phone # Listed on insurance card: _____

Signature: _____ Date: _____

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided.

A \$30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.