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

ADULT INITIAL ASSESSMENT QUESTIONNAIRE

Today's Date ________________

First Name ________________________ MI________ Last Name __________________________ M__F__
Home Phone # ____________________________ Cellular Phone # ________________________________
Address_________________________________City______________________State__________Zip______
Mailing address if different from above: ____
Date of Birth (DOB) ______________ Employer ____
Client E-mail ____
Preferred Contact Method ________________________ Is it okay to leave a detailed message? (Y / N)
Ethnicity __________________________________

Would you like to include aspects of faith and spirituality into our time together (Y / N)
What faith do you identify with? ____
Spiritual / Cultural Beliefs or Activities ☐ None ☐ yes -specify ______________________________
____
____

PERSONS TO NOTIFY IF EMERGENCY:
Name: ______________________________ Relation: ____
Address: _______________________________________ Phone: _____________________________
Name: ______________________________ Relation: ____
Address: _______________________________________ Phone: _____________________________

Name of person, organization, or ad that referred you: ____

Family Members (those living in household or regularly involved in your life)

Names	Age	Gender M	Gender F	Lives Home	Lives Away	Quality of Relationship w/ Client: Poor	Average	Good
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___
______________________	___	__	__	___	___	___	___	___

Revised 5/10/2021

1. What is your main concern that you want to address in counseling? _____
_____
_____
_____

How long have you had these concerns? □ less than 6 months □ 6 months or more

2. List several goals for what you would like to achieve from counseling.

a. _____
b. _____
c. _____

3. Please describe any significant problems or stresses you are experiencing in the following areas. Also list how long you've been bothered by each one.

a. Mental or Emotional: _____
_____

b. Family Relationships: _____
_____

c. Work or School: _____
_____

d. Health: _____
_____

e. Legal Concerns: _____
_____

f. Financial Pressures: _____
_____

4. How would your rate your use of alcohol or drugs?

_____
_____

5. Are you concerned about your physical safety? Explain.

_____
_____

6. Please rate the support or adequacy you feel in the following areas: (On a scale of 1 to 5, 1 being "terrific" and 5 being "lousy.")

_____ Housing _____ Employment/work situation _____ Education
_____ Family support _____ Spouse/Partner support _____ Relationships w/friends
_____ Ability to care for yourself

7. Family History: Please check the following problems you know have occurred either with yourself or with your immediate family, the family you grew up in or other relatives.

- ☐ Substance Abuse
- ☐ Other addictions
- ☐ Sexual abuse (molestation, rape, incest)
- ☐ Physical abuse (hitting, beating, excess force)
- ☐ Mental illness
- ☐ Family "Secrets"
- ☐ Mental or emotional abuse
- ☐ Depression
- ☐ Suicide or attempted suicide
- ☐ Infidelity
- ☐ Chronic lying
- ☐ Children out of wedlock
- ☐ Divorce
- ☐ Other family dysfunction

8. List all medications you are taking, the dosages and what condition they are treating

Medication	Condition	Dosage	How Often	When Started

9. Are you currently seeing a physician for an ongoing medical condition such as diabetes, thyroid disorder, cancer treatment etc.? If yes, then please explain/describe.

_____
_____

10. Any medical/relational patterns in your family (i.e., history of obesity, domestic violence, infidelity, hoarding, etc.) _____
_____

11. Have you been in therapy before? ___ (Y/N)
If yes, when was the last time you saw a therapist? _____ (date)

12. Have you found therapy to be helpful in the past? What worked and what didn't?

_____
_____
_____ _____

13. How would you describe your sleep? _____
_____

14. What physical or mental or emotional symptoms are you experiencing recently? Please check any symptoms that you have noticed or others have noticed about you.

- □ Muscle twitches
- □ Decrease in energy (Fatigue)
- □ Hyperactivity
- □ Impulsiveness
- □ Sexual problems
- □ Restlessness
- □ Problems at work or school
- □ Over-aggressiveness
- □ Withdrawn from friends or family
- □ Stealing or Dishonesty
- □ Destructiveness
- □ Disorganization
- □ Difficulty speaking
- □ Trouble with Authority figures
- □ Injuring self
- □ Breaking rules, pushing limits
- □ Anxiety
- □ Fears
- □Jitteriness
- □ Panic Attacks
- □ Phobias
- □ Hyperventilating
- □ Excessive worry
- □ Anger
- □ Apathy
- □ Depressed mood or lingering sadness
- □ Emotional highs
- □ Guilt struggles
- □ Helplessness
- □ Hopelessness
- □ Hostility
- □ Crying spells
- □ Irritability
- □ Reduced interest/enjoyment in life
- □ Low self-esteem
- □ Noticeable mood swings
- □ Tears come easily
- □ Difficulty speaking
- □ Difficulty thinking or concentrating
- □ Easily distracted
- □ Difficulty making decisions
- □ Racing thoughts or speech
- □ Tendency to go off on tangents
- □ Unsure of what is real
- □ Sometimes feel you are outside your body watching yourself
- □ Feel unhappy w/ body shape/weight
- □ Unrealistic goals or thoughts of self
- □ Sometimes think you are hallucinating
- □ Trouble getting thoughts out of your mind
- □ Concerns that others are spying on/poisoning you
- □ Excessive fears of _____
- □ Flashbacks of a distressing event
- □ Sometimes think about suicide
- □ Medical or health problems
- □ Chronic pain
- □ Nervousness
- □ Binge eating
- □ Change in appetite
- □ Below your normal weight
- □ Trouble getting to sleep or staying asleep
- □ Too much sleep
- □ Trouble with drugs or alcohol
- □ Other symptoms
- □ Feelings of rejection

15. What do you see as your greatest strengths that will help you attain your therapy goals? _____
_____
_____

16. What may hold you back? _____
_____
_____

17. How would you describe your relationship with God? _____
_____
_____

18. How do you handle anger? _____
_____

19. How do you handle sadness? _____
_____

20. How do you handle anxiety? _____
_____

21. What do you like most about yourself? _____
_____

22. What do you do to take care of yourself? _____
_____

23. Anything else that would be helpful for me to know? _____
_____

24. What are three changes you hope to see in your self after therapy? _____
_____
_____

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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 inspecialized 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), Mundfulness, 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

yourout 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 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 alterative 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): _____

ACKNOWLEGEMENT 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,_____ REQUEST: Shawnda Brese, MA, LMFT
(name of client)

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

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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 or until my balance is paid in full 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

☐Visa ☐MasterCard ☐Discovery ☐American Express ☐ Other

Card Credit Card Number _____
Date of Expiration _____/_____
V-code (3-digit Security code on back of card) _____

Cardholder Signature
_____

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Child, Adolescent, Adult & Family Therapist
601 Valley Ave NE, Suite F, Puyallup, WA 98372
(253) 961-0552 www.koalasmiles.com

BEHAVIORAL HEALTH INSURANCE INFORMATION

Todays 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: _____

Revised 5/10/2021

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.