Sharon M. Dillinger, PhD, LMHC **Psychotherapy Services**

10202 Pacific Avenue S. suite. 211 **tel. and fax: 253.548.8824**
Tacoma, WA 98444 **www.pacificsouthcounseling.com**

First Name:_____ Middle Initial:___ Last Name:_____

Address:_____ Apt: _____

City _____ State _____ Zip:_____

Home Phone:_____ Email:_____

Cell Phone:_____ Date of Birth:_____

Work Phone: _____ message ok? Yes____ No____

Male___ Female___ _____Marital Status: Married__ Single__ Divorced__ Other__

Employed: Yes___ No___ Occupation:_____ Soc. Sec. _____

Employer's Address:_____ City/State/Zip_____

Referred By:_____ Address_____

Emergency Contact Name:_____ Relationship:_____

Address:_____ City/State/Zip _____

Contact Phone Number _____ email _____

RESPONSIBLE PARTY and/or INSURANCE INFORMATION

Name of Responsible Party and/or Insurance Policy Holder: _____

Address:_____ City/State/Zip_____ Phone:_____

Male___ Female ___ Date of Birth:_____ Policy #:_____
Please include alpha characters located on insurance card

Patient's relationship to Insured: Self:___ Spouse:___ Dependent:___ Other:___

Insurance Company Name:_____ Address:_____

Employer's Name/Address:_____ Occupation:_____

City:_____ State:_____ Zip:_____ Phone:_____

SECONDARY INSURANCE INFORMATION

Name of Responsible Party and/or Insurance Policy Holder:_____

Address:_____ City/State/Zip_____ Phone:_____

Sex: Male___ Female ___ Date of Birth:_____ Policy #:_____

Insurance Company Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Employer's Name/Address:_____ Occupation:_____

I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment.
I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of medical benefits to my provider for services rendered (this does not apply to Employee Assistance Program Services).

_____ _____

Signature ***Date***

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Washington License# LH00003540

DISCLOSURE STATEMENT AND CLIENT INFORMATION

In accordance with the Washington Administrative Code and the Revised Code of Washington, the following Client Disclosure Information is provided for the client and must be signed by both client and therapist. Counselors practicing counseling for a fee must be certified or licensed with the Department of Health for the protection of the public health and safety. Registration of an individual with the Department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. Questions or complaints may be directed to the Department of Health / Business & Professional Administration / P O Box 9012 / Olympia , WA 985040-8001 / 360.753.1761.

PURPOSE OF THIS INFORMATION

Welcome to Pacific South Counseling. In order to provide the best care, clients must have as much relevant information as possible. This document contains important information about my therapeutic approach, my education, my fees, and your rights as a client, including your rights regarding your private health information. You have the right and responsibility to choose a mental health provider and treatment modality which best suits your needs and to refuse any treatment you do not want. You also have the right to terminate treatment at any time. Please read this document carefully and ask any questions that help you fully understand the contents of this disclosure statement and agreement for services.

CLINICIAN INFORMATION – SHARON DILLINGER, PhD, LMHC

Again, welcome. I am a solo practitioner, licensed as a Mental Health Counselor in the State of Washington and subject to the laws and ethical requirements specific to my professions. I received my PhD in Psychology from Saybrook University in San Francisco and my MA in Social Science from Pacific Lutheran University. I have been a counselor since 1988 and licensed since 1992. I have worked in a variety of clinical settings. Prior to clinical work, I spent 16 years in business management. My practice involves providing therapy for individuals (13 and over) and couples.

My approach to counseling focuses on providing a safe place where you can process feelings, experiences, and memories about current or past experiences in adaptive ways. Additionally, we may explore the meanings and contexts of distressful symptoms often associated with these experiences and/or discover those obstacles preventing successful living. I use a variety of approaches, depending on the presenting concerns and symptoms. These may include cognitive-behavioral, supportive, solution focused, and/or EMDR (Eye Movement Desensitization and Reprocessing). I am not able to propose an appropriate course of treatment for you until we have spent some time together. As soon as I am able to identify an appropriate course of treatment, however, I will discuss it with you.

While the goal of therapy is healing, there are no guarantees that the results of therapy will conform to your every expectation. Effective treatment depends to a significant degree on your openness, your commitment to change, and your cooperation; much of the responsibility for a successful outcome is yours. I will at all times respect that this is your life and that you ultimately choose the response and the extent of time spent in therapy.

APPOINTMENTS AND FEES (**Please read this section very carefully)**

Regular therapy appointments are 50-55 minutes and my fee per session is $175. (A shorter appointment of 40-45 minutes will be billed at $150.) I charge $250 for the initial assessment and diagnostic session. Your appointment time is reserved exclusively for you. Therefore, if you miss your scheduled session (except for a medical type emergency) with less than a 24 hour notice, **you will be charged a late charge of $75 for that session. Remember, insurance will not reimburse for missed appointments**. Likewise, if I fail to keep your appointment session for any reason other than an emergency or medical reason, without appropriate notice, I will cancel your portion of the fee for your next appointment.

Fees are charged for telephone conversations and consultations with attorneys, and other professionals (with your permission) which are longer than ten minutes and are pro-rated at the per session rate. If you become involved in legal proceedings that require my participation as a non-expert witness, you are expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

PAYMENT

Payment for your therapy is due at the end of each session unless we have made other arrangements. Your medical insurance **MAY** reimburse for all or part of the cost of your therapy; however, third party payers may require that I provide them with information regarding the services I provide to you. This information may include type of services provided, the dates and times of services, your diagnosis, treatment plan, a description of impairment, progress of therapy, and case notes and summaries. If you do not want me to provide your confidential information to your insurance company, let me know so that we can discuss alternatives.

You are responsible for understanding your benefits and for your account. You are responsible to pay any portion not covered by your insurance. Additionally, your copay, if you have one, is required at the time of your session. It is your responsibility to secure any necessary referrals and establish that your therapy with me meets your insurance requirements. Accounts not paid according to the terms and conditions described above are a concern. An unpaid account is both a therapeutic and a financial issue. Returned checks are subject to a $25 reprocessing fee in addition to the back fee charged to me. In the event that your account is significantly overdue, it may be turned over to medical collections unless other satisfactory arrangements are made. Information necessary for collection will be released to the collection agency. A rebilling fee may be assessed to your account each month that contains no payment activity.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9AM and 6PM Monday through Thursday, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by a confidential answering system. I will make every effort to return your call on the same day you leave a message, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. I do not generally send or receive text messages. If you are unable to reach me and feel that you cannot wait for me to return your call, please call 911 or the Crisis Line at 800 576 7764. You may also choose to contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of several colleagues to contact if necessary. I maintain a referral list of other counselors with a wide range of specialties. I will provide you with a referral to another counselor if I feel your needs are beyond the scope of my expertise or if you request such referral information.

SUPERVISION AND CONSULTATION

I seek ongoing supervision and consultation from colleagues in order to provide you with the best services possible. I may disclose information about your counseling session in consultation with colleagues, in which case I will withhold your name and limit the information I disclose to a minimum necessary. I also have an agreement with Kristine Dillinger 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 Kristine Dillinger accessing your file in case of my incapacity, please let me know so that I may make alternative arrangements.

CONSENT FOR TREATMENT

By signing this document, you are attesting that you have received, read, understand, and consent to the disclosures, terms, and conditions above and that you have received a copy of your HIPAA and Washington State Notice of Rights and Privacy Practices, have read and fully understand these rights, and have been given the opportunity to ask questions.

Patient Signature _____ **date** _____

Clinician Signature_____ **date**_____

HIPAA **– Health Information Portability and Accountability Act**

This section contains important information about your rights regarding confidentiality and your medical records. Please read it carefully, make a note of any questions you might have so that we can discuss them, and sign to indicate that you understand your medical records rights.

CONFIDENTIALITY

The State of Washington and the federal Health Insurance Portability and Accountability Act (HIPAA) require most issues discussed with me remain confidential. These laws protect your right to privacy. For example, the information that I record in my psychotherapy notes is protected by HIPAA and cannot be used or disclosed without your specific, written authorization.

There are some instances in which your right to confidentiality is automatically waived. Any or all of your health information, including anything in my psychotherapy notes, may be released without your consent or written authorization in the following circumstances.

- If I become aware that a child under 18, a developmentally disabled person, or a dependent elder is being abused, exploited or neglected (RCW 26.44).
- If you become a danger to others, I must take actions to protect others and you by reporting to the appropriate authorities and/or at-risk other (RCW 71.05.120).
- If you become mentally ill and become unable to take care of your basic need or become a danger to yourself and also refuse treatment, I must report your condition to the authorities (RCW 71.05).
- If you report that you are HIV positive and are not using safe measures, under a physician's care, I must report your risk behavior to the local health officer (WAC 248-100-072).
- If in the event of a complaint by you, my professional licensing board subpoenas me as part of its investigation, hearing, or proceeding related to the discipline, issuance or denial or licensure of state licensed professionals, I must comply with its orders and disclose your relevant health information (RCW 18.130.180).
- If you are involved in a court proceeding and request is made for information about the professional services that I have provided to you and the records pertaining to them, such information is privileged under state law and I will not release information without the written authorization of you or you legal representative or a court order signed by a judge. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered. You will be informed in advance if this is the case (RCW 18.83, RCW 71.05.390 and RCW 71.05.630).
- If you file a worker's compensation claim, with certain exceptions, I must make available upon request, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury (in the opinion of the Washington Department of Labor and Industries [RCW 51.36.110]).

Other health information is provided somewhat less protection by state and federal law. Examples include information pertaining to medication prescription and monitoring, counseling session start and stop times, dates of treatment, results of clinical tests, and summaries of your diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. This information is called Protected Health Information (PHI) because it is still safeguarded and can be released only in limited circumstances and for specific reasons. In particular, it may be used or disclosed for purposes of treatment, payment, or health care operations.

- **Treatment** involves the provision, coordination or management of your health care and other services related to your health care. An example of treatment would be my consulting with another health care provider, such as your family physician or another therapist.
- **Payment** involves the reimbursement for your healthcare. This can include the disclosure of your PHI to your health insurer, when required, to obtain reimbursement or to determine benefit eligibility or coverage.
- **Health Care Operations** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

By signing below you provide your consent for me to use and disclose your PHI for these three purposes.

In all other instances beyond those listed above I will obtain an authorization from you before using or disclosing any of your health information. A valid authorization must be signed by you and specify the recipient of the information. A written authorization is valid until you revoke it. You may not revoke an authorization for information that has already been disclosed based on that authorization. Neither may you revoke an authorization that was obtained as a condition of obtaining insurance coverage. Your authorization will automatically be revoked at the termination of you treatment with me.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION (PSI): You have the following rights concerning the health information that I maintain about you (for as long as your records are maintained – a minimum of 5 years).

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to the restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations –** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request If considered problematic. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- **Right to Restriction of PHI to a Health Plan** if you pay out-of-pocket for the health care service.
- **Right of Notification of Breach Unsecured PHI.**
- **Prohibition of Release of Information without Authorization** for any use not described in the Policy Statement above.

PLEASE READ THE *DISCLOSURE AND CLIENT INFORMATION* FORM VERY CAREFULLY. SIGN THIS FORM ONLY AFTER YOU COMPLETELY UNDERSTAND THE FORM. (THIS ESSENTIALLY BECOMES A CONTRACT FOR HEALING BETWEEN YOU AND ME). YOUR SIGNATURE CONVEYS THAT YOU HAVE RECEIVED A COPY OF THIS POLICY STATEMENT AND THAT YOU AGREE TO ABIDE BY ITS TERMS.

Patient Signature _____ date _____

PERSONAL HISTORY QUESTIONNAIRE

This questionnaire is intended to help your clinician review general information quickly so that your discussion with her can focus on the concerns which have led you to schedule this appointment. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. Your clinician will follow up with you for additional information pertaining to some items on this form which will be held in confidence as part of your patient record in this office.

YOUR NAME: _____ TODAY'S DATE: _____

PLEASE SUMMARIZE YOUR REASONS FOR SEEKING SERVICES AT THIS TIME:

_____

_____

_____

_____

EDUCATIONAL/MILITARY HISTORY:

What is the highest school degree you have earned? _____

During school, did you receive any: ____ Special education? ____ Tutoring? ____ Alternative schooling?

Have you ever served in the military? _____ If yes, please answer the following:

Dates of service: _____ Type of discharge: _____ Combat experience: _____

VOCATIONAL HISTORY:

What is your current occupation? _____ How long in your present position? _____

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment which lasted four months or longer? _____ If yes, please briefly describe the circumstances: _____
_____

_____

Are you satisfied with your current job? _____ Have there been any major changes in your current work situation during the past year? _____ If yes, please describe: _____

MEDICAL HISTORY:

Please list all medications you are currently taking, including dosages if you know them:

MEDICATION **DOSAGE** **PRESCRIBED BY**

_____

_____

_____

_____

_____

continue list at end of questionnaire if needed

Please list all over the counter medications, sleep aids, vitamins/ minerals/ herbs or dietary supplements currently using:

PRODUCT **DOSAGE** **CONDITION/PROBLEM** **PRESCRIBER**

_____

_____

_____

_____

continue list at end of questionnaire if needed

Have you ever had major surgery? _____ If yes, please list: _____

Have you ever had a head injury which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion or behavior? _____

Have you ever had an extremely high fever (greater than 103 degrees F)? _____

Have you ever fainted or had a seizure? _____

Do you have any food or seasonal allergies or sensitivities? ____ If yes, please specify: _____

_____

Do you engage in physical exercise?_____ To what level? _____

Do you regularly use cigarettes or other tobacco products? _____ Ever use in the past? _____

Please list any other medical conditions or concerns: _____

_____

Date of last medical examination: _____

PSYCHOLOGICAL TREATMENT HISTORY:

Have you ever taken medication for psychological/psychiatric reasons? _____

If yes, please indicate when, and for what conditions/ problems: _____

_____

_

Have you received counseling or psychotherapy previously? _____

If yes, please indicate when, and by whom: _____

Have you ever been hospitalized for psychological/psychiatric reasons? _____

If so, when and where: _____

_____

Has anyone in your family (parents, grandparents, siblings, other relatives) been diagnosed and/or treated for psychological/psychiatric conditions?

_____

_____

ALCOHOL/DRUG HISTORY:

If you drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequencies: _____

_____

If you have used, or use any street drugs, please describe which ones and your pattern of use: _____

Have you ever tried to cut down on your use of alcohol or drugs: _____

Has anyone gotten angry at you because of your alcohol or drug use? _____

Have you ever felt guilty or worried about your use of alcohol or drugs? _____

Have you ever received outpatient alcohol and/or drug treatment or detoxification services? _____

Has anyone in your family had a problem with alcohol or drugs? _____

LEGAL HISTORY:

Please check all legal actions or proceedings you have been a part of:
_____arrests/assaults _____arrests/other* _____DUI (how many)

_____restraining/protective order(s) _____divorce/custody _____disability claim(s)

_____Child Protective Services _____*other (describe) _____

PERSONAL INFORMATION:

Have you experienced a loss (death, divorce, or significant situational losses) within the last 24 months? _____If yes, please indicate when and type of loss: _____

Did you experience any losses as above during childhood or adolescence? _____ If yes, please indicate whom, and your age at the time of loss: _____

Did you experience abuse at any time in your childhood or adult life? _____ If so, what kind? _____

Do you own or have access to firearms? _____

Have you relocated or changed jobs within the past 24 months? _____

How many siblings do you have, and what is your birth order among them? _____

Were you adopted or separated from your birth parents during childhood? _____

Were your parents divorced (if yes, please indicate your age at the time of their separation)? _____

Please indicate your parents' ages, or their ages at the time of their death:
Mother: ____living ____deceased ____age
Father: ____living ___deceased ____age

List 5 words to describe your childhood: _____

Has religion or spirituality played an important role in your life? _____

Thank you for taking time to complete this questionnaire. Please use the space below to provide any additional information that you think would be important for use to know. Also, please feel free to use the space below to describe your current goals for the services we will be providing.

_____

_____

_____

_____

Signature: date: