CLIENT INFORMATION

Name:____
Last Name First Name Middle Initial

Street Address____

City____ State __________ Zip___________________

Home Phone_______________________________ Cell Phone________________________________

Sex______ Age_____ Birthdate__________________ Marital/Partner Status_______________________

ClientEmployer/School____________________________________Occupation _______________________

Employer/SchoolAddress____

Preferred email____

Would you like to be on my email list to subscribe to my newsletter and be notified of events? Y___ N___

How did you hear about my services? ____

In case of emergency who should be notified? ____

Phone ____________________ Relationship to you____

CLIENT BACKGROUND

Client Name:_________________________________

Please describe your reasons for seeking treatment at this time (include when the problems started):

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____

Please list other health care professionals currently treating you: ______________________________

____

Please list current health problems and any medications you are taking: ________________________

____

Please indicate past problems with a "P" and current problems with a "C".

____Depression	____Chronic Illness	____Marriage/Relationship Issues
____Anxiety	____Chronic Pain	____Sexuality/Sexual Issues
____Stress	____Loneliness	____Family Conflict
____Grief/Loss	____Eating or Weight Problem	____Behavioral Problems
____LD/ADHD	____Abuse/Victimization	____Schizophrenia/Psychosis
____Anger	____Domestic Violence	____Phobias/Fears
____Obsessions/Compulsions	____Manic Episodes	____Drug/Alcohol Issue
____Trauma	____Legal Matters	____Other Addiction Issue

____Other____

Please indicate how the problems you are experiencing are affecting your life:

	No Effect	Little Effect	Moderate Effect	Much Effect	Extreme Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of Treatment:

Inpatient/Outpatient	Provider Name	Medication/Dose	First Seen	Last Seen

2310 130th Ave NE · Suite 200 · Bellevue, WA 98005 · 425.283.0444 · Fax 425.283.0443

KAY DUNCAN, MSW, LICSW

DISCLOSURE STATEMENT

Therapeutic Relationship: Psychotherapy is a supportive, collaborative relationship. To better participate in your treatment, it is important that you understand certain aspects of this relationship. Washington State Law requires that you be informed of your rights as part of your initial consultation.

You have the right to decide whether or not to work with me as your psychotherapist. If you wish, I can provide you with the names of other qualified therapists. You have the right to end therapy at any time, without any legal or moral obligation. I request that should you decide to terminate therapy, you do so in person rather than by phone, email or letter. You also have the right at any time to discuss with me, the course of therapy and my particular treatment methods. Should you have any questions, please do not hesitate to ask.

Emergencies: If you have an emergency and you need to speak with someone right away, please call the King County Crisis Clinic at (206)461-3222, call 911, or go to your nearest hospital emergency room.

Licensure: For the protection of the public health and safety, counselors practicing counseling for a fee must by registered or licensed with the Department of Licensing. Licensure of an individual with the Department does not include recognition of any practice standards, nor necessarily implies effectiveness of any treatment.

Records: A record of the mental health care I provide to you is kept by me. You may ask to see a copy of that record. You may also ask me to correct that record, if you believe the information within your record is in error. A copy of your corrections will be placed within your record, at your request. I will not disclose your record to others unless you direct me to do so in writing. Please let me know if you wish to see your record or have questions concerning that record.

Confidentiality: I am required to report to the appropriate authorities if it appears you are a danger to yourself or someone else. Additionally, if I have reasonable cause to suspect abuse of a child, dependent adult or developmentally disabled person, I need to contact the proper authorities. I may at times consult with other professionals. All consultations will be done in a manner to protect your anonymity.

Background: I received a Master of Social Work degree in 1986 from the University of Iowa. As part of my graduate education, I completed a two-year training program in marriage and family therapy. I have over 25 years of experience in the mental health field as a therapist, educator, trainer, clinical supervisor, and executive director. My work has been in a variety of clinical settings including a crisis intervention center, domestic violence program, chemical dependency counseling agency, community mental health center, hospital-based eating disorder program and private practice. I am a Washington State Licensed Independent Clinical Social Worker (#4661) and a member of the National Association of Social Workers. I work primarily from a family systems model while also using cognitive-behavioral, mindfulness-based, and other therapy methods.

If you have any questions about the material presented here, please let me know. Please sign below to indicate you have read and understand this information and have received the State of Washington Department of Health booklet. I will make a photocopy of this form for you to take with you.

Signature	Date	Witness	Date
Signature	Date	Witness	Date

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FINANCIAL INFORMATION

The initial appointment is 60 minutes in length and billed at $185 for Individual Therapy and $195 for Couple Therapy. Subsequent appointments are 45 minutes long and are billed at the rate of $140 per session for Individuals and $150 per session for Couples. Longer sessions are billed an additional $45 (Individual Therapy) or $50 (Couple Therapy) for each quarter hour segment. Emergency telephone sessions are billed at the same rate, in quarter hour segments, after the first 5 minutes.

Sessions cancelled with less than 24 hours notice must be done so by phone (425-283-0444) and will be charged at a fee of $100. Missed appointments with no notice or with less than 24-hour notice by email will be charged at a fee of $140 for Individuals and $150 for Couples. Please note that insurance will not cover missed session or late cancellation fees.

Payment is due at the beginning of each session unless prior arrangements have been made with me. It's helpful if you have your check/cash/credit card ready to pay me as you come in. This will allow us to devote our entire attention to the therapy process. Some insurance plans may cover my services as an out-of-network provider. At the end of each session I will provide you with a receipt that you can submit to your insurance if you choose to seek reimbursement. I recommend that you check with your insurance carrier directly to learn about your specific benefits.

This contract is exclusively with me, Kay Duncan. My work with you is as an independent practitioner and not in affiliation with any group practice.

Having read the above contract, I understand my responsibilities for payment. My signature confirms acceptance of the above terms and constitutes informed consent for psychotherapy without exception.

____ _________________________
Signature Date

____ _________________________
Signature Date

____ _________________________
Therapist Date

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