**Intake Form for Counseling**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of the Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone:**

**(Home)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Cell)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(**Work)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(E-Mail) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:**

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of the Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can we contact your physician? Yes / No Please give your initial \_**\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medications? Yes/No ( If yes, please continue the following section)**

Medication Dosage Frequency Purpose 1st Day of taken

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you had counseling before?**  Yes / No **(If yes, please continue the following questions)**

Where did you go for counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you were in counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the reason(s) for counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to come to this counseling office?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we send a thank you note?** Yes/No **Please initial here** \_\_\_\_\_\_\_\_\_

**What are your goals in counseling?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Fee Agreement**

**Appointments**

Sessions are **50 minutes** in length. Consistency in keeping appointments is essential to the counseling process. A client must give **24 office hours notice (Monday – Friday between 9:00 am and 5:00 pm)** to his or her therapist. If client is unable to keep an appointment, he or she will **be charged** for the full session fee.

**Fee Policies**

The standard fee for a counseling session service with Laura Tsang (LMFT) is **$150**. Payment in full (or-co-pay, in the case of insurance) should be remitted to the therapist at each session. If a client’s account becomes past due, the therapist will not be able to schedule additional appointments until payments become current.

**Client agreement to pay for service**

If I do not have insurance or choose not to use my insurance, I agree to pay all charges for services that I incur.

If I use insurance to cover some or all of my counseling with Laura Tsang (LMFT), I agree to pay for all charges for services that I incur with Laura Tsang (LMFT) that my insurance carrier does not pay (after my contacted adjustments are applied to my account). This may include, but is not limited in, services and changes that are determined by my insurance carrier to be not medically necessary and/or services and charges that are not covered by my plan with insurance carrier, including missed appointments.

**I have read, understand and agree to the above, I agree that my fee for a counseling session with Laura Tsang (MS, LMFT) is $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please initial here \_\_\_\_\_\_\_\_ if you do not plan on using insurance.**

**Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

T**herapist ‘s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disclosure Statement**

**Laura Tsang MS, LMFT**

***Mission Statement***

***I strive to bring happiness and completeness to individual and families. While resolving differences, I emphasize growth and maturation in a nurturing and supportive environment. I believe that the definition and formation of family problems must be viewed in personal, historic, relational, systematic, multigenerational, psychosocial, and cultural contexts. Therapy and solution not addressing all these issues may not produce long-lasting change, and only fix symptoms instead of cause.***

***Young Children***

Please do not leave young children unattended the waiting room. We cannot be responsible for their safety.

***Emergencies***

In the event of **emergency** when the office is closed for holidays and after office hours, please call or leave a message at **206-992-6597**. If you don’t hear the call back within one-half hour, please call Crisis Clinic at **206-461-3222 or 911.**

***Training and professional background of your counselor***.

Laura Tsang is a licensed Marriage & Family Therapist (license # LF00000895). She graduated from the University of Manitoba, Canada in October of 1997. She has a Maters of Science Degree in Family Studies, with a research concentration on marital happiness. After she moved to the United States, she completed her post-graduate program in Marriage and Family therapy in the University of Nevada, Las Vegas. Currently, she is undergoing a doctoral program for sex therapy accredited by American Association for Clinical Sexology (AACS).

***Theoretical orientation and approach to counseling***.

Laura Tsang’s therapeutic orientation to counseling is based on the intersystem approach. She sees families as individual units with inherent resistance, boundaries, alliances, structures, coalitions and rules. These family units are thus interlocking systems of individuals in their social and cultural concern. She believes the presenting problems are only symptoms of system dysfunction. She integrates different frameworks tailored to each client’s need.

***The rights of clients in counseling***

It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of the therapy and the cost. As informed consumers, it is the client’s responsibility to choose the counselor and counseling modality which best suits their needs. Clients have the right to request a change in counseling approach, referral to another counselor or termination at any time.

Laura Tsang (LMFT) is bound by the ethical codes of the American Association for Marriage and Family Therapy (AAMFT) and by the laws of the State of Washington. If a client thinks his/her therapist is not meeting the ethical responsibility, he/she is strongly encouraged to address this with the therapist.

I keep a record of the health care services I provide for you. You may ask us to see and copy that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. To see your record or get more information about it, please contact me directly.

**See “Rights and Responsibilities of Clients and Counselors” which is given to all new clients at the time of intake.**

***Confidentiality***

Counseling sessions are held in strict confidence. It is the client, not the therapist, who determines whether information may be released to person outside the counseling office, and only then with a release signed by the client. Exceptions to this rule, state law mandates that there is no confidentiality where child abuse or abuse of a developmentally disabled adult has occurred within the last seven years. The counselor may also be required to break confidentiality in life-threatening situation where the client poses a clear and present danger to self or others or is unable to provide minimum life-sustaining self-care. Here, the counselor would take steps necessary to secure the safety of the client or others,

I have received and read the Disclosure Statement.

Client Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By the signature below I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I received a copy of the Notice of Privacy Practice for my counseling service with Laura Tsang (MS, LMFT.).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or personal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or personal representative Date

**Client’s Insurance Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc Sec # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male \_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Employed \_\_\_\_ Full-Time Student \_\_\_\_ Part-Time Student \_\_\_\_\_

Is patient’s Condition Related to (please check one of the following)

Employment \_\_\_\_\_\_ Auto Accident \_\_\_\_\_ Other Accident \_\_\_\_\_

State in which occurred \_\_\_\_\_\_\_\_\_\_\_\_

If there is a specific injury or illness which precipitated coming for counseling

Date of current injury or illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of same or similar condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work lost due to current condition from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization due to current condition from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client or Authorized Persons Signature – I authorize the release of my medical or other information necessary to process this claim or any further claims. I also request payment of government benefit either to myself or to the party who accepts assignment below.**

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured or Authorized Person’s Signature – I authorize payment of medical benefits to my counseling service with Laura Tsang (MS, LMFT).**

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Information Primary Coverage**

Policy Holder Information:

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male \_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_\_

Client relationship to Insured: Self \_\_\_\_\_\_ Spouse \_\_\_\_\_\_\_ Child \_\_\_\_\_\_\_\_\_\_\_\_

Under employer’s health plan? Yes / No

Insured’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ins Co Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company Information Secondary Coverage**

**If there is another health benefit plan, please complete the following**

Other Insured Information

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male \_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_\_

Client relationship to Insured: Self \_\_\_\_\_\_ Spouse \_\_\_\_\_\_\_ Child \_\_\_\_\_\_\_\_\_\_\_

Under employer’s health plan? Yes / No

Insured’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ins Co Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**