NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055

CLIENT INFORMATION

Name_____ Birthdate_____ Age _____ Male ☐ Female ☐

Last Name First Name Middle Name

Social Security # _____

Single ☐ Married ☐ Couple ☐ Separated ☐ Divorced ☐ Widowed ☐

Spouse's Name (*if applicable*) _____Marriage Date _____

Last Name First Name Middle Name

Prior Marriages? From _____ to _____ Prior Marriages? From _____ to _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Work Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Cell Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Employer _____ Job Title _____

Referred by? _____ Primary Care Physician _____

People in home **Children out of home**

Name	Age	Relationship	Name	Age

Emergency Contact _____ Relationship to You _____

Phone (_____) _____

INSURANCE INFORMATION

Primary Insurance Co. Name _____ **Telephone** (____) _____

Policy Holder's Name _____ Birthdate _____

Social Security # _____ Member ID # _____

Policy Holder's Employer _____ Grp. # _____

Secondary Insurance Co. Name _____ **Telephone** (____) _____

Policy Holder's Name _____ Birthdate _____

Social Security # _____ Member ID # _____

Policy Holder's Employer _____ Grp. # _____

I affirm that the above information is correct and complete.

Signature _____ Date _____

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CLIENT QUESTIONNAIRE

Name _____

This questionnaire is designed to help you indicate in what ways you might want some assistance. Please circle the most appropriate response to indicate your level of concern. Also specify for how long each issue/symptom has been a problem.

1 Not a Problem	2 A Mild Problem	3 A Moderate Problem	4 A Serious Problem

YOUR PHYSICAL FUNCTIONS		How Long?
Sleep too much	1 2 3 4	
Can't get to sleep or stay asleep	1 2 3 4	
Fatigue	1 2 3 4	
Speech (stuttering or stammering)	1 2 3 4	
Appetite Changed	1 2 3 4	
Weight Gain	1 2 3 4	
Weight Loss	1 2 3 4	
Sexual Functioning	1 2 3 4	
YOUR INNER THOUGHTS & IDEAS		***How Long?***
Trouble Concentrating	1 2 3 4	
Thinking about something over & over	1 2 3 4	
Memory Problems	1 2 3 4	
Worrying about your Health	1 2 3 4	
Believing you are Inferior to Others	1 2 3 4	
Believing you are Better than Others	1 2 3 4	
Experiencing Confusion	1 2 3 4	
Thoughts about Hurting Yourself	1 2 3 4	
Thoughts of Hurting Others	1 2 3 4	
Phobias	1 2 3 4	
YOUR FEELINGS & MOODS		***How Long?***
Depression/sad a lot	1 2 3 4	
Euphoria (feeling "high")	1 2 3 4	
Frequent Crying	1 2 3 4	
Anxiety (Nervousness)	1 2 3 4	
Lack of Energy	1 2 3 4	
Feeling Angry or Hostile	1 2 3 4	
Not Liking Self	1 2 3 4	
Not Liking Others	1 2 3 4	
Helplessness	1 2 3 4	
Excessive Guilt	1 2 3 4	
Worthlessness	1 2 3 4	
Hopelessness	1 2 3 4	
Sudden Changes in Mood for No Apparent Cause	1 2 3 4	
Feeling Lonely	1 2 3 4	

YOUR BEHAVIOR		How Long?
Difficulty with Daily Routine	1 2 3 4	
Letting Others Take Advantage of You	1 2 3 4	
Hyperactivity (can't sit still)	1 2 3 4	
Repeating Certain Acts, again & again	1 2 3 4	
Physically Abusing Others	1 2 3 4	
Using Alcohol to Cope with Problems	1 2 3 4	
Using Drugs to Cope with Problems	1 2 3 4	
Lying	1 2 3 4	
Stealing	1 2 3 4	
Withdrawing from Others Socially	1 2 3 4	
Attempted to Hurt Self	1 2 3 4	
Verbally Abusing Others	1 2 3 4	
Dependency (relying on others to make your decisions)	1 2 3 4	
YOUR WORK EXPERIENCE		***How Long?***
General Performance	1 2 3 4	
General Satisfaction	1 2 3 4	
Lateness	1 2 3 4	
Absenteeism	1 2 3 4	
Negative Feelings about Work	1 2 3 4	
Relating to Co-Workers	1 2 3 4	
Relating to Supervisors	1 2 3 4	
Relating to Supervisees	1 2 3 4	
PROBLEM AREAS		***How Long?***
Raising Children	1 2 3 4	
Relating to your Spouse or Partner	1 2 3 4	
Death of a Loved One	1 2 3 4	
History of Physical Abuse	1 2 3 4	
History of Sexual Abuse	1 2 3 4	
Handling Financial Problems	1 2 3 4	
Handling Legal Problems	1 2 3 4	
Handling Health Problems	1 2 3 4	
Family Violence (actual or threatened)	1 2 3 4	
Handling Someone Else's Alcohol or Drug Problem	1 2 3 4	
Dealing with Aging Parents	1 2 3 4	

What is the primary problem that has brought you to counseling?

_____

_____

Please list the goals you hope to achieve in counseling (be specific).

_____

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Current Medications including Dose	When Started?	For What Condition?	Prescribed By?

Are you currently under the care of a physician? If yes, please list the name, practice name and phone number of the physician.

For what conditions are you being treated?

Please list additional medical conditions, past and present:

SUBSTANCE USE HISTORY	Amount used and frequency IN LAST MONTH example: 3 beers per day	Amount used, frequency used and dates WHEN YOU USED IT THE MOST (ex: 6 beers per day in 1991)
Coffee-tea-caffeinated soda		
Cigarettes		
Alcohol		
Marijuana		
Cocaine		
Amphetamines (uppers)		
Barbiturates (downers)		
Tranquilizers		
Hallucinogens		
Opiates		
Other _____		

Name(s) of prior Mental Health/ Chemical Dependency provider(s)	Dates	Helpful? *(Y or N)*

List any family history of mental health issues and chemical dependency

Years of education _____ Highest Degree _____

What are your hobbies and leisure time activities?

Does your social support system work for you?

Provide any other information you feel is important.

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INFORMED CONSENT AND DISCLOSURE STATEMENT

(For your records, a copy of this policy is available at www.nancyadlerjones.com)

Introduction

Welcome! The decision to work with a counselor is an important one that only you can make based on the match of your needs and the counselor's skills. Please read the following information about my practice so you will understand more about my background and how we might work together. Please wait to sign the Signature Page until we begin our first session together. I will clarify your fees and you can ask me any questions you have that are not covered in this statement.

As an independent practitioner, I am not affiliated with any organization, group practice, or other individual(s), including those who are also located at 21321 65th Ave. SE, Suite B, Woodinville, WA 98072 or 3101 Oaks Ave., Everett, WA 98201.

My Education and Training

I received my Masters of Social Work degree in 1975 from the University of Washington. In the years since, I have done psychotherapy in a wide variety of settings and have taught the counseling process to other professionals. I am licensed to provide counseling in Washington State (LW #00004257), and am also nationally recognized as a Board Certified Diplomate in Clinical Social Work. I have additional credentialing as a Board Certified Coach and Telehealth Provider.

Modality and Therapeutic Orientation

The decision to seek counseling is often a difficult one. My goal in working with you is to address the concerns **you** have, tailoring treatment to your personality and needs. My treatment approach draws from aspects of Solution Focused Therapy, Cognitive Behavioral Therapy, Insight Oriented Therapy, Mindful Self-Compassion, and Emotional Brain Training. Some clients need only a few sessions, while others may benefit from longer term counseling. Above all, my approach is to be human and authentic as we work together.

Although a successful outcome cannot be guaranteed, I will use my best abilities and forty-plus years of experience to help you overcome the difficulties that led you to seek professional help.

If you believe you are not receiving what you need from our sessions, please let me know so we can work better together. As a client, you have the right to refuse any treatment you do not want, and the responsibility to choose a treatment provider and modality that best suits your needs. You have the right to ask questions about what we are doing, to request changes in my approach, and to take a break or end counseling at any time. If your concerns are beyond my areas of expertise, or at your request, I will refer you to another professional.

Appointments

When you schedule an appointment, you are asking me to set aside a time especially for you. As a courtesy to me and to others who may wish to schedule, please notify me by **telephone**, giving me as much notice as possible if you need to change or cancel your appointment. **YOU WILL BE EXPECTED TO PAY A MISSED SESSION FEE OF $100 WHEN LESS THAN 24 HOURS NOTICE IS GIVEN. YOUR INSURANCE COMPANY WILL NOT COVER ANY PORTION OF THIS CHARGE.**

Typically, sessions are 45-55 minutes long. They begin at the scheduled time, not when you arrive, and include time to schedule your next appointment and accept payment. I request your cooperation and assistance in ending sessions on time. If you are paying by check, please have your check written out in advance. If paying by cash, please have the exact change. In consideration to those with sensitivities, please come to appointments FRAGRANCE FREE. As research has shown that split attention from the presence of cellphones undermines the effectiveness of therapy, please consider turning off your phone.

Fees

The fee is $175 for the first session, $155 for 55 minute sessions and $125 for 45 minute sessions. Occasional exceptions may be negotiated based on financial circumstances. Acceptable forms of payment are cash or check. This fee will be charged on a pro-rated basis for any additional time spent in session, telephone

consultation of 5 minutes or more, report preparation, or other activity. In the unlikely event that there would be legal involvement in your situation, you will be billed according to the legal fee schedule and policies current at that time.

A $40 fee will be charged for any check returned unpaid. A bookkeeping fee of $5.00 per month will be applied to any unpaid private balance over sixty (60) days past due. Past private balances must be paid in full within 90 days to avoid being sent to collection. If your account is turned over for collection, you will be charged a collection fee in the amount allowed by law at that time. Additionally, your confidential identifying information will be disclosed. If unusual circumstances make it impossible for you to meet these financial arrangements, please talk to me directly. This will avoid misunderstanding and enable you to keep your account in good standing.

Limitations of Confidentiality

Please also refer to the Notice of Privacy Practices posted on the website and the Insurance Billing section below. Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions 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
- 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 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, identifying information, and amount past due 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.

Please note that when you use a check to pay your fees, you may be exposing the information that you are in counseling. It is advisable to not write in the memo line of your check that it is for counseling if you wish to ensure a higher degree of confidentiality.

Also, be aware that if you have a smartphone and you have location services enabled, it can be discovered that you have come to the counseling office location.

Insurance Billing

You are responsible for knowing your insurance benefits for "behavioral health" services and for providing the information I need to complete billing forms. If you are unsure about your coverage, phone your insurance company and ask what services you plan will cover and if I am listed as a covered provider. It is your responsibility to confirm your coverage to determine your co-payment, co-insurance, deductible, and any pre-authorization they might require and the limits of your coverage.

There are advantages and disadvantages to utilizing insurance benefits for mental health services. You need to be aware of what it means to participate in insurance-monitored health care. Insurance companies and managed care plans often require information about your treatment to justify or limit your coverage. This sharing of information can compromise your confidentiality. Occasionally therapist notes are reviewed for auditing purposes. More often, treatment progress or summary information is required for requesting additional sessions. A diagnosis is required on all insurance claim forms. This information becomes a permanent part of your medical record. When this information goes to your physician, it can mean that your health care is more comprehensive. It can also mean that you may have difficulty qualifying for disability or life insurance at a later date.

My office is happy to file insurance claims and receive payment if there is a contract in place with your insurance company or Third-Party Payer and your plan includes me as a provider. You will be responsible for paying for non-covered services, deductibles, co-payments, or other unpaid charges.

Occasionally, a managed care company denies further sessions when you feel you are not ready to end treatment. In that case, unless prohibited by contracts, you have the right to pay for those services yourself.

Federal law mandates that the primary insurance subscriber be informed through an "explanation of benefits" that insurance benefits have been paid on behalf of their covered family members. If you receive insurance benefits under someone else's insurance plan, you have the right to request that your claims information be kept private from the subscriber. To do so, call the insurance company and ask to speak with the privacy officer.

End of Treatment

Though you may terminate the therapeutic relationship at any time, I recommend that you schedule at least one final session to review our work, discuss how you can continue to make progress on your own, and say a proper goodbye. There are circumstances in which I may be required or obligated to terminate the therapeutic relationship, including, for example, therapy goals have been achieved, significant lack of progress toward therapy goals, client requires in-patient treatment, client does not participate in therapy, referral to another professional has been made, a conflict of interest is identified, other circumstances change (e.g. insurance coverage). Treatment is considered ended when 60 days have elapsed since our last contact.

Communication – Website – Social Media

Telephone:

Please use the telephone to reach me to schedule or cancel appointments or to communicate any therapeutic information that you feel cannot wait until your next scheduled session. The best way to reach me is by leaving a message with my voice message service (**425) 948-4055**. I check for messages multiple times a day on weekdays until 6:00pm Pacific Time and I will return your call as soon as I am able (occasionally that may mean the next day). If your call is urgent, please say so.

I make a concerted effort to return calls promptly. To accomplish that, I use an electronic system. Usually, that means I am more accessible. Occasionally, the electronics break, or get updated. When this happens, it is for a very short time period. Therefore, if you have not heard from me within 24 hours, please assume your message did not reach me and call back.

Email:

I only use Email to occasionally send articles or other information to clients. If you need to communicate with me between sessions, please contact me by phone. That way, I can respond to you more quickly. I request that you not use Email to communicate with me.

My Emails are not encrypted. If you decide to communicate with me by Email anyway, I will assume that you have made an informed decision and I will view it as your agreement to take the risk that such communication might be intercepted. You should also know that any Emails I receive from you and any responses that I send to you become part of your clinical record.

Website:

I host a website for the purpose of informing potential clients about my services. Additionally, I post articles that I think might be relevant to current clients. These can be found on the website by going to the menu and selecting "Articles of Interest".

Social Media Policy:

I do not accept friend requests from current or past clients. I am prohibited from responding to feedback left in public forums such as Healthgrades. Please tell me directly if you have any concerns or comments about our work together.

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Emergencies

DO NOT CALL ME IN CASE OF EMERGENCY because it may be some time before I am able to retrieve and return your message. Rather, take one or more of the following measures to get immediate help:

1. Call 911
2. Go to the Emergency Room of the nearest hospital
3. Call your primary care physician or psychiatrist and explain that you are in a crisis
4. Call the Care Crisis Line at (425) 258-4357 (Snohomish County) or (206) 461-3222 (King County)
5. In addition to the above, take other appropriate measures, e.g. call a family member or friend

Ethics and Accountability

I am licensed in the State of Washington, and am accountable for my work with you. If you have any concerns about your treatment, bring them to my attention immediately. If your concern is not resolved, or if you believe I have been unethical or unprofessional (RCW 18.130.180), you may contact the Department of Licensing in Olympia at the Health Professions Quality Assurance Customer Service Center PO Box 47865 Olympia, WA 98504 / Telephone: (360) 236-4700

Ethical guidelines discourage social or business interactions between counselor and client outside the context of therapy.

Acknowledgement and Consent for Treatment

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

By signing this document, you are attesting to your consent to participation in counseling services by Nancy Adler-Jones, MSW, LICSW.

Client Signature Date

Therapist's Signature Date

Rev 03/04/19

EVERETT OFFICE
3101 Oakes Ave.
Everett, WA 98201

MALTBY OFFICE
21321 65TH Ave. SE, Suite B
Woodinville, WA 98072

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Authorization for use or disclosure of protected health information to Third Party Payers

I,_____ (birthdate),_____authorize NANCY ADLER-JONES, MSW to obtain and/or disclose the following protected health information: benefits, eligibility, demographic information, billing information, diagnosis, treatment plan, current treatment update, discharge/transfer summary and/or progress notes.

The purpose of this disclosure of information is to bill and receive payment from your insurance company, managed care organization or other third party payer. Only the minimum necessary information to obtain benefit eligibility and coverage information as well as to submit claims for payment and to comply with medical necessity and utilization review purposes will be disclosed.

Recipient of Protected Healthcare Information

Name of Insurance Co., EAP or Other Third Party Payer: _____

Revocation. It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.
Duration. If not previously revoked, and provided there are no obligations imposed by my insurer in order to process or substantiate claims made under my policy, this authorization will expire when benefit claims are no longer pending and my account has been paid in full.
Signature. Signature below authorizes use and/or disclosure of protected health information for the above purpose.

_____

Client Signature Date

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