

**Laura Caldwell, MS, LMHC**  
*Licensed Mental Health Counselor*  
*National Certified Counselor*  
**(360) 694-4739**

**400 E. Evergreen Blvd., #100**  
**Vancouver, WA 98660**

**[laura@caldwellcounseling.com](mailto:laura@caldwellcounseling.com)**

## **INTAKE PACKET**

### **INFORMED CONSENT STATEMENT**

#### **WELCOME**

This document is designed to inform you about my counseling practice and to answer some important and frequently asked questions. Please read this information carefully. Your questions about therapy or anything in this form are welcome.

In order to make the process of therapy most successful, it requires an investment of your time and energy. I will begin with an evaluation of your needs and goals and then we will discuss how we can proceed. It is important to remember that therapy may occasionally result in emotional discomfort, changes in your relationships, or temporary worsening of your symptoms. This should subside as the work progresses. You may always request changes in the treatment or to refuse treatment at any time.

#### **CREDENTIALS**

I am a Licensed Mental Health Counselor in the State of Washington (#LH00004062), a National Certified Counselor (NCC #3501), and hold a Masters degree in Counseling (MS) I have over 25 years of clinical experience working with individuals, couples, families and groups in private practice and agency.

I specialize in working with couples and individuals on relationship and marriage problems including sexual concerns and desire issues. I also address problems with communication, self-esteem, depression, anxiety, trauma, and life transitions including recovering from affairs and divorce.

I am involved in ongoing consultation and supervision, as well as continuing education.

#### **PAYMENT FOR SERVICES**

My fee is \$185 for the initial intake session and \$150 per 50-minute session thereafter. If I am covered by your health insurance, your deductible and/or co-payment are due at the time of service. Payment may be made by check or cash at the time of service.

#### **Cancellation Policy**

**I require 48 hours notice for all cancellations. Without such notice you will be charged your usual fee for missed sessions.** Insurance will not reimburse for missed sessions or sessions cancelled without adequate notice.

#### **Insurance**

Your health insurance plan may reimburse you under its coverage for mental health, for all, or part of the cost of treatment. My office will bill your insurer directly, but you are responsibility for monitoring your number of sessions covered. **I advise you to consult with your insurance provider, prior to our first session, both to verify if I am covered by your plan, and to determine your contribution at the time of service.** Sometimes insurers will compensate “out of network” providers at a reduced percentage, such as 50% of “reasonable and customary” charges, and you would be responsible for the rest of my fee. Be sure to ask if this is an option.

Some insurance companies cover me, including:

- \*Preferred provider for Blue Cross Blue Shield of Oregon
- \*Participating provider for Regence Blue Shield of Washington
- \*Non-participating provider (covered at 50%) for Premera Blue Cross of Washington

**Other billable services** include professional time spent on consultation, reports or letters, telephone conversations beyond ten minutes is charged on a \$150 per hour basis. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the complexity of legal involvement, I charge \$250 per hour for preparation, time and travel for any legal proceeding.

**INCLEMENT WEATHER**

In the case of inclement weather, particularly on wintry ice or snow days, scheduled client sessions will be conducted by phone. This can also be arranged if you are homebound with a sick child or have other physical or time constraints. At the time of your appointment I ask that you call me, and take steps to insure whatever privacy you prefer for your session.

I conduct sessions with some clients by telephone on a regular basis because they are out of state or some distance away. They report satisfaction and progress with this service.

**EMERGENCIES/PHONE CONTACT**

My office phone number is 360-694-4739. You can leave a confidential telephone message for me on my voice mail 24 hours a day, 7 days a week. I will do my best to return your call by the end of the business day. Please be aware that I am slower to respond on weekends and holidays.

**\*\*If you are in crisis and need assistance immediately, please call:**

**Emergency Services: 911**

**Vancouver Crisis Line: (360) 695-3416 (24 hours a day)**

**Portland Metro Crisis Line: (503) 223-6161 (24 hours a day)**

**CONFIDENTIALITY**

I abide by the laws and ethical principles that govern privilege and confidentiality. Apart from treatment and payment information pertaining to billing your insurance, I will not disclose to any anything you tell me, nor even the fact that I have seen you without your written authorization by way of a signed release of information.

There are a few exceptions to this standard, and they are outlined in my *Notice of Privacy Practice*, regarding the *Health Insurance Portability and Accountability Act* known as **HIPAA**, which you can read on my website, or in my waiting room. HIPAA is the federal law that provides patient protections and rights with regard to health care information for the purpose of treatment, payment and health care operations. Please take time to carefully review this document.

**RELEASE OF INFORMATION**

Please sign below to show that (1) you have read, understand and will abide by the terms outlined above in Laura Caldwell’s Informed Consent Statement, (2) that you authorize the release of your private health information to your insurance company.

\_\_\_\_\_  
*Client Signature*

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

\_\_\_\_\_  
*Signature of Parent, Guardian*

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

CLIENT INFORMATION FORM

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

Address (Including Zip): \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

May I contact you regarding appointments, treatment and other pertinent client care information

Home phone: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Work phone: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Cell phone: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

E-mail address: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

I authorize the following person(s) listed to receive information about appointments:

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

Occupation: \_\_\_\_\_ Current relationship status: \_\_\_\_\_

Names of children:

\_\_\_\_\_ Age \_\_\_ Sex \_\_\_

\_\_\_\_\_ Age \_\_\_ Sex \_\_\_

\_\_\_\_\_ Age \_\_\_ Sex \_\_\_

\_\_\_\_\_ Age \_\_\_ Sex \_\_\_

Others living with you: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Emergency contact: (Name, address, phone number, relationship to you):

\_\_\_\_\_

Any illness requiring medical or hospital treatment in last 12 months: \_\_\_\_\_

Physician: \_\_\_\_\_

**Current Medications:**

Medication	Dose	Start Date	Symptoms addressed	Prescriber

**Medication History:**

Medication	Dose	How helpful did you find the medication?

Has anyone ever complained about your use of use of alcohol and/or drugs?:

---

---

**Please check the following behaviors and symptoms that occur more often than you would like:**

- |  |  |
|--|--|
| <input type="checkbox"/> Sleep Problems            | <input type="checkbox"/> Difficulty concentrating          |
| <input type="checkbox"/> Major health problems     | <input type="checkbox"/> Loss of interest in life          |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Less sexual interest              |
| <input type="checkbox"/> Eating disorder           | <input type="checkbox"/> Increased alcohol consumption     |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Use of non-prescription drugs     |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Excessive fear of the future      |
| <input type="checkbox"/> Suicidal thoughts         | <input type="checkbox"/> Feeling others are out to get you |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Financial problems                |
| <input type="checkbox"/> Panic                     | <input type="checkbox"/> Family problems                   |
| <input type="checkbox"/> Relationship problems     | <input type="checkbox"/> Eldercare issues                  |
| <input type="checkbox"/> Problems at work          | <input type="checkbox"/> Grief or loss                     |
| <input type="checkbox"/> Weight loss or gain       | <input type="checkbox"/> Anger problems                    |
| <input type="checkbox"/> Feeling hopeless          | <input type="checkbox"/> Employers request for counseling  |
| <input type="checkbox"/> Aggression                | <input type="checkbox"/> Dizziness                         |
| <input type="checkbox"/> Delusions                 | <input type="checkbox"/> Distractibility                   |
| <input type="checkbox"/> Elevated mood             | <input type="checkbox"/> Fatigue                           |
| <input type="checkbox"/> Gambling                  | <input type="checkbox"/> Memory impairment                 |
| <input type="checkbox"/> Irritability              | <input type="checkbox"/> Mood swings                       |
| <input type="checkbox"/> Loneliness                | <input type="checkbox"/> PMS                               |
| <input type="checkbox"/> Worry                     | <input type="checkbox"/> Phobias/fears                     |
| <input type="checkbox"/> Racing thoughts           | <input type="checkbox"/> Nightmares                        |
| <input type="checkbox"/> Self Harm                 | <input type="checkbox"/> Sexual addiction                  |
| <input type="checkbox"/> Smoking                   | <input type="checkbox"/> Sexual difficulties               |
| <input type="checkbox"/> Over spending             | <input type="checkbox"/> Isolating yourself                |
| <input type="checkbox"/> Computer use              | <input type="checkbox"/> Body pain                         |
| <input type="checkbox"/> Other                     | <input type="checkbox"/> Obsessive thoughts                |

**Briefly describe what brought you here today:**

**Previous counseling experience:**

For what reason? \_\_\_\_\_

Approximate dates: \_\_\_\_\_

Were you satisfied with results? \_\_\_\_\_

Why did counseling end? \_\_\_\_\_

Additional counseling on other side of page.

**Referral source:**

Name: \_\_\_\_\_ Laura's website \_\_\_ Yellow pages \_\_\_ BCBS web site \_\_\_

It is common practice to thank a referral source. Would you have any objection? Yes \_\_\_ No \_\_\_