Eric Anderson, LICSW
2215 Broadway
Vancouver, WA 98663
(360) 906-7156

CLIENT INFORMATION FORM

Name: _____ DOB: _____ Today's Date: _____

Address_____ City_____ State_____ Zip_____
Home Phone (_____)_____ ☐ OK to leave message.

Work Phone (_____)_____ ☐ OK to leave message.

Gender: Male ☐ Female☐ By who were you referred? _____

Guardian's Name (If you are a minor): _____

Marital Status: Single ☐ Married ☐ Committed Partner☐ Separated☐ Divorced ☐

Partner's Name: _____
DOB: _____

EDUCATION

Currently enrolled in school? Yes☐ No ☐ Total number of years completed/degree: _____
If you are a minor: Current school_____ Teacher_____ Phone_____

EMPLOYMENT

Are you currently employed? Yes☐ No ☐
Employer: _____

Occupation:_____ Job responsibilities and stress level of job:_____

_____

LEGAL

Are you involved in any legal activities (civil, criminal, custody, probation, etc.)? Yes☐ No ☐

If yes, please describe: _____
Past History: Traffic Violations? Yes☐ No☐ DUII/DWI? Yes☐ No ☐
Felony/misdemeanor charges/convictions? Yes☐ No☐ Civil/custody lawsuits? Yes☐ No ☐

MENTAL HEALTH TREATMENT

Have you participated in counseling before? Yes☐ No☐ If so, with whom? _____

Reason for treatment? _____

PRESENTING PROBLEMS

Please describe what brought you here today? _____

_____

_____

What do you hope to gain from therapy? _____

_____

_____

What do you do to help cope or feel better? _____

_____

_____

CONCERNS

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

- ☐ Aggression
- ☐ Alcohol use
- ☐ Angry outbursts
- ☐ Argue/conflicts
- ☐ Anxiety
- ☐ Computer use
- ☐ Confused thoughts
- ☐ Depression
- ☐ Delusions
- ☐ Disorientation
- ☐ Disorganized thoughts
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug use
- ☐ Eating
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood swings
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Racing thoughts
- ☐ Reoccurring thoughts
- ☐ Self-harm
- ☐ Sexual addition
- ☐ Sexual difficulties
- ☐ Smoking
- ☐ Spending money
- ☐ Sleeping problems
- ☐ Social isolation
- ☐ Suicidal thoughts
- ☐ Worrying

Briefly describe how the above checked symptoms impair your ability to function effectively: _____

_____

_____

Have you ever had thoughts about hurting yourself or seriously harming someone else?
Yes ☐ No ☐

If yes, please describe: _____

_____

Have you ever purposely hurt yourself or another? Yes ☐ No ☐ If yes, please describe:_____

_____

FAMILY HISTORY

Relationship	Name	Age	Deceased	Quality of relationship
Mother				
Father				
Step-Mother				
Step-Father				
Significant Other				
Children				

MEDICAL INFORMATION

Current Physician: _____
Phone: _____

Physician's address: _____

Date of most recent complete physical examination: _____

Do you have a history of any of the following medical conditions?

- ☐ Serious accident
- ☐ Head injury
- ☐ High fevers
- ☐ Vision problems
- ☐ Digestion problems
- ☐ Abortion
- ☐ Cancer
- ☐ Seizures
- ☐ Surgery
- ☐ Meningitis
- ☐ Hearing problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Chronic pain
- ☐ Heart problems
- ☐ Allergies
- ☐ Hospitalization
- ☐ Headaches
- ☐ Loss of consciousness
- ☐ Pregnancy/Miscarriage
- ☐ Speech/language problems
- ☐ Sexually transmitted disease
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Hepatitis A,B,C,D,E,G
- ☐ Fibromyalgia
- ☐ Anemia/Blood problems
- ☐ Immune deficiencies
- ☐ Significant weight gain/loss
- ☐ Other_____

Any other current health concerns:_____
_____

Medications	**Dosage**	**Date first prescribed**	**Prescribed by**

Current over-the-counter medications: _____
_____

Please list any allergies or adverse reactions to medications: _____

_____

Do you smoke? Yes ☐ No ☐ Amount:_____

Drink alcohol? Yes ☐ No ☐ Type & Amount:_____

Use illegal drugs? Yes ☐ No ☐ Substances & Amounts:_____

Daily intake of caffeine:_____

Do you exercise regularly? Yes ☐ No ☐ Amount & Type:_____

Please list top 3 stressors in order of most to least:

1._____

2._____

3._____

Eric Anderson
Licensed Clinical Social Worker

Informed Consent and Disclosure

Please read the following information and initial after each section. If you have any questions, please wait to initial and sign this form and we can go over it together.

Limits of Confidentiality

Information discussed with you as a client is confidential and cannot be released without your written permission. There is a separate Consent to Use or Disclose Clinical Information sheet attached, and an in depth Notice of Privacy Practices as required by federal HIPAA is available for you to keep. Some legal exceptions to confidentiality apply:

1. The client authorizes in writing by signing a release of information to communicate with an identified person or organization.
2. The disclosure is allowed by court orders.
3. The disclosure is made to medical personnel in a medical emergency.
4. The client commits or threatens to commit a crime against any individual.
5. The client threatens to seriously harm him or herself.
6. The client is suspected of abusing or neglecting a child, elder, or developmentally disabled person.

State law requires informing potential victims and appropriate state and local authorities so protective measures can be taken. If your records are subpoenaed, or you testify in court about treatment or evaluation, or report to an agency which requires a response, the privileged nature of communications between us may be compromised.

There may also be partial disclosure for the purpose of consultation or supervision with another professional.

INITIAL HERE _____ (CLIENT)

FINANCIAL RESPONSIBILITIES

The fee for an initial evaluation is $150.
The fee for follow up sessions is $135. A session is 50 minutes.

Some insurance carriers may cover therapeutic services. The client is responsible for obtaining prior authorization for treatment from their insurance carrier. I will bill your insurance company; however, you are responsible for co-payment and deductible as set by your benefit plan. Payments are due at the time of service.

If you are not using insurance for services or become ineligible for insurance coverage, you are responsible to pay the session rate due on the day of service.

INITIAL HERE _____ (Client/and/or responsible party)

CANCELLATIONS/MISSED APPOINTMENT POLICY

Please call to cancel or reschedule appointments 24 hours prior. If an appointment is missed or cancelled with less than 24 hour notice, you will be billed the regular scheduled fee. Your insurance company will not be billed for fees associated with missed or canceled appointments.

INITIAL HERE _____ (CLIENT/responsible party)

CONSENT FOR TREATMENT

By signing this agreement you authorize and request Eric Anderson, LICSW, to carry out treatment and/or diagnostic procedures, which now or during the course of your treatment become advisable. You have the right and responsibility to be active in treatment planning and can refuse therapy at any time. The purpose of procedures will be explained to you upon request and are subject to your agreement. While the course of treatment is designed to be beneficial, Eric Anderson cannot guarantee the outcome of treatment. Furthermore, the process of psychotherapy can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. This is a normal response to working through unresolved life experiences and these reactions will be addressed in therapy. If you have any question, or need clarification, please let me know.
INITIAL HERE _____ (CLIENT)

CLIENT RESPONSIBILITIES

It is the responsibility of the client to make and keep appointments (if you need an appointment during high stress times, please call to make an appointment prior to our regularly scheduled appointment); to arrive on time; to do any homework assignments to the

best of your ability; to be honest and open to communicate difficulties; and to let the therapist know when a procedure or assignment is or is not working well for them.

INITIAL HERE _____ (CLIENT)

I AGREE, UNDERSTAND, AND WILL COMPLY WITH THE ABOVE STATEMENTS. I ATTEST THAT THE INFORMATION LISTED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
Eric Anderson, LICSW	Date

Eric Anderson, LICSW

CONSENT TO RELEASE INFORMATION TO INSURANCE COMPANY OR THEIR DESIGNATED MANGAEMENT ORGANIZATION

This document provides the authorization for the release of relevant information to your insurance company or to their designated management or review organization if one exists. This information may be required in order to authorize treatment or services to pay benefits.

_____ _____ _____

Client Name Date of Birth SS#

_____

Client Address City State Zip

_____

Client Phone

I, the undersigned, hereby authorize Eric Anderson, LICSW to send information:

Primary Insurance: _____ Subscriber: _____

Address: _____

ID or SS#_____ Group Policy #_____

Phone ( ) _____ DOB: _____

_____ _____

Signature Date Signed

Responsible Party (if different from primary insured):_____

SS#_____ DOB: _____

Address: _____

_____ _____

Signature Date Signed

This authorization for release covers all dates of treatment.

This written consent is subject to revocation by the undersigned at anytime, except to the extent that the action has been taken in reliance heron. If not earlier revoked, or by other agreement specified below, this consent shall expire one year after termination of treatment.

Your signature below will authorize the insurance companies to make payment directly to Eric Anderson, LICSW

_____ _____

Signature of client, parent or legal guardian Date Signed

_____ _____

Eric Anderson, LICSW Date Signed

Authorization for Eric R. Anderson, LICSW to use or Disclose My Health Care Information

Patient Name: _____ Date of birth: _____

Previous Name: _____

I. My Authorization

You may use or disclose the following health care information (Check all that apply):

□All health care information in my medical record

□Health care information in my medical record relating to the following treatment or condition

□Health care information in my medical record for the date (s): _____

□Other (e.g., X-rays, bills), specify date (s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment ` for (check all that apply):

□ HIV (AIDS virus) □ Psychiatric disorders/mental health

□ Sexually transmitted diseases □ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____City:_____State:_____Zip:_____

□

Reasons (s) for this authorization (Check all that apply):

□ at my request □ other (specify):_____

□ check only if [practice/facility] requests the authorization for marketing practice

□ check only if[practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

□ in 90 days from the date signed □ on (date): _____

□ when the following event occurs: _____

(No longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or:
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Eric R. Anderson based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization:

  Fill out a revocation form. A form is available from our office or write a letter to the office of Eric R. Anderson. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

1 authorize Eric Anderson, LCSW to use and disclose the health and clinical information of _____ for the purposes of Treatment*, Payment** and Health Care Operations***.

*Treatment (includes activities performed by Eric Anderson, LCSW providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional)

.**Payment (includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre certification and preauthorization).

***Health Care Operations (includes the administrative and business functions of this practice).

You should review Cascade Center for Wellness Notice Of Privacy Practices for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because we reserve the right to change our privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the Notice of Privacy Practices may change also. A summary of the Notice of Privacy Practices will be posted in the lobby indicating the effective date of our current Notice of Privacy Practices in the upper left hand corner. We will offer you a copy of the Notice of Privacy Practices on your first visit to us after the effective date of the current Notice of Privacy Practices. You will be given a copy of the Notice of Privacy Practices at your request.

As more fully explained in the Notice of Privacy Practices, you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. We are not required to agree to your request. If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who provide coverage for this practice are required to use and disclose your protected health information consistent with the Notice of Privacy Practices .

Please verify that you have received a copy of our Notice of Privacy Practices by signing your initials here_____.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Eric Anderson, LCSW has already used or disclosed the information in reliance on this CONSENT.

Signature of Client_____Date_____

____ Signature of Legal Guardian or Representative_____Date_____

_____

Please indicate the nature of your relationship to the client_____

Eric Anderson, LCSW

Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT

YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET

ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions or requests concerning this notice, please contact the office manager of Cascade Center for Wellness at 360-906-7156.

WHO WILL FOLLOW THIS NOTICE.

This notice describes the information privacy practices followed by this practice, professionals, staff and other office personnel including any practitioner who might provide "call coverage" for your practitioner.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the services you receive from this practice.

We are required by HIPAA law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

By State law and the ethics of our mental health professions, we must have your written, signed Consent to use and disclose health information for the following purposes:

- For Treatment. We use health information about you to provide you with clinical services. We may disclose health information about you to office staff or other personnel who are involved in taking care of you and your health.

- For Payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. It is our policy to release only diagnoses, date, demographics and type of service when we have your consent to bill third party payers. If more information is requested by a payer, we will request your written authorization for that disclosure.

- For Health Care Operations. We may use health information about you in order to run the practice and make sure you receive quality care:

i.e. Appointment Reminders. We may contact you as a reminder that you have an appointment.

Please notify us if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contact.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you are receiving Substance Abuse Treatment Federal and State law require your written Authorization each time we release health information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time. However, if we are unable to fulfill our requirements related to treatment, payment or health care operations, we may choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- To Avert a Serious Threat to Health or Safety. Based on professional judgment, we may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- Required By Law. Based on professional judgment , we will disclose health information about you when required to do so by federal, state or local law. Disclosures may be compelled by DHHS for compliance and enforcement purposes

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena. Such disclosures would be based on professional judgment.

- Law Enforcement. We may release health information if required to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- Family and Friends. In situations where you are not capable of giving authorization (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we would disclose only health information relevant to the person's involvement in your care. For example, if you were in a mental health crisis, we might involve a family member or friend in helping you get to an appropriate care facility.

Additional disclosures are permitted under HIPAA regulation. These additional disclosures will not be made by this practice without your authorization; and they may be contrary to state law. However, once information leaves this practice and becomes part of any data resource beyond our control, HIPAA permits disclosure in the following circumstances:

- Research. Health information about you can be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address or other information that reveals who you are.

- Military. Veterans. National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you. HIPAA also permits release of information about foreign military personnel to the appropriate foreign military authority.

- Workers' Compensation. Health information about you may be released for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Public Health Risks. Health information about you may be disclosed for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- Health Oversight Activities. Health information about you may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- Information Not Personally Identifiable. Health information about you may be disclosed in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

This practice will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will require a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy your health information, such as clinical and billing records. You do not have the right to inspect and copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

You must submit a written request to the designated privacy contact in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment when the information is kept by this office.

  To request an amendment, complete and submit a clear statement of the amendment you request to the designated privacy contact.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment

- Is not part of the health information that we keep

- You would not be permitted to inspect and copy

- Is accurate and complete

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to the designated privacy contact. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not call you at your office, or that we not communicate with a certain family member, no matter what the circumstance.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may simply advise us in writing of specific limitations or restrictions you want placed on our use of health information for treatment, payment or healthcare operations. We will not ask you the reason for your request. We will accommodate all reasonable requests.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may simply advise us in writing of specific limitations or restrictions you want placed on our communications with you. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact designated privacy contact.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, write to our designated privacy contact

You will not be penalized for filing a complaint.