

**La Perla Counseling and Trauma Response Services, Inc.**

**Steve Sandvik, MA, LMHC**

1611-116<sup>th</sup> Ave N.E. Suite 215, Bellevue, WA, 98004

425-449-8171

**Client Registration**

**(Please Print)**

Name (including prefix): \_\_\_\_\_ Today's Date: \_\_\_ / \_\_\_ / \_\_\_

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

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

Email: \_\_\_\_\_

Birthdate: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_ Marital Status: \_\_\_Single \_\_\_Married \_\_\_Separated \_\_\_Divorced

Spouse's name (if married): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

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

Client's Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date Hired: \_\_\_ / \_\_\_ / \_\_\_

Referred By (if applicable): \_\_\_\_\_

**Person Responsible For Bill, If Not Client**

Name (including prefix): \_\_\_\_\_ Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Relationship to client: \_\_\_Spouse \_\_\_Child \_\_\_Dependent \_\_\_Other: \_\_\_\_\_

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

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

**PLEASE NOTE: Claims submitted to Insurance are subject to individual plan provisions and are not a guarantee of payment. \*\*The provider is not responsible for any unpaid claims; please check with your Insurance Company to receive full benefits\***

**PRIOR TO CLAIMS BEING PAID YOUR INSURANCE POLICY MAY REQUIRE ONE OR MORE OF THE FOLLOWING FROM YOU:**

- Obtain preauthorization prior to your first appointment
- See a contracted plan provider
- A written referral through your primary care physician

**Full fees charged for sessions cancelled with less than 48-hour notice.**

**By signing below I fully understand the above stated information, and I am responsible for my total fees at the time of service and I may seek insurance coverage with this provider on my own.**

**Signed:** \_\_\_\_\_ **Today's Date:** \_\_\_ / \_\_\_ / \_\_\_

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**Personal Data**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Parents' Names: \_\_\_\_\_

Siblings' Names: \_\_\_\_\_

Spouse (or Significant Other): \_\_\_\_\_

Children: \_\_\_\_\_

Support Person: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

\_\_\_\_\_

Losses: \_\_\_\_\_

Reason For Visit: (please circle) Addiction Depression Traumatic Event Co Dependency Life Changes  
Other: \_\_\_\_\_

Are you involved in a 12-step program or Support Group of some kind? Yes No

What kind of Counseling do you prefer? (please circle) Traditional Christ Centered

Do you have a religious preference? \_\_\_\_\_

Place of Worship: \_\_\_\_\_

Current Medications (including dosage): \_\_\_\_\_

\_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you use any of the following? If so, how often? (please circle)

**Coffee:** Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: \_\_\_\_\_

**Tea:** Yes No *Frequency: Daily Weekly Monthly Yearly Never* Number of cups per day: \_\_\_\_\_

**Alcohol:** Yes No *Frequency: Daily Weekly Monthly Yearly Never*

Number of drinks at each sitting: \_\_\_\_\_

**Marijuana:** Yes No *Frequency:* \_\_\_\_\_ **Tobacco:** Yes No *Frequency:* \_\_\_\_\_

Other: \_\_\_\_\_

Person Referred By: \_\_\_\_\_

Goals for Treatment/Visit Today: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why Now? \_\_\_\_\_  
\_\_\_\_\_

Current or Past Treatment Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever received Psychological Counseling or Psychiatric Counseling before? Yes No  
Counselor or Doctor's Name(s) and Place(s) of Practice: \_\_\_\_\_  
\_\_\_\_\_

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate the severity of your problems on the scale below: (please circle)  
Mild                      Moderate                      Severe                      Extremely Severe                      Incapacitating

Please indicate the major stressors in your life in the last twelve months: (please circle)  
Serious Injury/Illness                      Death of a close friend or Relative                      Major Illness in Family  
Divorce/Separation                      Job Change                      Gain of New Family Member  
Other (please describe): \_\_\_\_\_  
\_\_\_\_\_

Please describe what you would like to be different in our life when you are done with therapy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever thought about suicide? Yes No  
Have you ever attempted suicide? Yes No                      If Yes, when? \_\_\_\_\_  
Have you ever had a traumatic brain injury? Yes No                      If Yes, when? \_\_\_\_\_  
Have you ever been involved in an accident where your head was hit? Yes No  
(For example: Diving into a pool, car accident where your head hits the windshield, falling off a horse)  
If Yes, when? \_\_\_\_\_

Are you required by a court, the police, or a probation officer to have this appointment? Yes No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else that is important for me, as your therapist, to know about that you have not written on any of these forms? If yes, please explain here or on another sheet of paper: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Steve Sandvik, MA, LMHC

### La Perla Counseling & Trauma Response Services, Inc.

Provider Credentials: LH 60443136 EIN#: 201049804 NPI#: 1023485968

Campus Office Park, 1611 116<sup>th</sup> Ave. N.E., STE 216 Bellevue, WA 98004

Cell phone/Voicemail/Scheduling of Appointments: (206) 669-3456

[stevensandvikma@me.com](mailto:stevensandvikma@me.com)

### DISCLOSURE STATEMENT AND CLIENT CONTRACT

We are about to begin a counselor/client relationship that I believe will be a helpful, rewarding, and healing process. I also believe that choosing a mental health counselor or marriage and family therapist must be made from an attentive and conscientious course of action. I expect our first 1 – 3 sessions together will be a time to evaluate whether or not we will be able to work effectively together. However, before we do, we should have a mutual understanding of what each of us should expect from our session.

The State of Washington requires specific information be provided to you regarding services rendered by a mental healthcare provider. The purpose of this STATEMENT OF DISCLOSURE ([RCW 18.19.060](#)) is to inform you of your rights, responsibilities, and the provisions of state law. The STATEMENT OF DISCLOSURE is also designed to share with you my background, philosophy of treatment, and expectations.

You should read it carefully to make certain you understand what I am saying and to be sure our philosophies fit. If you do not believe I am the appropriate counselor for you, either after reading this document or at any time during treatment, you are free to terminate our professional relationship and seek counseling from someone else.

#### **Education and Training**

At Antioch University Seattle, I completed the graduate school coursework in The Center for Programs in Psychology in the Child, Couple, and Family Therapy (CCFT) combined with Mental Health Counseling (MHC) Program. By design, both the CCFT and MHC programs are grounded in a curriculum that is intended to provide the basic competencies needed for effective clinical practice. The focus of the Combined Program prepared me for the practice of child, couple, and family therapy and mental health counseling and to meet Washington State licensure requirements.

I am capable to offer you “mental health counseling” as defined under RCW [18.225.010](#). I have the provider credential “Mental Health Counselor License” (LMHC) after the successful completion of the supervised experience requirement under RCW [18.225.090](#); I was officially with two certified supervisors, Robert Hossack, PhD, and Rob Baker, MA, LMHC, LMFT and CSAT-S in a process to maximize my licensed mental health counselor opportunity in Washington State. The licensure hours for Washington are complete; and the National Clinical Mental Health Counselor Examination (NCMHCE) for Washington is passed. I have received comprehensive trainings in problematic sexual behavior. I have also completed work (Mod 1) toward Patrick Carnes’ certified sex addiction therapist (CSAT) candidate certification. I have received comprehensive client trainings and in vivo hours leading group counseling.

In fall 2006, I exclusively advanced in a graduate student MHC Internship. MHC students at Antioch University Seattle must complete their internships during a minimum 600 on-site hours. At least 300 of the internship hours must involve direct face-to-face client contact. I have concluded therapy with clients directly related to my MHC Internship at CoHear, and engaged for more than the required 600/300 internship hours leading to a Master’s Degree in Psychology. I also gained additional group experience and internship hours as a co-therapist under Myrna Pinedo, PhD, treating sex offenders under court order residing in the community as a graduate student.

Leading up to my MHC Internship and to help me learn a range of counseling business perspectives and practices, I was independently contracted with CoHear as an office staff member; I provided contract therapy services in my role as a LMHCA (“Mental Health Counselor Associate License” provider credential) for CoHear from 2007-2012.

I was also an employee for the Washington State’s Department of Corrections (DOC). Within the DOC, I had the provider credential “Counselor Agency Affiliated Registration” who treated incarcerated sex offenders (June 2008 – April 2012).

### **Therapeutic Orientation**

I believe it is essential to establish a safe space to look at one’s presenting problems. I also believe the past experiences of a client strongly influence whom they become later in life, and affect patterns of thought, emotions, and behavior. I focus not only on the whole person (biological, cognitive, emotional, and social/spiritual components of health), but also on their family system. Furthermore, I carefully think and listen by way of a broadminded perspective, and notice one’s personal choice, opinion, conformity, and belief concerning their life or family.

Individuals seek mental health counseling or marriage and family therapy for many reasons and with a variety of expectations and/or fears. One of the first things we will do together is to explore your reasons for being here, and what you hope to accomplish. The evaluation of your goals will be an ongoing process that we will return to throughout our time together.

I practice a wide-ranging therapeutic orientation with clients and use methods and interventions that are mostly based in Attachment-Focused EMDR (Eye Movement Desensitization Reprocessing), Cognitive-Behavioral, Humanistic, Group, and Solution-focused brief therapies. These theoretical perspectives are more *intrapersonal and individual-oriented*.

I also work in Family Systems oriented theory. Family therapy uses methods and interventions from theoretical perspectives that are more *interpersonal and system-oriented*. In this sense, I will concentrate more on your relational, social, and cultural experiences of your family while taking into account the context of your inner world.

Predominately, I am paying attention to various clinical issues where the client and/or family suffer from behavior in an *addiction cycle, a sexual compulsivity, and risk-taking behaviors* (e.g. pornography, prostitution, drug and alcohol use/abuse); *women and men’s issues* (i.e. restoring couples intimacy and trust, dating, career, fatherliness); *codependence; family dynamics* (i.e. origin, the past) and *trauma resolution and healing*.

**In order for you to gain the most from our sessions together, I would like to comment on three areas of concern.**

*First, I would like to comment on my role as a counselor.*

I will provide counseling treatment to an individual, couples, and the family. When you request treatment for yourself or for person for whom you are responsible, be assured that I shall do my best to perform all services in a professional manner. You should expect from me the best and most thoughtful counseling I can offer. You should expect me to be open and honest with you and to respect your confidentiality. I will work with you to the best of my abilities consistent with my philosophy of treatment to give you the guidance and counseling you and your family require.

I shall endeavor to explain the nature of the treatment I recommend for you and the length and course of treatment as well as other options that may be available to you in treating the kinds of issues or problems discussed. In this view, it is always appropriate, and I encourage you, to raise questions about the nature and course of your treatment. You also have a right to request a review of your records.

As a counselor, I would like you to know that my perspective is influenced by Christian spiritual principles. I will endeavor to simultaneously honor the sacredness of each client's chosen spiritual orientation and welcome a diversity of clients. I will work to the best of my abilities to provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

*Second, I would like to comment on your role and responsibility as the client.*

Our relationship will be a joint undertaking (i.e. firstly rapport-building, leading to a therapeutic alliance) where we will work together to solve the problems you are experiencing and with a goal of healing you and your family's wounds. The course of treatment will be openly discussed with you and/or with your family at whatever time is necessary and appropriate. You should remember that our relationship is entirely voluntary, and that you have the absolute right to end it at any time you wish and for whatever reasons you desire.

I, too, may end our relationship if I believe it is not producing productive results. Therefore, if we are to work together, we must clearly understand what we should expect from each other. For your part, I expect you to be open and honest with me, to show up for your appointments on time, and to meet your financial obligations pertaining to the counselor/client relationship. Any veiled threats of acting out violence or violent outbursts in the office by you will result in immediate termination of therapy and a referral to another counselor.

There are no guarantees that the results of therapy will conform to your every expectation. I promise no particular outcome from treatment. In fact, effective therapy every now and then confuses, and is from time to time emotionally painful. Effective treatment depends to a significant degree on your openness, your commitment to change, collaboration, and a therapeutic alliance in place.

*Third, I would like to comment on my standards about confidential information.*

In order for me to counsel you effectively, I believe we must be as open and honest as possible with each other. I will preserve private or confidential information you disclose to me as long as this privacy is legal and ethical. I will share no information that could be personally identifying to anyone (including your name) unless I have written permission to do so from you.

**Standard #1: If you are seeking counseling with your entire family.** If you are seeking counseling with your entire family I will share with all family members what you share with me. I believe in the free flow of information within families to facilitate the breaking of barriers and stimulate the healing process better if I am free to discuss all family matter with all family members. If, on the other hand, you are seeking counseling as an individual, I will not share the fact you are seeking counseling from me, or anything that is said in our sessions with anyone else without your prior written permission.

**Standard #2: If the law or ethical rules require me to release information.** There are certain circumstances when the law or the ethical rules that apply to counselors require me to release information I have learned during our sessions without your written permission to do so. Clients are to be informed of the extent of confidentiality provided by chapter [18.19.180](#) RCW. The exceptions are:

- (1) With the written consent of that person, or; in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;
- (2) That a person registered under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;

- (3) If the person is a minor and the information acquired by the person registered under this chapter indicates that the minor was the victim or subject of a crime, the person registered may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;
- (4) If the person waives the privilege by bringing charges against the person registered under this chapter;
- (5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter [18.130](#) RCW; or
- (6) If I learn a child is being subject to abuse or neglect. I am also required to report such incidents to authorities. "Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child by any person under circumstances that indicate that the child's health, welfare, and safety is harmed, as required under chapter [26.44](#) RCW. I am also required to report such incidents to authorities if I learn an adult dependent or developmentally disabled person has suffered abuse or neglect.

I may release information I have learned during our sessions without your written permission when:

- (1) An involuntary commitment for mental health assessment seems necessary.
- (2) You are unable to pay my fees on time or in full, hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. I have the option of using legal means to secure payment.

### **Duty to Warn or Report**

Washington State Law requires counselors to report instances of abuse and we may be required to report harmful, dangerous or criminal action intended against oneself or another human being. In these cases, it is the counselor's legal duty to warn specific individuals of such intentions. For example:

- (1) A family member of the client who is likely to suffer grave personal harm.
- (2) A family member of the client who intends to harm oneself or others.
- (3) Law enforcement officials, hospitals, or child protective services (CPS).

I will first take steps to share that intention with you, if you are the client, before informing anyone and/or making a report to anyone who may need to be warned.

No child under the age of twelve (12) can be left unattended in the waiting area due to the need for child protection and safety. If you have a child under this age, appropriate childcare must be provided for them while you are occupied in a counseling session with me.

Adolescents in the State of Washington who are age thirteen (13) or older may have specific rights to confidentiality with their counselor. Parents who request treatment for an adolescent for whom they are responsible please notice and be knowledgeable of your adolescent's legal rights to confidentiality. Please feel free to direct your questions or concerns regarding these specific teenage rights to confidentiality to me.

### **Disclosure or Release of Information**

If you are a minor (under 18-years old) and the victim of a crime, I may be required by law to testify at an inquiry concerning that crime. Also some of the information you give me may be discussed with your parent or guardian.

Under certain circumstances, which you are a minor or an adult, information that you reveal may be subpoenaed. A court of law would determine any information that would be revealed. If you choose certain information to be disclosed or released to a third party (e.g. another counselor, physician, social worker), you will need to sign a written consent for me to disclose or release it.

### **Client Consultations**

There are times when I may determine it is your best interest for me to seek consultation about your case from other professionals in my field or in other physical or mental health areas. If I do, I will always do so without identifying you. This way, I can seek the best course of treatment for you while maintaining confidentiality in our therapeutic

relationship. Your case may be discussed with a certified mental health professional, a physician, or a licensed supervisory consultant whose services have been contracted solely for professional consultation.

The following licensed healthcare practitioners provide me consultation for the counseling work I do:

Brian L. Whitney, MA, LMHC, LMFT

Rob Baker, MA, LMHC, LMFT, CSAT-S

Sonja Rudie, MA, LMHC, EMDR-S, CSAT

### **Information Practices**

Healthcare providers are required to provide you with the following information:

Records of services provided to you are safely kept and you may ask for a copy of that record. Also, you may ask for the records to be corrected. You may see your record or get more information about it from me. The record will not be disclosed to others unless you direct me to do so, or unless the law authorizes and compels me to do so. Your records will be kept for seven (7) years. After seven years, they may be destroyed through a disposal service that maintains a confidentiality practice.

### **Scheduling & Statement of Treatment**

All appointments are scheduled by me and are occasionally offered during off peak business hours (e.g. after 7:00 pm).

Please call (206) 669-3456 to leave a confidential message or schedule an appointment M – F.

Office hours are Monday, Tuesday, Thursday, and Friday (7:00 a.m. – 7:00 p.m.) and Wednesday (7:00 a.m. – 12 p.m.).

I may make return calls during/after these normal business hours. In the event of an emergency, when I am not available to speak with you, my cell phone is answered by voicemail and monitored frequently during office hours

If you cannot wait for me to return your call,

- (1) Contact your family physician or the nearest emergency medical center
- (2) Contact the Crisis Line at (206) 461-3222
- (3) Dial 911

The duration of therapy will be based upon a treatment schedule designed by the client and me that will address his or her needs.

Group therapy is provided by verbal contract for a minimum 12-week commitment and this signed DISCLOSURE STATEMENT acknowledges a 12-week financial commitment in spite of your attendance.

### **Fees**

Intake, Standard, and Group Fees

Our initial counseling session is called an *intake*. An intake is a significant session to obtain past and present information from you; so your first session will take 60 minutes.



The one-time fee for an *initial intake* counseling session is \$165 (REV: 1/7/2016)

If you require a longer initial session to meet your needs, please talk about it with me; and you can make a second appointment or extend this *intake* session.

A following *standard* counseling session is \$140 and will take 50 minutes in my office (REV: 1/7/2016).

If you prefer more standard session time, it can be prearranged ahead of a scheduled appointment. I apply the remaining 10 minutes of a scheduled counseling session for your case management, phone calls, file updates, progress notes, treatment planning, and obtaining suitable releases of information.

A weekly *group* counseling session is \$50.

If you are unable to pay my fees on time or in full, and arrangement for payment have not been agreed upon, after 60 days I have the option of using legal means to secure the payment.

If the arrangements have not been made, I may need to discontinue our relationship if you fail to pay for services rendered by me.

### **Cell phone Conversations/Email Correspondence**

There is a fee for cell phone discussion that lasts 15 minutes or longer. The dialogue will be prorated at my *standard* fee (\$140) during regular business hours. For example, if we consult on the telephone for 20 minutes, the fee for this discussion is \$56 (i.e. \$140/50 min. x 20 minutes).

Telephone discussion that you initiate outside regular business hours will be considered emergency hours.

The fee for emergency dialogue will be prorated at my *initial* fee (\$165).

Confidentiality cannot be protected via Internet for counseling services. However, the Internet may be used to answer a request for information or questions you may have.

### **Additional Services**

File and case reviews (\$200/hr)

Report writing (\$200/hr)

Transportation to Court (\$200/hr)

Waiting for Court to testify (\$300/hr)

Court testimony or deposition (\$400/hr)

Parking reimbursement (100% of parking cost)

### **Payment and Insurance**

Clients or their responsible guardian are responsible in full for their accounts.

Payment in full is due at the time services are rendered. Important therapy time is protected if your check is completed prior to the beginning of your counseling session. I also accept cash, credit cards and money orders as a method of payment.

Counselors practicing counseling for a fee must be credentialed with the department of health for the protection of the public health and safety.

Again, my provider credential is the “Mental Health Counselor License” from the Washington State Department of Health. I am credentialed to diagnose mental disorders or to conduct psychotherapy as defined in WAC [246-810-010](#) (14). I am able to screen a client’s level of functional impairment as described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

It is not my best practice for me to “bill” your insurance coverage at this time. I will provide you a receipt with a CPT & DX Code (when appropriate) for services rendered to you by me; it is up to you to submit receipts to your insurance provider to cover (or not) any monetary reimbursements for services rendered.

### **Missed Appointments/Improper Cancellation/Collections**

All scheduled appointments are charged; and a 2-day notice is required to cancel a scheduled appointment with me. If you have an emergency, you may call to inquire about the availability of a change. Your call will be returned as soon as an available opening occurs, or to inform you that there is no opening.

The client’s cost per counseling session will be charged for a scheduled appointment that is missed, or where notification is not received two (2) days in advance of the recognized appointment. Let’s work together to make certain it doesn’t happen to you. You are responsible for last-minute sick calls (i.e. less than a 2-day notice to cancel a scheduled appointment) will render at half-rate (50%) as a consideration to you. Group meetings are the exception. All group meetings are held within a 12-week “Session” schedule (and can be less or more), and your seat is held by your verbal and monetary commitment during a group’s weekly schedule.

Furthermore, dropped cell phone calls or missed messages due to cell phone practice are not the responsibility of this counselor. Please consider using a landline for doubtful contact or else you will be responsible for the appropriate fee if I have not received timely conversation in/or a message from you.

I do, a times, accept advance payments (i.e. outside the time services are rendered) for individual, family or group counseling sessions. There are times when this practice is unavoidable (e.g. correct change for the fee for service rendered is unavailable in my office).

Refunds will be a collaborative responsibility between the client and/or family and me.

### **Termination of Treatment**

The following language must appear on every client’s DISCLOSURE STATEMENT:

“Credentialing of an individual with the department of health does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.”

I am required to inform clients about the purpose of the Counselor Credentialing Act chapter [18.19](#) RCW is to:

- (A) Provide protection for public health and safety, and
- (B) Empower the citizens of the state of Washington by providing a complaint process by those counselors who would commit acts of unprofessional conduct.

Concerns about your counselor may be made to:

Washington State Department of Health  
Health Professions Quality Assurance  
P.O. Box 47860  
Tumwater, WA 98504-7865

An Internet hyperlink of the acts of unprofessional conduct in RCW [18.130.180](#) is provided to you in this disclosure in this DISCLOSURE STATEMENT.

Your signature below indicates you have been given a copy of the required disclosure information

Your signature also indicates that you read the information provided and understand and accept the general conditions described in this document; and your signature also indicates that you received and understand the department of health's education and assistance brochure, *Counseling or Hypnotherapy Clients*.

Furthermore, your signature below indicates you have received a copy of the following:

- (1) Disclosure Statement (this document)
- (2) Statement of Treatment (included in this disclosure)
- (3) Limits of Confidentiality (included in this disclosure)
- (4) Financial Requirements (included in this disclosure)
- (5) Washington State brochure titled, *Counseling of Hypnotherapy Clients* (I do not offer Hypnotherapy)
- (6) Authorization of Healthcare Release
- (7) Accounting Disclosures

Signature of client/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Steven E. Sandvik, Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

My signature indicates the accuracy of the information and my declaration to uphold my responsibilities described in this document.

I am a *Mental Health Counselor* (WA Dept. of Health Provider Credential: LH 60443136), Steve Sandvik, MA, LMHC. I remain a division in the business and legal entity of La Perla Counseling & Trauma Response Services, Inc. If my name appears in context with other practitioners or professionals it is not intended to specify or imply any mutual liability.

**La Perla Counseling and Trauma Response Services, Inc.**  
**Steve Sandvik, MA, LMHC**  
1611-116<sup>th</sup> Ave NE, Suite 215, Bellevue, WA 98004  
425-449-8171

**Therapy Contract/Informed Consent**

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date First Seen: \_\_\_\_\_ Referred By: \_\_\_\_\_

Check this area if you do not wish to have progress notes kept on your case: \_\_\_\_\_

**Steve Sandvik, MA, LMHC, has agreed to provide an outpatient treatment in the following manner:**

**Frequency:**

**Individual therapy:**

**Conjoint/Family therapy:**

**Group therapy:**

**Estimated Length of Treatment:**

**Goal of Treatment:**

**Travel time:**

**Fee**

**\$**

**\$**

**\$**

**same as hourly fee door to door**

I have read the treatment plan indicated above. This treatment plan reflects Mr. Sandvik's professional opinion and my stated personal preference. I understand this treatment plan can be modified by me, in consultation with Mr. Sandvik, at a later date. I understand that Mr. Sandvik is a Licensed Mental Health counselor and that Mr. Sandvik's fee is \$165 for an intake session, \$140 for a 45 minute standard session, and \$165 for a 60 minute extended session. I understand Mr. Sandvik consults with a professional case consultation group where my case may be discussed from time to time to ensure the best application of treatment planning is made available for my care.

Please ask for clarification if you are unsure how the work we are doing pertains to your reason for seeking therapy. This meets the disclosure requirements as set by the Health Department for the State of Washington.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_



# **La Perla Counseling and Trauma Response Services, Inc.**

**Steve Sandvik, MA, LMHC**

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425-449-8171

## **Insurance Benefits**

Most Health insurance companies now include some form of mental health care coverage. If you have mental health insurance, there are certain issues I believe are important for you to consider.

### **Medical Necessity**

Most people with health insurance assume they can just use their mental health benefits on the basis of their desire to participate in counseling or psychotherapy, or with a letter of referral from their doctor. The reality is that insurance companies require that mental health care treatment be considered “medically necessary”. To be considered medically necessary, the treatment must address a mental disorder. Counseling or psychotherapy intended solely for self-improvement or normal life stress reactions is not considered medically necessary by insurance companies, and therefore, not covered by insurance mental health benefits.

### **A Mental Health Diagnosis**

Medical necessity can be established when an individual describes certain psychiatric symptoms and/or behavior that affects their ability to function on the job, school, or relationships. For example, someone might begin therapy because they are feeling depressed and are having trouble feeling motivated to complete tasks, visit with friends, and/or are having trouble sleeping.

When someone begins therapy and describes such symptoms, their insurance company requires that the therapist assign them a mental health diagnosis. You should know that all diagnoses have certain actuarial ramifications, as do smoking, age, weight, sex, and other past medical conditions. You should also realize that if you are ever asked whether you have been treated for a psychiatric problem you will have to answer “yes” because your permanent medical records will contain this information.

### **Confidentiality and Privacy**

When you submit a claim to your insurance company for reimbursements for treatment, you are required to sign a release form in which you are giving your insurance company the right to ask for whatever documentation and information it deems necessary to determine the legitimacy of the claim.

# La Perla Counseling and Trauma Response Services, Inc.

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## Authorization for Use and Disclosure of Protected Health Information

For Purposes Requested by  Provider or  Patient

Name of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Provider/Recipient of Information: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Attorney: \_\_\_\_\_

Check one:  Insurance  Other: \_\_\_\_\_ Deliver copies by:  Mail  Email  Fax

For the following purposes: \_\_\_\_\_

### Types of Information to be Disclosed:

- Entire Medical Record  Office Chart Notes  Discharge Summary  All Hospital Records  
 Emergency and Urgent Care Records  Medical Records for Continuity of Care  Police Reports  
 Substance Abuse Treatment Reports  Teacher Reports  Guardian Ad Litem Reports

### Extent of Information:

I am aware that these records may contain information concerning the testing, diagnosis, and treatment for HIV/AIDS, other sexually transmitted diseases, and/or substance abuse services governed by 43 CFR Part 2, and/or mental health services governed by RCW 71.

### Revocation:

It is my understanding that this authorization can be revoked at any time, except to the extent that use and/or disclosure made in good faith may have already occurred in reliance on this authorization.

Revocation Date: \_\_\_\_\_ Re-disclosure Date: \_\_\_\_\_

### Expiration:

If not previously revoked, this authorization will expire 180 days from the date of signing or (date): \_\_\_\_\_

(Specific limitation: Except as to third-party payers, this authorization does not include disclosure for health care services received more than ninety (90) days from the date of last signature.)

### Signature:

*My signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment, or eligibility for benefits.*

Initial Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient's Representative (If applicable): \_\_\_\_\_

Witness: \_\_\_\_\_

Renewal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient's Representative (If applicable): \_\_\_\_\_

- Sonja Rudie, MA, LMHC, CSAT, C-EMDR  Julia Jenkins, MA, LMHC-A, CSAT-C, A-SOTP  
 Blair Schmautz, MA, LMHC, CSAT  Steve Sandvik, MA, LMHC  Kerry Fitzgibbons, MA, LMFT, CEAP