La Perla Counseling and Trauma Response Services, Inc.

Blair Schmautz, MA, LMHC, CSAT

1611-116th Ave NE, 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**: ___/___/_____

La Perla Counseling and Trauma Response Services, Inc.
Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 215, Bellevue, WA 98004
425-449-8171

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:____/____/______

La Perla Counseling and Trauma Response Services, Inc.
Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 215, Bellevue, WA 98004
425-954-6647 | 425-449-8171 | Blairslpc@gmail.com

Therapist Disclosure Statement

National Provider Identifier (1790112779),
State of Washington Mental Health Counselor (LH 60526883)

The purpose of State Counseling Credentialing Act is to:

A. To provide protection for public health and safety.

B. To empower the citizens of the State of WA by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

C. To provide Ethical and Professional Standards.

a. Maintaining professional standards is a priority. I am a life-long learner and pursue ongoing training and education.

b. If you have any questions or concerns about the quality of my services or any administrative matter, please discuss it with me. I am committed to providing the highest quality professional service, managed in a fair manner.

D. Therapeutic Orientation and Course of Treatment:

a. I received a Master's in Counseling Psychology in 2005 from Northwest University and work with individuals, couples, teens, and groups. I also, currently work with sexual addiction for the acting out party and their partner.

b. Treatment is specifically designed and adapted to your needs and the typical duration of treatment is variable. Counseling is not easily described in general statements. It varies depending on the personality of both the counselor and the client, and the particular issues that you bring in. I use several different approaches which can be utilized to address the concerning issue.

c. I will use a variety of modalities depending on what protocol is needed for your specific situation. I use a cognitive-behavioral approach to help individuals identify, evaluate, and change their thoughts, beliefs, and behaviors that influence their feelings and interpersonal relationships. Identifying your belief systems is key to discovery the way you process your feelings. I use ideas from family systems theory to help family members understand and change their thoughts and actions within a family setting. Narrative Therapy is sometimes used to help verbalize and understand the story within the story. Sometime a Solution Focused approach is used to create an atmosphere of change. Therapy is not like visiting a medical doctor, in that it

requires active effort on your part. In order to be most successful, you will be invited to take on assignments to further enhance your growth and development.

d. Counseling has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Counseling often requires recalling unpleasant aspects of your history. Additionally, difficulties with people important to you may occur, family secrets may be disclosed, and despite our best efforts, therapy may not work out well. Counseling has been shown to have benefits for people who undertake it. Research has shown that counseling often leads to a significant reduction of feelings of distress, better relationships and resolution of specific problems.

e. As a client, you have a responsibility to be an informed consumer and as such are responsible for choosing the provider and treatment modality which best suits your needs. As such, you may refuse or request a change in treatment at any time, or ask for a referral to another therapist. You have the right to seek a second opinion about your condition and treatment. You do not have to agree with me or do anything I suggest or recommend. If, you threaten violence or harass me, or my family, I reserve the right to terminate treatment immediately and unilaterally.

f. It is my desire that the therapeutic process to be characterized by openness and a collaborative attitude on both of our parts. Please feel free to share any concerns, ask questions, about any aspect of the counseling process; including, treatment approach, progress, and termination process.

E. **Professional Fees/Billing and payments:** My fee is **$140.00 per 45-minute session**. I accept cash, check, or credit/debit cards. You will be expected to pay for each session at the time it is held, unless we agree otherwise. If you prefer more session time than the standard 45 minutes, it can be arranged ahead of the appointment time. In the remaining 15 minutes of an hour is used for case management, phone calls, faxes, file updates, progress notes, treatment planning, billing, and obtaining appropriate releases on your behalf. *A portion of each therapy session will go to La Perla Counseling & Trauma Response Services, Inc. for office and administration.*

Initial visits are called intakes. It is important to gather historical information from you, so your first session time will be one hour long. Initial intakes, therefore, have a one-time charge of **$165.00** and they are 60 minutes in length.

F. **Contacting Me:** I am available by telephone at **425.954.6647**. I check voice mail at the end of business days, Monday through Friday. I will make every effort to return your call with the exceptions of weekends, holidays, and vacations. If you cannot reach me, and you feel that you cannot wait for me to return your call, you may call the **Crisis Clinic at 206-461-3222**, (toll free at: 866-427-4747), or your family physician, or contact the nearest hospital emergency room. You can also call 911 in an emergency.

G. **Telephone Conversations/Email:** There will be a charge for telephone consultations with other professionals (including attorneys and mental health care providers), especially those

which arise out of legal matters that are a party to a client case. These will be pro-rated based on the length of the call. If there are multiple calls, which collectively last over 10 minutes, they will be put together and charged to your account as appropriate. During regular business hours (Monday through Friday, 11:00am-7pm), the fee is $140.00/per hr. Consultations outside these hours will be considered emergency hours and will be billed at $200.00 per hour.

H. **Confidentiality:** In general, the confidentiality of all communications between a client and a counselor is protected by law, and I can only release information about our work to others with your written permission by filling out and Release of Information (ROI). However, there are several exceptions.

a. In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it.

b. There are some situations that I am legally required to take action to protect others from harm, even though it requires revealing some information about a client's treatment:

i. If I suspect that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

ii. If I believe that a client is threatening serious bodily harm to another; I am required to take protective action that may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.

iii. If, a client threatens to harm him/or herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

iv. If, I am aware that you are HIV positive, I may be required by state law to report your HIV status to health authorities.

v. If you are recklessly behaving in ways that could spread HIV of if you require help in notifying past partners of their possible exposure to HIV.

c. Other situations where the law allows disclosure of information without the client's authorization are:

i. To other mental health providers.

ii. To public health authorities.

iii. Person requiring information for an audit, quarterly assurance, peer review, legal, or financial counselor.

d. I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I will make every effort to avoid revealing your identity. Unless you object, I will not tell you about these consultations, unless I feel that it is important to our work together.

I. Sessions and Missed Appointments

a. When an appointment is scheduled, that time has been set aside especially for you, so please make every effort to attend. Twenty Four (24) business hours advance notice of cancellation is expected if you cannot keep an appointment.

b. **When an appointment is scheduled and is not kept, you will be expected to pay the full fee of $140.00**, unless 24 hours' notice is provided or, unless, we both were unable to attend due to circumstances beyond our control, major illness or sickness, car accident. If your short cancellation is less than 24 hours, there is a courtesy half fee charge for the missed appointment.

J. Professional relationship

a. Since building trust and having a clear understanding are of paramount importance in the provision of counseling service, it is my intention that matters which pertain to our business and professional relationship be explained and discussed openly, and that is the reason for this document.

b. If you have any concerns about these policies or questions not addressed by this summary either now or in the future, my request is that you will discuss them with me.

K. Consent for Counseling Services

a. I have read and understood this document; have had an opportunity to discuss it with Blair Schmautz, agree to its terms, and have received a copy, if desired.

b. This authorization constitutes **informed consent for counseling services** from Blair Schmautz, MA.

L. Notice of Privacy Practices (HIPAA Privacy)

a. A record of your services is filed by me and you may ask to see and copy that record at any time. You may also ask to correct that record.

b. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

"No Secrets" Policy for Family Therapy and Couples Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the pair in treatment) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment couple before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment couple). I do not provide assessments for parenting evaluations nor in divorce proceedings since that is another area of treatment specialty.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated.

I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure.

Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family.

This policy is intended to prevent the need for such a termination.

We, the members of the couple/family or other unit being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Blair Schmautz, MA, and that we enter into individual, couples counseling and/or family therapy in agreement with this policy.

___________________________________ _______________________________Date: ___/___/___

Name of Client (*please print*) (*please sign*)

___________________________________ _______________________________Date: ___/___/___

Name of Client (*please print*) (*please sign*)

___________________________________ _______________________________Date: ___/___/___

Name of Client (*please print*) (*please sign*)

___________________________________ _______________________________Date: ___/___/___

Name of Client (*please print*) (*please sign*)

______________________________________ Date: ___/___/___Blair Schmautz, MA, LMHC, CSAT

La Perla Counseling and Trauma Response Services, Inc.
Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 215, Bellevue, WA 98004
425-449-8171

Therapy Contract/Informed Consent

Client: ______________________________ Date: __________

Home Phone: ______________________Work/Cell Phone: ________________

Date First Seen: ____________ Referred By: ____________________________

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

Blair Schmautz, MA, LMHC, CSAT, has agreed to provide an outpatient treatment in the following manner:

Frequency:	**Fee**
Individual therapy:	**$**
Conjoint/Family therapy:	**$**
Group therapy:	**$**
Estimated Length of Treatment:	
Goal of Treatment:	
Travel time:	**same as hourly fee door to door**

I have read the treatment plan indicated above. This treatment plan reflects Mr. Schmautz's professional opinion and my stated personal preference. I understand this treatment plan can be modified by me, in consultation with Mr. Schmautz, at a later date. I understand that Mr. Schmautz is a Licensed Mental Health counselor and as a Certified Sexual Addiction Therapist. I also understand that Mr. Schmautz's fee is $165 for a 60 minute intake session, $140 for a 45 minute session, $165 for a 60 minute extended session, and $280 for a 75-90 minute double session. I understand Mr. Schmautz 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 in 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.
Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 215, Bellevue, WA 98004
425-449-8171

Communication Agreement

Name: ____ Birthdate: ____/____/________

Your Healthcare Provider may need to contact you to discuss your health, review results of testing, or to coordinate your care. Please review and answer the questions below outlining your preferences regarding this communication. *Additional phone numbers can be listed below.*

1. May we leave messages regarding your health information on your answering machine or voicemail at home?
   _____NO ____YES ____N/A
2. May we discuss your medical care with anyone that answers the telephone at your home?
   _____NO ____YES ____N/A
3. May we leave messages regarding your health information on your answering machine or voicemail at work?
   _____NO ____YES ____N/A
4. May we leave messages regarding your health information on your cell phone voicemail?
   _____NO ____YES ____N/A
5. Are there members of your family, household, or those coming with you to this appointment with which we should not discuss any of your health care issues?
   _____NO ____YES ____N/A

   If yes, please explain:____
   ____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be canceled or modified. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

____ ____________
Patient or legally authorized individual signature **Date**

____ __________________
Printed name if signed on behalf of the patient **Relationship**

Home Phone: ______________________________ Cell Phone: _________________________
Email: ____

La Perla Counseling and Trauma Response Services, Inc.

Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 215, Bellevue, WA 98004
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.
Blair Schmautz, MA, LMHC, CSAT
1611-116th Ave NE, Suite 221
Bellevue, WA 98004
425-449-8171 | 425-954-6647
office@laperlacounseling.com | Blairslpc@gmail.com

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 Lietem 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** ☐ **Steve Sandvik, MA, LMHC**
☐ **Kerry Fitzgibbons, MA, LMFT, CEAP** ☐ **Danielle Melton, MA, LMHC, NCC**
☐ **Kristine Zimmerman, MA, LMHC, CSAT, CMAT**