Journeys of Hope Counseling, LLC

Carrie Basher, MA LMHC
307 N Olympic Ave, Suite 212, Arlington, WA 98223 *425-309-8149 * Fax 888-972-6247
**carrie@journeysofhopecounseling.com * journeysofhopecounseling.com *

Welcome to Journeys of Hope Counseling! Before we begin our therapy sessions together, there is some important information that you need to know. There is a lot to read, but it's very important as it is our working agreement. Legally, this agreement is called an *"informed consent"*. This informed consent will help you better understand what you can expect from me, and in turn, what I expect from my clients. This agreement will also explain some limitations to what you and I will be doing. Please complete this paperwork in its entirety **prior to our initial meeting** so that we can spend our time together focusing on the personal concerns that you wish to consult with me about. I look forward to meeting with you.

What You Can Expect: I work to provide a safe environment for you to explore and evaluate your inner thoughts, feelings, and attitudes. At the beginning of treatment, we will create a treatment plan which includes what you would like to see change and what you and I will do to change it. This helps us both to know if what we are doing is working for you. Occasionally, I may need to refer you to another therapist if I believe your concerns require specific knowledge that falls outside of my scope of practice. Please understand that our initial session is an assessment for both of us to determine whether or not we want to work together; it is not an indication that I have accepted you as a client or that you have accepted me as your counselor.

Potential Benefits and Risks of Therapy: Therapy is generally not easy work. It may include discussing deep, personal information. This may involve analyzing yourself within the context of relationships in love and work, as well as how you think, feel, and organize your internal and external worlds. Therapy consists of helping you identify and transform attachments, unexpressed emotions or emotional triggers, unresolved issues, and self-defeating thought patterns which are causing you emotional pain. At times this process may be painful. It may take a while for you to begin to feel better. I can't offer any promises about the results you will experience. Your outcome will depend upon a variety of factors. I do come to care deeply about my clients; however, I do not have social relationships with clients, even after we have completed our work together. Standard ethical practice says, "Once a client, always a client". This means that ethically I am required to keep the therapeutic relationship intact so that you have the option of returning to counseling with me at any point in the future. I am, however, under no obligation to reengage in therapy with any of my clients.

Confidentiality and Expectations: Under Washington state law and ethics, I am required to follow the professional code of ethical guidelines regarding confidentiality. Information shared in each session is **confidential** and can only be released with your written consent or as required by law. This confidentiality has the following **exceptions** as provided by law:

- If I believe there is a risk that you might harm yourself or someone else, I may be required to contact the authorities or the other person to give them the opportunity to protect themselves or the other person.
- If you or anyone else you tell me about are currently abusing or have abused children or vulnerable adults, I am required by law to notify the authorities so they can protect others from harm.
- If you become involved in any lawsuit in which your mental health is an issue, such as a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering and/or I receive a properly submitted subpoena or court order, I may have to release your information.
- If you file a complaint against me to the state licensing board, you lose the protection of confidentiality.

- When you sign the Release of Information form, giving me permission to share confidential information, then it is no longer considered "confidential" information between us.
- Insurance companies (when applicable) and other third-party payers are given information they request regarding services to clients.

I will keep clinical records of your sessions with me, as required by state law, for seven years beyond the end of therapy, at which time, it will be destroyed. You may ask to see this record and make requests to have corrections or additions made to your record. You will be charged my usual fee in 15 minute increments for the time involved. If copies of your records are requested, you will be charged 30 cents per page in addition to my time. If you are a minor under the age of 18, I may discuss with your parents or guardians some of the information from our counseling sessions. Whenever possible, I will obtain your permission prior to doing so.

My Training and Degrees: I received my Masters of Arts in Counseling Psychology from Northwest University, College of Social and Behavioral Sciences in 2015. This program is fully accredited by the Northwest Commission on Colleges and Universities to award degrees at the associate, baccalaureate, masters, and doctoral levels. My experience ranges from engaging clients at Catholic Community Services Children's Mental Health Clinic, where I received extensive training and experience with youth and adults in both agency and school-based contexts, specifically in the area of trauma-focused therapy. In addition to my formal training, I have more than 25 years of Christian ministry experience in a volunteer capacity as a youth ministry staff volunteer. I practice under the title of a Washington State Licensed Mental Health Counselor (LH 60823719). I participate regularly in confidential consultation groups with other professional therapists to ensure quality and performance for my clients.

Counseling Orientation: My approach to counseling is driven by the need to build a trusting counseling relationship based on empathy and compassion. Together we will explore your individual concerns and create realistic counseling goals. I use concepts that encourage you to find your strengths that will ultimately assist you in finding the solutions you seek. I utilize an integrated approach to therapy, as I believe there is no "one-size-fits-all" way of finding healing. I incorporate aspects of Cognitive Behavioral Therapy and Narrative Therapy into most sessions, and I appreciate the power of the here-and-now tools of Existential Therapy. When working with children, I integrate play and art therapy as well as Trauma-Focused Cognitive Behavioral Therapy when necessary. When working with adolescents, I often use many aspects of Dialectic Behavior Therapy (DBT). I work with a variety of issues including depression, anger and aggression problems, addictions, self-harming behaviors, trauma, anxiety, stress, communication issues, broken relationships, developmental challenges, and spiritual concerns. Although I am not a certified Christian Counselor, I am able to integrate Biblical counseling into our sessions when desired by the client.

Fees: The individual fee for counseling is $105.00 per 53-minute session and $150.00 per 90-minute sessions for couples. Fees are adjusted bi-annually on January 1st and June 1st and will not increase more than $10 per adjustment. Payments (cash or check) are to be made at the beginning of each session and made out to **Journeys of Hope Counseling**. A $35 fee will be charged for returned checks. Outstanding balances may be forwarded to a collection agency.

Missed Appointments: In the event that you are unable to keep an appointment, **please notify me via phone, text, or email** a minimum of three days (72 hours) in advance. If you miss your appointment for any reason and fail to give me adequate notice, you will be responsible for the full fee for the session. If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a therapy session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Legal Proceedings: If you become involved in legal proceedings that require my participation, even if I am called to testify by another party, you will be expected to pay for all of my related time, including preparations, transportation,

and time in court (both waiting and testifying). Due to the difficulty of legal involvement and my need to obtain my own legal counsel when involved, I charge $250 per hour for preparation and attendance at any legal proceeding.

Medical Concerns: I am not a medical doctor and therefore, cannot recognize or diagnose conditions. It is essential that you obtain a medical examination to determine if there is any medical origin of your psychological problem (e.g. neurological disorders, diabetes, medication side effects, etc.)

Emergency: If you need to reach me, my business cell phone number is 425-309-8149. I check my messages regularly throughout the day and will try to return calls within 24-48 hours. If I do not return your call, please call again as your message may have been lost. I do not routinely check messages in the evenings and on weekends. **If you cannot reach me, please call the Crisis Line at 425-258-4357 or 911**.

Each person entering therapy, the individual, each person in the couple, or each family member needs to sign below. **Your signature below indicates your understanding and acceptance of the general conditions outlined in this agreement, and that you authorize me, Carrie Basher, to render counseling for you. This authorization constitutes informed consent without exception and agreement to pay all applicable fees.** By signing this agreement, you are stating that you have also read and understand this agreement and received a copy for yourself. My signature indicates accuracy of the information and my declaration to uphold these conditions.

_____	_____	
Client's Name, Printed	**Client's Signature**	**Date**
_____	_____	
Client's Name, Printed	**Client's Signature**	**Date**
_____	_____	
Parent/Guardian Name, Printed	**Parent/Guardian Signature**	**Date**

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN

I was referred by: _____ Relationship to Client: _____

PCP Name: _____ PCP Address: _____

PCP Phone #: _____

I, _____, have been given written information explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned written information given to me. I understand that I am responsible to pay for all missed appointments and late-cancellation fees and for what my insurance does not pay and/or cover.

Patient and/or Guardian Signature: _____ **Date**: _____

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NEW CLIENT REGISTRATION FORM

(Please complete ALL areas of this form and provide a copy of your insurance card(s) (front and back))

PATIENT INFORMATION

Client Name: _____ Sex: M [ ] F [ ]

Client Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

OK to leave a message at: HOME Yes [ ] No [ ] WORK Yes [ ] No [ ] CELL Yes [ ] No [ ] Text OK [ ]

SS #: _____ Date of birth: _____ Employer: _____

Married: [ ] Single: [ ] Divorced: [ ] Remarried: [ ] Widowed: [ ]

Name of Spouse/Partner: _____ Emergency Contact: _____

Emergency Contact Ph #: _____ Relationship to Client: _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE CLIENT): _____

Responsible Party Billing Address/City/Zip code: _____

Relationship to Client: _____ Contact Ph #: _____ SS#: _____

PRIMARY INSURANCE

Primary Insurance Co. Name: _____

Claims Address (for Mental Health): _____ Phone #: _____ (Subscriber's)

Subscriber's Name: _____ Relationship to the Client: _____

Subscriber's Address: _____ Subscriber's Date of Birth:_____

Subscriber's Employer: _____ Insurance ID#: _____

Insurance Group #: _____ Type of Insurance Plan: ___HMO ___PPO ___Medicaid __Other

SECONDARY INSURANCE

Secondary Insurance Co. Name: _____

Claims Address (for Mental Health): _____ Phone #: _____ (Subscriber's)

Subscriber's Name: _____ Relationship to the Client: _____

Subscriber's Address: _____ Subscriber's Date of Birth:_____

Subscriber's Employer: _____ Insurance ID#: _____

Insurance Group #: _____ Type of Insurance Plan: ___HMO ___PPO ___Medicaid ___ Other

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AUTHORIZATION TO BILL INSURANCE

(PLEASE NOTE, ALL 3 AREAS MUST BE SIGNED IN ORDER FOR US TO BILL YOUR INSURANCE COMPANY)

Currently, I am billing **Ambetter**, Aetna, Amerigroup, **Beacon Health Options, Cigna**, **Coordinated Care**, **HMA (through Regence)**, Kaiser**, L & I, Medica, Medicaid, Molina**, Premera, **Providence Behavioral Health, Regence, UHC (United Health Care & United Health Care Community Plan),** and Tricare. I am a contracted provider with the bolded insurances listed above. I am currently in the process of applying to additional insurance company panels and will be adding other insurance companies to this list in the future. I will bill the insurances I am not contracted with as a courtesy to you. You will be financially responsible for what your insurance does not pay and/or cover if I am not a contracted provider with your insurance and/or you do not have mental health coverage through your insurance. It is your responsibility to know whether or not I am a participating provider with your insurance and what your insurance will and won't cover. Although we will check your insurance eligibility and benefits, it is ultimately your responsibility to know your insurance coverage, copay, co-ins amount, and deductible amounts.

I _____, [your name] hereby give my consent for Journeys of Hope Counseling/Carrie Basher MA, LMHC to bill my insurance company(s) for services rendered to me by the above-mentioned health care provider.

Patient and/or Guardian Signature: _____ Date: _____

ASSIGNMENT OF BENEFIT

I _____ [your name], authorize the above-mentioned insurance company(s) to pay medical benefits directly to Journeys of Hope Counseling/Carrie Basher MA, LMHC.

Patient and/or Guardian Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I _____ [your name], authorize Journeys of Hope Counseling/Carrie Basher MA, LMHC, to release necessary medical information to the above-mentioned insurance company(s) and/or to their designated managed care company. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and psychiatric disorders/mental health. You are specifically authorized to release all health care information relating to such testing, diagnosis, or treatment.

Patient and/or Guardian Signature: _____ Date: _____

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Client Information: Please provide answers to the following questions that apply to you. Some of the questions may produce some anxiety or cause distressful thoughts. If some questions trigger feelings that seem overwhelming to you, please skip those questions until we meet and we'll discuss them together. Please understand that all information requested is for the purpose of helping me to better understand and to assist you in reaching your therapeutic goals.

Is there anyone you authorize me to communicate with? If yes: Name: _____

Phone number: _____ Email: _____ Relationship: _____

Is Spirituality important to you? Yes _____ No _____ Neutral _____

Please briefly explain why you are seeking therapy. What is the problem? How do you see your situation?

_____

_____

_____

How does this impact your social, work, or academic functioning? _____

_____

How long have you experienced this? When did it first begin? _____

_____

_____

What have you already done to try to deal with this problem? _____

_____

_____

What are you expecting from our time together? _____

_____

_____

Please list prior counseling experiences you have received.

Psychotherapy Provider: _____ Date began: _____ Date ended: _____

Reason for treatment: _____

_____

How was your previous counseling experience? Positive (helpful)_____ Negative (hurtful)_____ Neutral_____

Any previous psychiatric inpatient hospitalizations or drug/alcohol rehab experiences?:

Place & Dates: _____

Reason: _____

Who can you count on to be your emotional support? (circle all that apply)

*Parent/parents *Spouse *Sibling(s) *Children *Coworkers *Church

*Extended family *Close friends *Neighbor *Self-help group *Other _____

When do you actually ask for or seek support?

Daily _____ Weekly _____ Monthly _____ Rarely _____

Which of the following current stressors have you experienced?

	In Past Month	In Past Year
Problem/change in couple relationship	_____	_____
Disruption in other family relationships	_____	_____
Death of a loved one	_____	_____
Change in work status	_____	_____
Change in residence	_____	_____
Significant health problems	_____	_____
Financial issues	_____	_____
Legal issues	_____	_____

Other significant changes or stressors? Please explain: _____

_____

_____

Current symptoms (please mark all that apply):

Affect/Energy

Depressed Mood
Diminished energy
Diminished interest
Increased irritability
Feelings of guilt
Feelings of hopelessness
Poor concentration
Poor decision-making ability
Increased energy, feeling "high"
Decreased energy

Anxiety

Generalized fears
Shortness of breath
Feeling disconnected
Chest pains
Feelings of "panic"
Hot/cold flashes
Fears of dying
Muscle tension
Worrying
Heart pounding
Stomach upset

Sleep Disturbance

Restlessness
Excessive sleep
Nightmares
Night terrors
Decreased ability to sleep
Change in sleep pattern
Waking in the middle of the night
No need for sleep >6 hrs. per night

Eating:

Increased appetite
Decreased appetite
Weight gain
Weight loss
Binge/purge
Compulsive over eating
Not eating

Avoidance:

Fear of specific places
Fear of social situations
Constriction of life style
Fear of leaving the house
Avoidance of many things (especially reminders of painful, scary events)

Post-Traumatic Stress

Intrusive memories
Hyper-vigilance (over watchful)
Easily startled/High strung
Distressed from triggers
Numb body
Uncomfortable body sensations
Agitated/irritable

Thinking/Cognitions:

Racing thoughts
Recurring troubling thoughts
Thoughts of hurting yourself
Thoughts of hurting others
Hearing things others do not
Seeing things others do not
Feeling invincible
Grand schemes

Emotions:

Crying spells
Mood swings
Angry outbursts
Numb (not feeling)

Other:

Intense fear of abandonment
Impulsivity (driving recklessly, drinking too much, overspending)
Unstable relationships
Need to be center of attention
Anger-control issues
Feeling special/unique
Feeling you deserve better than others
Unable to connect with others' feelings

Are you suicidal? Yes _____ No _____

Have you ever had any thoughts of suicide or ever attempted suicide? (If yes, please provide dates/details)

_____

_____

Are you homicidal? Yes _____ No _____

Have you had any thoughts or plans to harm another person? (If yes, please provide details)

_____

_____

Have you discussed this information with your physician? Yes _____ No _____

When was your last physical exam? _____

Any current medical or health problems you are dealing with? Please explain (e.g. injuries, illnesses, allergies)

_____

_____

Please list any medications you are currently taking and why they were prescribed:

Medication: _____ For: _____ Amount: _____ Date began: _____

Medication: _____ For: _____ Amount: _____ Date began: _____

Medication: _____ For: _____ Amount: _____ Date began: _____

Medication: _____ For: _____ Amount: _____ Date began: _____

List any medication you have EVER been prescribed for <u>any mental health condition</u>:

Medication: _____ For: _____ Amount: _____ Date began: _____

Medication: _____ For: _____ Amount: _____ Date began: _____

Medication: _____ For: _____ Amount: _____ Date began: _____

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Circle Yes or No: *Please describe if Yes*

Yes No Have you ever been engaged in any fights or acts of violence since childhood?

Yes No Have you ever inflicted harm to yourself (e.g. cutting, burning, hitting, etc.)?

Yes No Have you ever been incarcerated?

Yes No Is there any history of mental illness in your family? If so, please describe:

History of Abuse/Trauma (Circle Yes or No)

Yes No Has anyone ever hit, slapped, kicked, punched, or restrained you against your will?

Yes No Has anyone ever touched you in ways you were not comfortable?

Yes No Have you ever been sexually assaulted and/or harassed?

Yes No Have you ever been verbally/emotionally abused?

Yes No Have you ever been abused by someone in a church (e.g. pastor, pastoral counselor, etc.)?

Yes No Have you been mistreated and/or abused by any professional (e.g. therapist, doctor, instructor)?

Yes No Have you ever been threatened with serious physical harm or death?

Yes No Have you ever been involved in any serious auto accidents and/or other accidents?

Yes No Have you ever experienced or witnessed war combat?

Yes No Have you ever experienced a serious natural disaster?

Yes No Have you ever witnessed a loved one experiencing any of the above?

Yes No Have you ever suffered trauma/injury to the head? *If yes, please explain:*

Addictions/Addictive Behavior:

How many alcoholic beverages do you drink? _____ per day _____ per week _____ none

What kind of alcohol (beer, wine, vodka, etc.)? _____

Do you binge drink? Yes _____ No _____ How often? _____

How often do you use recreational drugs? _____ per day _____ per week _____ never

Name of drug choice (e.g. cocaine, marijuana, methamphetamines, heroin, hallucinogens, etc.)? _____

How often do you view pornography? _____ per day _____ per week _____ Never

Do you keep this a secret from your parent/spouse/significant other? Yes _____ No _____

Are you concerned about the effects and/or the amount of time involved? Please describe: _____

_____

Do you feel like you have any addictive behaviors not listed here? Please explain: _____

_____

What changes would you like to see as a result of therapy?

- Short-term (within 6 weeks) therapeutic goals: _____

  _____

  _____

- Long-term therapeutic goals: _____

  _____

  _____

What is your present level of commitment to address the issues you are currently aware of as well as any underlying issues which may arise during the process of therapy? Please circle one:

1 2 3 4 5 6 7 8 9 10 (10 = 100%)

What expectations do you have from me as your therapist? _____

_____

What are three of you major strengths?

1. _____
2. _____
3. _____

What are some areas where you want to experience growth? _____

_____

_____

What is going well in your life (for what are you thankful? _____

_____

Is there anything we haven't talked about that is relevant or important, or that you feel I should know about?

_____

_____

_____

Do you have any questions for me? _____

_____

I have answered the above questions truthfully to the best of my knowledge and ability. I am fully aware that based on my diagnosis, I may be referred to another therapist if my diagnosis is out of the scope of my practice.

_____ _____ _____

Client Signature **Client Printed Name** **Date**