CLIENT INFORMATION

Name: _____

Date of Birth: _____/_____/_____ **Age:**_____ **SS#:**_____-_____-_____

Spouse's Name:____ _____ **Spouse's Date of Birth:** _____/_____/_____

Address:_____ **Apt #:**_____

City:_____ **State:** _____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Other:**_____

Email Address: _____

Gender:__ _____**Male** _____**Female** **Ethnicity:** _____

Marital Status: _____**Single** _____**Married** _____**Divorced** _____**Separated** _____**Widowed**

Employment Status: __**Full-Time** __**Part-Time** __**Student** __**Unemployed** __**Disabled** __**Other**

Employer:_____ **Position/Occupation:**_____

Primary Care Physician/Psychiatrist:_____ **Phone #:**_____

Do You Want Information Released To Your Doctor? _____**Yes** _____**No**

If Yes, Please Provide Address:_____

Emergency Contact Name & #_____ **Relationship to Client:**_____

Who referred you:_____

Home Phone: _____ **May we leave a message? □Yes □No**

Cell: _____ **May we leave a message? □Yes □No**

Work Phone: _____ **May we leave a message? □Yes □No**

E-mail: _____ **May we email you? □Yes □No**
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Client (Or Guardian) Signature:_____ **Date:**_____

STACIE CROCHET, LCSW, SAP

HEALTH HISTORY

Name:_____ **Date:**_____

1. Please describe the reason(s) you are seeking treatment:

_____

_____

_____

2. When did the problem begin and what motivated you to seek treatment *now*?

_____

_____

_____

3. On the scale below, please estimate the current severity of the problem(s):

_____	_____	_____	_____
Mildly Upsetting	**Moderately Severe**	**Very Severe**	**Totally Incapacitating**

4. List all past or present mental health treatment:

Dates	Type Of Treatment	Doctor/Therapist Name	Where

5. List all current medications:

_____

_____

_____

6. List all medications taken in the past for emotional/psychiatric reasons and dates taken:

_____

_____

_____

7. Current Alcohol/Drug Use: **How Often:**

_____

_____

_____

8. Ever felt suicidal? YES NO **Ever felt homicidal? YES NO**

Currently? YES NO **Currently? YES NO**

9. Mark an (X) for any of the following that have ever applied to you:

MEDICAL	*MENTAL HEALTH*	
_____AIDS or HIV+	_____alcohol/drug problems	_____juvenile delinquency
_____cancer	_____anorexia	_____physical abuse
_____diabetes	_____bedwetting	_____rape
_____epilepsy	_____behavior problems	_____running away
_____heart trouble	_____binge eating	_____school phobia
_____kidney disease	_____childhood fears	_____sexual abuse
_____liver disease	_____confusion	_____sexual identity
_____mononucleosis	_____family problems	_____sexual problems
_____pancreatitis	_____hyperactivity	_____teenage pregnancy
_____thyroid disease	_____incest	_____truancy
_____venereal disease		

10. Please list any past or current significant medical problems or mental illnesses (depression, mania, anxiety, alcohol or drug abuse, suicide/homicide attempts, psychiatric hospitalizations, etc.) suffered by your children, brothers and sisters, parents or grandparents:

_____
_____
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11. What would you like to get out of treatment?

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Acknowledgement of Receipt of Privacy Policy & Procedures

I acknowledge that I have received a copy of the Privacy Policy & Procedures for the office of Stacie Crochet, LCSW. The Privacy Policy & Procedures describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Privacy Policy & Procedures also describes my rights and the responsibilities and duties of the office with respect to my protected health information. Stacie Crochet, LCSW reserves the right to change the privacy practices that are described in the Privacy Policy & Procedures. If privacy practices change, I will be offered a copy of the revised Privacy Policy & Procedures at the time of my first visit after the revisions become effective. I may also obtain a revised Privacy Policy & Procedures by requesting that one be mailed to me.

Name of Patient:_____ Date:_____

Signature of Patient:_____

Acknowledgement and Understanding

Please review this information and ask about anything you do not fully understand.

Benefits and Emotional Risks: The majority of individuals and families that obtain behavioral health services benefit from the process. The therapeutic process is generally quite useful, but some risks do exist. As counseling begins, please understand that some experience unwanted feelings, and that examining old issues may produce unhappiness, anger, guilt, or frustration. Important personal decisions are often an outcome of counseling. These are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed as negative by another. Don't hesitate to discuss treatment goals, procedures or your impressions of the services that are being provided. Counseling is voluntary and you have the right to end services at any time.

Completing or Stopping Therapy: Periodically we assess how our work is going. If you are considering stopping our meetings, you may wish to let me know in advance. If we allow ourselves 1-2 sessions for wrapping up, then we can summarize the work we have done and forecast how you can maintain the progress you have made. This will help you to retain any new habits and changes you may have achieved. I give full consent for completion of an evaluation and the provisions of ongoing mental health treatment as necessary until I otherwise notify this clinician.

Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____

Confidentiality Policy

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to law. However, there are limits to such communication some of which are mandated by state law. It is very important that you and those seeking counseling with you carefully read and understand the following limits of confidentiality.

Duty to Warn: Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as: The person or the family of the person who is likely to suffer the results of harmful behavior; the family of the client who intends to harm him/herself or someone else; associates, friends of those threatened, or making threats; and law enforcement and medical emergency officials.

Child Abuse: WA/OR. State law mandates the reporting of incidence of suspected incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies.

"Dependent Adult" and Elderly Abuse: WA/OR law requires the incidence of "dependent adult" or elderly physical abuse reported to your counselor must also be reported to State authorities.

Family and Couple Therapy: Family members and couples may be seen at limes individually or conjointly. Information shared during these sessions or in related settings (e.g. telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. Ms. Crochet will use her discretion in handling these matters. This is simply a "no secrets" policy. It is important that you understand this policy before treatment begins. It supports the belief that healthy relationships are built on openness and truth.

Case Evaluation: In order to ensure the best treatment possible for each client, Ms. Crochet does consult with other professional counselor regarding cases. This is traditional in both out-patient and in-patient counseling facilities and is referred to as "case conference" or "peer review." If you have any concerns regarding this practice, please notify your therapist.

Neglect of Outstanding Debt: In the event that a client fails to honor, after reasonable efforts to collect; his/her debt, Ms. Crochet may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic information as well as accounting information. NO THERAPEUTIC INFORMATION WILL BE RELEASED.

Maintenance of records: A written record of contact will be maintained in a locked filing cabinet in a locked office. Records are released only with your written permission.

Other than the exceptions noted above, information is released only with your voluntary written permission. I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding the limits of confidentiality.

Signature: _____ Date: _____

Signature: _____ Date: _____

COURT APPEARANCE POLICY

Stacie Crochet, LCSW does not make any court appearances.

I am a Licensed Clinical Social Worker, who provides clinical services to parents, couples, families and adolescents. This clinical work takes the form of individual counseling, family and/or couples counseling. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client and client family who come to me for services. As a Licensed Clinical Social Worker, I cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all my clients. This is required by Washington/Oregon law, HIPAA Standards, and the NASW Code of Ethics.

Please do not ask me to write any reports for the court as I cannot do so. Do not ask me to testify in court, because this will destroy my professional relationship with my clients. I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to help families, parents and children. Furthermore, therapy is not the answer for legal disputes. Please do not request records for purpose of legal resolution.

Should Ms. Crochet be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the client, the client agrees to reimburse Ms. Crochet for any time spent for preparation, travel, or other time in which she has made herself available for such an appearance. Please ask for list of charges.

I/We the undersigned, have read and fully understand the above policies. I/We further agree to abide by the policies set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding these policies.

_____

_____

Signature/Date

SOCIAL MEDIA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FANNING
I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. All of the information shared on this page is available on my website. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.

INTERACTING
Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at info@staciecrochet.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

USE OF SEARCH ENGINES
It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

LOCATION-BASED SERVICES
If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking

enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

EMAIL

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CONCLUSION

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

_____

Signature/Date

CREDIT CARD INFORMATION

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card: _____ Visa or _____ Master Card

Credit Card Number: _____

3 Digit Security Code on Back of Card:_____ Expiration Date: _____

Name as printed on Card:_____

Billing address for Credit Card: _____

_____

_____

By my signature below, I grant Stacie Crochet, LCSW my permission to charge the account described above for missed session fees.

_____ _____

Signature Date

CANCELED APPOINTMENTS: Please remember that without a full **48**-hours notice, your credit card will be billed for **full payment** of your missed session. A missed session cannot be billed to insurance. If you do have to cancel an appointment, you may leave a confidential message 24 hours a day, seven days a week at 512-921-5925.

HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company and must be completed before your first session.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____
2. STREET ADDRESS _____
3. CITY, STATE & ZIP CODE _____
4. PATIENT'S DATE OF BIRTH _____
5. TELEPHONE _____
6. PATIENT'S SEX M_____ F_____
7. PATIENTS' RELATIONSHIP TO INSURED:
   SELF___ SPOUSE____ CHILD_____ OTHER_____
8. PATIENTS' STATUS:
   SINGLE____ MARRIED___ OTHER_____
   EMPLOYED_____ FULL-TIME_____STUDENT____ PART-TIME_____
9. SOCIAL SECURITY # _____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. NAME OF INSURED:_____
2. STREET ADDRESS OF
   INSURED:_____
3. CITY, STATE & ZIP CODE:_____
4. INSURED'S DATE OF BIRTH:_____
5. SOCIAL SECURITY #: _____
6. TELEPHONE: _____
7. INSURED'S PLACE OF EMPLOYMENT: _____

8. INSURANCE PLAN NAME OR PROGRAM NAME:

_____

9. INSURED'S INSURANCE ID NUMBER:_____

10. POLICY GROUP NUMBER:_____

***Financial Agreement and Authorization assignment of insurance benefits: payment is requested at the time services are rendered unless other financial arrangements are made. I understand that I am responsible for any health insurance deductibles or copayments. I give full consent for completion of an evaluation and the provisions of ongoing mental health treatment as necessary until I otherwise notify this clinician. I agree that the information above is accurate and complete to the best of my knowledge.**

I give my consent and authorization to Stacie Crochet, LCSW to bill my insurance noted above and I further acknowledge that my co-pay is _____to be paid at the time of the session or at the time otherwise arranged.

Signed:_____ Date:_____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Stacie Crochet, LCSW, and authorize Stacie Crochet, LCSW to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

Signed:_____ Date:_____