PATIENT REGISTRATION FORM **DX Code(s):** _____

(Please complete all areas of form and provide a copy of your insurance card(s)

PATIENT INFORMATION

Patient Name: _____ **Sex: M [ ] F [ ]**

Patient Address: _____

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

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

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

SS#: _____ **Date of Birth:** _____ **Employer:** _____

Occupation: _____ **Name of Spouse/Partner:** _____

Emergency Contact: _____ **Phone#:** _____

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

Responsible Party Billing Address/City/Zip Code: _____

Relationship _____ **Contact #:** _____ **SS#:** _____

PRIMARY INSURANCE

Primary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

SECONDAY INSURANCE

Secondary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN

I was referred by: _____ **PCP/Phone#:** _____

I, _____, have been given a handout 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 handout. I am also responsible to pay for all missed appointments and late cancellations.

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

BACKGROUND INFORMATION
Adult Form

Name of Client: _____

Address: _____

_____

_____

Phone Numbers:
(Self) Daytime _____ Evening _____

(Spouse) Daytime _____ Evening _____

What are your primary concerns at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Insurance Company: _____

Subscriber's Name: _____

Social Security Number of Subscriber: _____

Group Number: _____

Referring Party

Professional who first suggested that you contact a psychologist

_____

Name

_____

Address

_____

Phone

How did you get my name?

Referred by: _____

I usually contact the professional (e.g. physician, psychologist, social worker) who referred you for psychological services to let him/her know that you have made an appointment. May I have your permission to do so?

I give my permission for the referring parties named above to be contacted:

_____

Signature

I prefer that the referring parties **not** be contacted:

_____

Signature

Physician

Name of Physician: _____

Have you discussed the problem for which you are seeking evaluation or therapy with your Physician? _____

Should the results of the evaluation or the progress of therapy be communicated with your Physician? _____

Employment

Name of employer: _____

Brief job description: _____

_____

_____

_____

_____

Previous Counseling

Name of Therapist: _____

Address: _____

Phone Number: _____

Dates of Counseling: _____

Number of Sessions: _____

Employment History

Please list the jobs you have held for the past 10 years beginning with the most recent.

Job Title	Employer	Dates

Health History

Please list any current health problems for which you are being treated.

Condition	Physician

Please list any significant health problems you have had in the past.

_____

_____

_____

_____

_____

List any current medications

Medication	Dosage	Purpose

Have you ever been hospitalized for treatment of a nervous or emotional breakdown?

Dates	Where Hospitalized	Reason

Have you ever been treated for alcohol or drug addiction or attended AA?

Dates	Condition	Therapist or Physician

How much alcohol do you consume?

Per Day	Per Week

How frequently do you use nonprescription drugs?

Drug	Frequency	Amount

Educational History

Please list the schools you have attended.

School	Dates	Degree

Have you ever been in trouble for disruptive behavior, truancy or poor school performance as a child? If yes, please describe.

Family History

List the names and ages of the people with whom you currently live.

Name	Age	Relationship

List the names and current location of the people with whom you lived when you were a child.

Name	Relationship	Location

Have any members of your immediate family been treated for a psychological condition, an emotional disorder or an addiction?

Relationship	Condition or Diagnosis

AGREEMENT REGARDING FEES AND SERVICES

"Ensuring Fully Informed Consent for Counseling"

MATTHEW R. EVICH, MA
LICENSED MENTAL HEALTH COUNSELOR: #LH 60080464
COUNSELING NORTHWEST

16000 Bothell Everett Highway
Suite 270
Mill Creek, WA 98012
(360) 840-1903 or (425) 357-8023

This agreement outlines what you can expect of me as a therapist and what I will expect of you if you choose to commit to a course of psychotherapy. I have a master's degree in counseling psychology from City University and am a licensed mental health counselor in the state of Washington. My practice focuses on the psychological treatment of adults, children ages 3 through 12, adolescents and families. I have specialized training in family therapy, play therapy, and filial therapy (a highly effective method in which parents are taught how to do play therapy with their children).

My approach to providing treatment of psychological issues for adolescents and adults involves helping them to acquire improved coping strategies and to develop beliefs and life skills that promote effective problem solving and success in their interpersonal relationships and developmental goals. My approach to providing treatment with younger children involves working with the child AND members of their families to resolve emotional and behavioral concerns of both children and parents. Homework assignments outside of the therapy are routinely assigned to promote the development of skills and adaptive strategies.

The first one to three sessions is generally evaluative. I will need to collect information from you in order to assess the nature of the difficulty you are experiencing and to design an appropriate treatment plan. Once I have completed my initial evaluation, I will outline for you my understanding of the nature of the problem which you present, and will discuss treatment goals, methods, and anticipated length of treatment.

I cannot promise to make any particular diagnosis, nor can I promise any particular therapeutic outcome. Successful therapy requires the mutual effort of client, family members, and therapist. However, I do promise to use the best of my ability to help you (and your child) to overcome the difficulties that led you to seek psychological help. I further agree to provide services in an ethical and professionally competent manner.

You are free to discontinue therapy at any time. Should you choose to work with another therapist, I can refer you to others in the community and will provide phone numbers.

CONSULTATIONS

A few clients don't respond to therapy. Others' needs are outside my area of expertise, and in their best interest, I must refer them elsewhere. I do not accept clients that I feel I can't help. Upon accepting a new client, I am optimistic about his/her progress. In the event that I recommend a medical examination or more intensive testing from a specialist, I will fully discuss my reasons with you so that you can decide what is best. I promise to coordinate my services with physicians or the appropriate professionals. In the interest of providing the best clinical services to you, I receive on-going consultation with other experienced professionals. If I discuss aspects of our work I will do so without revealing identifying information about you.

WHAT TO EXPECT FROM OUR RELATIONSHIP

As a mental health counselor in the State of Washington I am accountable for my work with you under the laws set by the state. I follow and uphold the Code of Ethics and Standards of Practice as prescribed by the American Counseling Association (610/594-2651). Considerable trust is required in counseling treatment between client and therapist. Having dual relationships or social or business interactions outside of the therapy context are discouraged. Intimate relations between clients and therapists are always inappropriate. If you have any questions about my professional conduct or ethics, please discuss them with me. You may also contact the Department of Licensing in Olympia (360/236-4910).

ABOUT CONFIDENTIALITY

All information discussed in the course of therapy is strictly confidential. Both the Federal government and Washington State have laws that protect the disclosure and release of your health care information. My policies and practices to protect the privacy of you (and your child's) health information are outlined in detail. I will provide you a copy of my current policy, in addition to the information outlined in this section.

Information concerning the treatment or evaluation may be released only with the written consent of the person treated or the person's parent or guardian (if the patient is a child under 12 years of age), or under order of the court. A record of services provided to you is maintained. I will not disclose your record unless you direct me to do so or the law authorizes me to do so. You may see your record or get more information by asking me. You may also ask to me to correct that record.

The law requires release of confidential information to the appropriate authorities when issues of personal safety are involved. These include suspected child abuse, potential suicide, intent to harm a vulnerable adult, threatened physical harm to another, and infection with contagious disease including HIV. In addition, the law requires release of medical records to the authorities during the course of criminal and administrative investigations. The courts may subpoena records under other circumstances.

If you plan to pay for your treatment through use of your health insurance, be advised that most insurance companies require a statement of the type of service provided and a diagnosis. In addition, some require more detailed information, such as progress reports or treatment summaries. If you wish this type of information to be provided to your insurance company, you will need to sign the informed consent form below which specifies that you have given me permission to communicate such information to your insurance company. If you have questions about what your specific insurance plan requires, please discuss this with me before signing this portion of the release.

Medical billing for this office is done through Liberty Billing, LLC. In order to bill your insurance they need to be provided with the following identifying information: name, address, and telephone numbers of patient and parents, a copy of your insurance card and driver's license, copies of authorizations for treatment from your insurance company, your diagnostic code, and the date and type of services provided. Liberty Billing is not authorized to release your medical information to any party other than the insurance company solely for billing purposes.

CONFIDENTIALITY OF MINORS IN TREATMENT

The law in Washington State grants confidentiality to minor children between the ages of 13 and 17. As a counselor I must consider the "best interests" of an adolescent when disclosing their private communications with me to their parents. While the law doesn't explicitly grant these rights to younger children, some level of confidentiality is needed to explore their feelings and concerns. I will, however, provide general updates to parents about their child's progress in therapy.

Your child's confidentiality does not extend to my knowledge of circumstances that pose safety threats to your child. It is my policy to inform parents when their child discloses information to me about behavior that places them in danger of harm to self or others. Examples of these kinds of behaviors include but are not limited to: drug abuse, plans to run away from home, riding with intoxicated drivers, unsafe sexual activity, suicidal ideation, and threats to harm others.

In cases where parents are involved in *marital dissolution or other family court related involvement,* I cannot provide recommendations to the court regarding a proposed parenting plan or modification of an existing one. Children in these family situations have an especially great need for privacy and a neutral relationship with their therapist where they can discuss their concerns. In order to protect your child's therapeutic relationship, it is my policy to refrain from testifying to the content of your child's therapy sessions in divorce proceedings. In the same vein, I will not release treatment records to parents or their attorneys for use in divorce proceedings. Your signature on this consent form indicates your acceptance of my policy and your agreement to comply with these conditions.

IMPORTANT NOTE

In Washington State, I am required to inform you of the following: "Counselors practicing counseling for a fee must be registered or licensed with the Department of Health for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment."

"Clients are to be informed of the purpose of the Counselor Credentialing Act. The purpose of the law regulating counselors is: (a) To provide protection for public health and safety; and (b) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct."

APPOINTMENTS

While I am willing to be flexible, I have found that therapy is more effective when it occurs at a regular time each week. Appointments are 50 minutes in length. I keep phone conversations as

brief as possible because it is not an appropriate method of conducting psychotherapy. However, if a phone contact is more than fifteen minutes in length a fee will be charged at my hourly rate.

FEES AND PAYMENTS

The fee for a standard 50-minute session is $125; my initial intake fee is $175. I ask that you pay your insurance co-pay at the time of each appointment. I accept cash, check, or credit card. I reserve the right to not accept all insurances, and cannot guarantee that any particular insurance will pay; in that case, the client becomes responsible for whatever costs the insurance company fails to cover. You will be scheduled an appointment time. I cannot bill your insurance for missed appointments. As such, you will be billed for charged $75 for missed appointments and cancellations no made at least 24 hours prior to the this fee.

INSURANCE

Insurance plans differ in terms of the amount that the patient is required to pay per visit and in the number of visits covered. Insurance plans vary regarding the types of treatment for which they will reimburse. I can arrange to bill your insurance directly. However, I cannot guarantee the types of treatment for which they will reimburse. It is the patient's (or the patient's parent's) responsibility to contact the insurance company and find out if physician referrals, pre-certification, or pre-authorization are required, and complete these procedures prior to the first session. If your insurance does not cover the costs of treatment, you will be responsible for assuming payment of the balance of your bill.

EMERGENCIES

My phone number is (360) 840-1903. I check my messages throughout the day, all week. I generally return calls at the end of the same day. If you ever need to speak to someone immediately, you can call the crisis hotline at 1-800-584-3578. When I am out of town or unreachable, I will make an arrangement with a colleague to take emergency calls for me. I will discuss with you ahead of time my vacation schedule and we will determine together if it would be appropriate for you to see another counselor while I am gone.

PATIENT RIGHTS

You have the right to ask me about anything that happens in therapy or about my treatment approach with your child. You always have the right to refuse my recommendations or to not answer questions without penalty.

Either of us may choose to terminate therapy when we both believe that it is no longer in your best interest. If you wish to stop therapy at any time, I ask that you agree now to meet for at least one session to review our work together. If you would like your child to take a "vacation" from therapy, we should discuss this as well.

INFORMED CONSENT

In order to indicate that you have read and understood this agreement, please sign the first portion of the authorization, permitting me to provide counseling services to you or your child. If there is any portion of this agreement to which you do not understand or about which you have questions, please discuss it with me before signing the authorization. The second portion indicates your receipts of my privacy policies. The third portion of this authorization form gives me permission to release information requested, by you insurance company.

I hereby authorize Matthew R. Evich, M.A., to render psychological services to:

_____(Patient's name). This authorization constitutes informed consent without exception. I have read and understood this agreement and have received a copy for myself.

Signed: _____
(Adult Patient or Parent/Guardian for child)

Signed: _____
(Minor child Age 13 – 17)

Signed: _____
(Matthew R. Evich)

Dated: _____

I have received a copy of Matthew R. Evich's *Policies and Practices to Protect the Privacy of Your Health Information* and have had the opportunity to ask questions.

Signed: _____
(Parent/Guardian for child)

For: _____
(Name of child)

Date: _____

INSURANCE
I hereby authorize Matthew R. Evich, MA to release information required by Liberty Billing to provide bookkeeping services to Matthew R. Evich, and to my insurance company to process my/my child's claim.

Signed _____
(Adult Patient or Parent/Guardian for child)

Signed _____
(Minor child Age 13 – 17)

Date _____

Directions to our Mill Creek Office
16000 Bothell Everett Hwy – Suite 270
Mill Creek, WA 98012
425-357-8023

Scheduling Cindy 360 691-9290

Our office is located in the Mill Creek Office Park next to the Mill Creek Post Office on Bothell Everett Hwy. The parking lot is off of Mill Creek Blvd. Office is on the second floor.

From I-5 (Northbound)
Exit at the 164th Street Exit, #183
Turn right onto 164th Street heading east towards Mill Creek.
Make a left turn onto Mill Creek Blvd. This is the third traffic light. There is a Frontier Bank and a Washington Mutual on the right hand side of this corner.
Make a right turn into the Mill Creek Post office. Make the right turn into the parking lot of the Mill Creek Office Park.

From I-5 (Southbound)
Exit at the 128th Street Exit, #186
From the exit ramp turn left onto 128th Street.
Make a right turn onto Bothell Everett Hwy (You will need to watch for signs for 527 southbound and make two right turns in order to head south on Bothell Everett Hwy. You will turn right at the light in front of Fred Meyer. After a few hundred feet you will make another right onto Bothell Everett Hwy. You will head south for approximately a mile before you turn right onto Mill Creek Blvd.
From the highway turn east onto Mill Creek Blvd. You will be heading into the retail/commercial area and away from the apartments. Make a left hand turn into the Mill Creek Post Office. Make the right turn into the parking lot of the Mill Creek Office Park.

From I-405
Take Exit 26, Bothell Mill Creek.
Make a right hand turn onto Bothell Everett Hwy. Head north on Bothell Everett Hwy for approximately a mile and a half.
Make a left hand turn onto Mill Creek Blvd. This will be the next light after you cross over 164th Street.
Make a left hand turn into the Mill Creek Post Office. Make the right turn into the parking lot of the Mill Creek Office Park.

From Bothell Everett Hwy
From the highway turn east onto Mill Creek Blvd. You will be heading into the retail/commercial area and away from the apartments. Make a left hand turn into the Mill Creek Post Office. Make the right turn into the parking lot of the Mill Creek Office Park.