Breeze C.S. Potts
1101 Harris #22
Bellingham, WA. 98225
360.201.1014

Intake Form and General Information

Name: _____ Date of Birth: _____

Address:_____

Cell Phone:_____ work Phone:_____

May I contact you on your cell: Yes / No at work: Yes / No

by email: Yes / No email address:_____

Which is the best way to contact you? _____

In the event of an emergency, please notify: _____

Phone: _____

Are you under medical care? Yes/No If yes, please explain:

Physician's Name: _____

Phone: _____

Date of Last examination: _____

Please list any psychiatric/mental health medications you are currently taking or have taken:

Prescribing Physician (if different from above):_____

Phone:_____

Have you previously been under the care of a psychiatrist, psychologist or counselor? Yes / No

If yes, please explain, including therapist's name, date of treatment and brief summary of the problem that required attention and how it was resolved:

_____

_____

_____

_____

Name/Location/Phone Number of Psychiatrist: _____

_____

Have you ever been diagnosed with a mental illness? Yes / No

___ Anxiety Disorder
___ Depression
___ Self Mutilating/Harming Behaviors
___ Borderline Personality Disorder
___ Dissociative Identity Disorder
___ Obsessive Compulsive Disorder
___ Bipolar Disorder
___ Eating Disorder (bulimia, binge eating disorder, anorexia)

___ Schizophrenia
___ Substance abuse/chemical depency
___ Anger
___ Seasonal Affective Disoder
___ Sexual Disorder
___ Other - please explain: _____

_____

Please use the space below to briefly explain why you are seeking counseling now:

_____

_____

_____

_____

_____

How long has this been a problem? _____

How do you hope I can help?

_____

_____

How would you estimate the severity? Mildly upsetting Moderately severe

Very Severe Extremely Severe Incapacitating

What have you done about this problem to date? _____

_____

Have you ever been suicidal? Y/N When?_____

Have you ever been homicidal? Y/N When?_____

Would you be willing to sign a release form to obtain information from

medical/psychological professionals you've worked with? Yes/No

Do you consume alcohol regularly? Yes/No How often?_____

How much?_____

Do you take non prescribed drugs? Yes/No How often?_____

Any other information you feel is important for your counselor to know that could impact therapy? If so, please describe._____

_____

_____

How did you hear about me? _____

_____ _____

Client signature date

I hereby declare that the above information is accurate. I understand that the information I have provided shall remain confidential according to Washington State Law. By signing this document, I am agreeing to actively engage in and participate in the counseling process as agreed upon by myself and my counselor.

Client Consent and Acknowledgement of the following:
Privacy Practices, Confidentiality, Cancellations and No Shows

Training/Education:
MA, Mars Hill Graduate School, Seattle
Licensed Mental Health Counselor, LMHC 60345513

I was trained at Mars Hill Graduate School (now The Seattle School of Theology and Psychology). I was introduced to a variety of counseling theories and approaches but our educational training focused largely on the object relations and psychodynamic perspectives. Within these models, and during my continued work and personal growth, I have come to find a passion for working with women (18 and older) who seek to address concerns affecting who they see themselves to be. My education impressed upon me the value of relationships, being a place that reinforce particular habits, patterns or ways of thinking/being or being a place that allow us to wrestle with those things and come to a deeper, more holistic understanding of ourselves and those around us.

Since graduating in 2006, I have worked on staff at Bridging Counseling, in private practice and as a counselor in the Western Washington University counseling center.

Confidentiality
I place a high value on confidentiality. All notes, records and personal information are kept confidential. I am honored that you would be willing to share your life with me and consider it sacred. I will share your story with no one under any circumstances **unless** one of the following has taken place or has been agreed upon by client and therapist:

1. By the state of Washington, I am bound to report any known or reasonable suspected cases of child abuse or neglect.
2. There is any known or suspected intention of harming oneself (suicide).
3. There is any known or suspected intention of harming others.
4. When written consent has been given by me, the client, to release my private records or information.
5. When charges are brought against a counselor in response to a subpoena from a court of law or administrative agency.
6. When there is reason to suspect a crime or harmful act

By signing below I acknowledge that counseling is provided on the condition that clients recognize this policy of and agree that my counselor will and is free to break confidentiality under any of the above circumstances. **I recognize that by signing this document I am stating that I understand and agree with these exceptions to confidentiality.**

It is possible that we have mutual acquaintances or may run into each other on occasion in the community. Please note that it is my duty to protect your anonymity, and therefore, I will not initiate any form of contact with you and will not disclose any working relationship with you to another person.

Unprofessional Conduct

By signing this form, I acknowledge that I have received copies (if requested), thoroughly reviewed and understand the information disclosed on this form and my right to contact the State of Washington Health Department if I believe my therapist has acted in an unprofessional manner or has breached my confidentiality outside of the above listed exceptions, as I am protected under the counselor credentialing act (Chapter 18.19 RCW). If you believe my treatment has been unprofessional in any way, you may contact the State of Washington Health Department "counselor programs:"
P.O. Box 47869 Olympia, WA. 98054-7869
360.664.9098

I also acknowledge that I have carefully reviewed the Notice of Privacy Practices. _____

Fees

I understand that I am financially responsible to Breeze Potts for all charges. Rates are per session costs, billed at $100 per hour. I do not bill insurance directly but can assist you with a self-billing insurance claim. Please contact me if you'd like to discuss this process. You will be charged a full session fee for missing an appointment without contacting me with 24 hours notice (illness and emergencies may be excused). Fees may increase periodically and are subject to change without prior notice. I accept cash, check and credit cards as forms of payment. Please note that I do all my banking at Whatcom Educational Credit Union (Sunset and Fairhaven branches). If you choose to pay by check or card, there is a small chance that a minimal amount of identifying information will be revealed while processing your payment. _____

Please note that I am happy to provide a sufficient financial record for an out of network insurance claim. I am not a contractor provider with any insurance carrier and cannot bill your insurance on your behalf. Please check with your insurance provider to determine your mental health benefits with an out of network provider.

Please note: phone calls over 20 minutes between sessions will be billed at my hourly rate, and due at our next session. _____

Any unpaid balance over 12 months is subject to an interest rate of 10% per month overdue.

Appointments

Appointments are made on a weekly basis. Appointment times are not assumed on your behalf, it is your responsibility to confirm your next scheduled appointment time. **You have the right to terminate therapy at any point**, although I think it is in your best interest to discuss this prior to making the decision to not return. The amount of sessions varies from person to person, but the counselor and the client, will evaluate regularly their progress and determine together their course of treatment, and treatment length. Factors of time and finances will be considered.
I acknowledge that I have discussed all of this information with my therapist including the exceptions to confidentiality, my right to terminate participation at any time and the importance of discussing termination with my therapist prior to acting on it. _____

Contact Information
You may leave a message at 360.201.1014. Please let me know if your call is urgent. I will return your call as soon as possible.

Emergencies
If you are in an emergency and cannot reach me, the following numbers can assist you.

911	general emergencies
800.584.3578	care crisis services
800.244.5767	crisis clinic

_____ _____
Client Signature date

_____ _____
Counselor Signature date

I have received a copy of the Washington State Privacy Practices

_____ _____
Client Signature date