Adams & Associates | Sheryl Adams, LICSW
5224 Olympic Dr. NW, Suite 105, Gig Harbor, WA 98335
Mailing address: PO Box 2403, Gig Harbor, WA 98335
(253) 514-9948
sheryladamscounseling.com

INTAKE FORMS

CONFIDENTIAL CLIENT INFORMATION

Name	DOB	Age	Gender
Address	City	State	Zip
Email Address		Ok to email?	
Client Phone (preferred)			Ok to leave voicemail?
Client Phone (secondary)			Ok to leave voicemail?

In order to protect your privacy, I do not identify myself as a counselor when I call, though I will leave my name. I attempt to return calls and emails within 1 business day of receiving them.

		FT/PT
Marital Status	Employer/School	
Parent/Guardian (if under 18)	Parent/Guardian Phone	
Emergency Contact	Phone 1	Phone 2
Primary Care Physician (PCP)	PCP Phone	

Family Information/Others in Household

Name	Age	Relationship to Client

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Are you currently being treated for any physical or psychological illness? Describe:

Current Medications/Dosages:

Description of Current Health/Medical Problems:

Description of Significant Past Medical/Health Problems:

Previous Therapy Experience (Name of therapist(s), dates, presenting concern(s):

Briefly describe the concerns that brought you here?

What do you hope to achieve through therapy?

How did you hear about Sheryl Adams?

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DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT

TO COUNSELING CLIENTS

As your therapist, I am pleased to offer you counseling and psychotherapy services and look forward to working with you. Please read the following information. This document is provided to give you the information needed to make a decision about whether to consent to treatment, to state office policies, and to clarify your rights and our responsibilities. If you have any questions about this material, feel free ask questions at any time.

YOUR RIGHTS

You have the right to: 1) Decide whether or not to receive treatment; 2) Know the course of treatment and our preferred methods; 3) End therapy at any time without any legal or moral obligation; 4) Request the opportunity to review your records; 5) Request in writing that no records be kept except the required information.

PROFESSIONAL STANDARDS

Your therapist is accountable for the work done with you. If you have any concerns about the work, please discuss them with your therapist. The Counselor Credentialing Act is in place to provide protection for public health and safety and to empower you by providing a complaint process against those counselors who would commit acts of unprofessional conduct. Contact information for reporting is: The Dept. of Health, Health Professions Quality and Assurance Division – PO Box 47869, Olympia, WA 98504-7869. (360) 236-4700.

CONFIDENTIALITY

Within certain limits, information revealed by you during treatment will be kept strictly confidential and will not be revealed to any other person or agency except as needed to conduct normal business.

Exceptions to this law are:

1) You or your legal representative provide written consent; 2) You reveal the contemplation of a crime or harmful act; 3) You are a minor and the victim or subject of a crime; 4) You waive the privilege of confidentiality by filing charges; 5) I receive a subpoena from a court of law; 6) You reveal the abuse of children, adult dependents or developmentally disabled persons.

In such cases, your therapist has mandatory reporting requirements that she must adhere to. Your therapist may inform you of her actions although the law does not require that she do so.

In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will use her clinical

judgment when revealing such information. Your therapist will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment.

Disclosure of confidential information may be required by your health insurance carrier or EAP in order to process the claims, including the clinical notes. If you instruct your therapist, only the minimum necessary information will be communicated to the carrier. Your therapist has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health claim for reimbursement may carry a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Uses and Disclosure of Protected Health Information (PHI) with your consent:

1. Treatment: PHI can be shared with professionals who are treating you to help manage the treatment you receive
2. Health Care Operations: PHI can be used to improve health care operations such as audits, quality improvement, and care coordination
3. Payment: PHI can be used to coordinate payment for services from a health plan

Uses and Disclosures Requiring Your Authorization:

1. Psychotherapy notes
2. Court Proceedings

Uses and Disclosures Not Requiring Your Authorization:

1. Child Abuse, Adult Abuse, and Domestic Violence
2. Health Oversight
3. Serious Threat to Public Health & Safety Issues/Self or Others.
4. Worker's Compensation
5. Complying with the Law

Your Rights:

1. Get a copy of your health and claims records
2. Ask me to correct health and claims records
3. Request confidential communications
4. Ask me not to use or share certain health information for treatment, payment or health care operations but I may say no if it would affect your care
5. Get a copy of this privacy notice
6. Choose someone to act for you (i.e, power of attorney, legal guardian)
7. File a complaint if you feel your rights have been violated. Letter of complaint can be sent to U.S Deptarment of Health and Human Services Office for Civil Rights, 200 Independence Avenue SW, Washington DC, 20201 or call 1 (877) 696-6776, or visiting www.hhs.gov/privacy/hipaa/complaints/

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APPOINTMENTS

Appointments are 50 or 75 minutes. Individual sessions are 50 minutes and family sessions are 75 minutes.

FEES

Fees are due at the time of service. We accept cash, personal check, and credit cards. You have the option of keeping credit card information on file so that we do not use your appointment to process payments.

If your stored payment card declines payment, your provider will call or email to let you know. If you can resolve the problem with the same payment card (i.e. add funds or resolve with the bank) then contact your provider and ask her to process the card again. If you need to change the stored payment card, please contact your provider and she will provide you with a new credit card authorization form.

Payment for the unpaid session will need to be made as soon as possible. Unless prior arrangements are made with your provider, after one unpaid session you will be removed from the schedule until your account is up-to-date and all services are paid in full.

Fees are $185 for 50-minute sessions, $225 for 75-minute sessions, unless other agreements have been made. My fee may be increased at any time with prior written notice. $25.00 is charged for returned checks.

MY OFFICE

The office is located at 5224 Olympic Drive NW, Suite 105, Gig Harbor, WA 98335. The building has free parking and a reception area where you can be seated until you are called for your appointment.

NO SHOW/CANCELLATION POLICY

You will be charged the amount agreed upon for the session for any cancellations less than 24 hours prior to appointment time, or for which you do not show. Exceptions might be made in the case of emergencies or serious illness or if other mutually agreed upon arrangements are made.

If you arrive late for an appointment, we will still conclude the session at the scheduled time and you will be charged the full fee. If you are more than 15 minutes late and have not called, you are considered absent and your therapist may leave the office.

Please call if you are late or unable to come. For cancellations, you may contact your therapist via telephone (please leave a voicemail if there is no answer) or text. Keep in mind that insurance companies don't reimburse for missed sessions.

Private Pay Clients: If you are more than 15 minutes late and have not notified me, you are considered absent and your therapist may leave the office. Your appointment will need to be rescheduled within the same week or you will be charged the full fee. Please call if you are late or unable to come.

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For Insurance Clients: Arriving 10 or more minutes late is considered a missed session and will need to be rescheduled within the same week or you will be charged the full fee. Your insurance company will not cover missed session fees.

Fees for late cancellation or missed sessions may be charged without prior notice.

SLIDING SCALE/REDUCED FEES

If you have made an arrangement with your therapist to receive services at a discounted rate, it is expected that you will maintain integrity with your therapist and follow the agreed upon written or verbal agreement as it pertains to insurance, fees, and cancellations.

RESCHEDULING

In the instance that you need to cancel an appointment your therapist will try to make it possible for you to reschedule it during the same week. If we are able to reschedule within 7 days of your missed appointment, the late cancellation fee will be waived, and you will only be responsible for payment of the session for which you were present. If it is not possible to reschedule your appointment within 7 days of your missed appointment, then you will be responsible for the session fee.

PHONE CALLS/EMAIL/SOCIAL MEDIA

I do not use email to communicate with clients because it is not secure unless it is encrypted from both sender and receiver, which is difficult to ensure. It is a common mistake is to feel that email correspondences are private. Also, email has become such a pervasive method of communication on the Internet that it is easy to miss reading one.

I do not accept friend or contact requests from current or former clients on any social networking site such as Facebook, LinkedIn, or Twitter. It is my belief 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. While Social Media is a wonderful way to allow people to share content quickly, efficiently and in real-time, it is also a way to make public the matters that you might prefer at some point in time to have been kept private.

Please call (and leave a message) or text when making changes to scheduling. If you cancel an appointment and do not wish to reschedule, please indicate in your call or text whether you want me to contact you. When leaving voicemails, please leave your phone number, even if you think I already have it and let me know when a good time is to call you back. When I call you, I will identify myself my by name and leave my phone number but nothing more. It is important to keep in mind that cell phones are not set up for confidentiality.

I will use texts only to arrange or modify appointments and only with your permission.

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CRISIS CALLS

Your therapist will be spending most of her working hours in counseling sessions and may be difficult to reach directly during a crisis. If you are experiencing an emergency, please call 911. Your therapist will return voicemails within 1 business day unless the voicemail greeting specifies otherwise because of leave or vacation. Please do not use emails, faxes, or texts for emergencies.

Counseling is done during person-to-person sessions. If you have a problem that cannot wait until your next appointment and receive counseling by phone, you will be billed for that time and your insurance may not cover such services.

Please keep in mind that while emails and voicemails only go to your therapist, these are not considered secure forms of communication. When your therapist calls you, she will identify her name but will not say that she is a therapist.

TERMINATION

If you intend to terminate counseling, one final session may be requested by your therapist to conclude the counseling experience. At the conclusion of therapy, this agreement shall be concluded. The client's resumption of therapy with Sheryl Adams, LICSW will require a new and separate agreement**.**

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INSURANCE

I currently contract with Regence Blue Cross Blue Shield, Premera and First Choice. If you wish to have your counseling sessions billed through one of these insurance companies, please fill out your insurance information at the end of this section.

If you are a member of a different health insurance company, I can provide the appropriate documentation (claim forms) if you would like to submit them for your out-of-network benefits. You are responsible for paying the full fee at the time of service and submitting the claims yourself.

If you do not plan to use your insurance, please leave the insurance information section blank.

INSURANCE INFORMATION

Client/Insured Name: _____

Client/Insured DOB: _____

Client Phone Number: _____

Client Address: _____

Subscriber Name (if different from client): _____

Insurance Company Name: _____

Subscriber ID: _____ Group #: _____

Subscriber Employer: _____

Is there another health benefit plan? ☐ Yes ☐ No *If yes, please bring other insurance card to your first appointment.*

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CONSENT FOR TREATMENT

I have read or have had satisfactorily explained to me and I understand this disclosure of information, policies and client agreement. Any questions that I had about this statement including fees and payment policies have been answered and explained to my satisfaction. (For clients under the age of 18, consent must be given, and this form must be signed by either a parent or legal guardian.) I understand and agree to the description of confidentiality and its' exceptions as stated above. I consent to counseling under the terms described above. My signature below indicates that I have received a copy of this form.

Client Name (Printed)	
Client Signature	Date
Parent/Guardian Name (Printed)	
Parent/Guardian Signature	Date
Therapist/Counselor Signature	Date

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CREDIT CARD AUTHORIZATION

I hereby authorize Sheryl Adams, LICSW to keep my signature on file to charge my credit card account for psychotherapy services and late cancellation and no-show fees, when applicable. These services can include my participation in individual, couples, family, or group psychotherapy, telephonic consultation or coaching services.

For these services I authorize Sheryl Adams, LICSW to charge the credit card listed below in the amount of the contracted hourly session rate. I understand that if I decide to terminate any of the services and my account is paid up in full, I may withdraw authorization to charge my credit in the future, provided I communicate revocation of authorization in writing to Sheryl Adams, LICSW by mail or fax.

Client Name:

Card Holder's Name:
exactly as it appears on the card

Credit Card Billing Address (with zip code):
the address that the credit card is mailed to

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card #: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date (MM/YY): ___ ___ / ___ ___ Security Code
on back of card

Cardholder Signature:

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DISCLOSURES

Education and Licensure

Licensed Clinical Social Worker (LW000095140).

Master of Social Work, University of Washington

Bachelor of Art, Washington State University

Work Experience

I am a mental health counselor. I bring to my practice a love of learning – about the world and about my patients. My goal is to integrate the latest findings of psychology and medicine with the contemplative practice of mindfulness to help my patients make necessary changes for a happier, more satisfying, successful life.

For many years I taught at a community college where I developed expertise in how adults can learn new things that transform their lives. For the next ten years I worked as an employment counselor where I developed a program that matched people's strengths and talents to the world of work. Then I went on for the next 13 years to direct a healthcare clinic where I developed a deep understanding of the relationship between substance abuse, mental health, and physical health. For more than 9 years I worked for a military hospital where I counseled people who were experiencing serious health, occupational. and personal problems.

Certifications

- Prevention, Identification, and Treatment of Perinatal Mood Disorders
- The Body Keeps the Score: Trauma and Healing with Bessel van der Kolk
- Family Foundations Prenatal and Postnatal Training
- Promoting Maternal Mental Health During Pregnancy
- Educator of Infant Massage
- Interpersonal Psychotherapy
- Trauma Focused Cognitive Behavior
- Varied Treatment of Depression and Mood Disorder
- Telehealth for Mental Health Professionals