275 SE Cabot Drive, Suite B205
Oak Harbor, WA 98277
360-485-0980
seaside-psychotherapy.com
seasidepsychotherapy@gmail.com

INSURANCE INFORMATION

Health Insurance plans vary in the kind of Outpatient Mental Health Services they cover. Here are some important questions to understand about your coverage when checking on your benefits and eligibility. Please contact me at 360-485-0980 if you have any questions.

Telephone number to call and check my benefits and eligibility: ______________________

Does my Insurance cover Outpatient Mental Health Services?: ______________________

Is my Health Insurance Coverage Active? ______________________

If YES, my Policy became effective on: ______________________

Are my Mental Health Benefits based on a Calendar Year? ______________________

If NO, my Benefits are based on this range of dates: ______________________

How many Outpatient Mental Health Visits are Covered for one (1) year? ______________________

How many remaining visits do I have for the Current Year? ______________________

Is your Provider a "preferred" or "in-network" Provider for my Health Insurance Plan? ______________

For your Providers Services:

Do I pay a co-pay for each visit? ☐ Yes ☐ No

If YES, my co-pay for each visit is: ______________

Do I have a co-insurance cost for each visit (a percentage of the charge that I have to pay myself?)

☐ Yes ☐ No If YES, the co-insurance percentage for each visit is: ______________

Do I have to obtain an authorization for Services? ☐ Yes ☐ No

If YES, who must call? ______________________

The Telephone Number to contact to Obtain Authorization is: ______________________

Before the first appointment, you should obtain the above information. Please bring this completed form with you to your first appointment. Thank you.

____

Client Name **Date**

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CLIENT REGISTRATION FORM

Client Information

Last Name | First Name | Middle Initial

Mailing Address | City | State | Zip Code

Home Telephone | Daytime Phone ☐ Work ☐ Cell ☐ Other

Marital Status | Birth date (mm/dd/yyyy) | SSN | Gender

Mother's Name (if minor) | Father's Name (if minor) | Primary Care Physician

Subscriber

Last Name | First Name | Middle Initial

Address | City | State | Zip Code

Home Telephone | Relationship to Client | Birth date (mm/dd/yyyy)

SSN | Gender | Employer

Employer's Address | City | State | Zip Code

Employer's Telephone | Ext.

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown

Client Employment

☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown

Occupation | Employer | Employment Status

Address | City | State | Zip Code

Employee's Telephone | Ext. | Employer's Telephone | Ext.

Primary Insurance

Primary Insurance Company | Insured Name | Policy Effective Date

Relationship to Subscriber | Subscriber ID or Medicare #

Group # | Plan # | Subscriber's Employer

Secondary Insurance

Secondary Insurance Company | Insured Name | Policy Effective Date

Relationship to Subscriber | Subscriber ID or Medicare #

Group # | Plan # | Subscriber's Employer

Emergency Contact

Relationship to Client	Last Name	First Name	Middle Initial
Address	**City**	**State**	**Zip**

Home Telephone	Daytime Telephone	Cell

Financial Responsibility, Release of Information & Assignment of Benefits

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider of insurance company to release information required for processing my claims.

Printed Name	Signature	Date

Authorization for Treatment of a Minor

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

Printed Name	Signature	Date

SEASIDE Psychotherapy
LIMITED LIABILITY COMPANY

275 SE Cabot Drive, Suite B205
Oak Harbor, WA 98277
Tel: 360-485-0980
seaside-psychotherapy.com
seasidepsychotherapy@gmail.com

CLIENT INTAKE FORM

____
First Name **Middle Initial** **Last Name**

____
Address **City** **State** **Zip Code**

____
E-mail Address **Preferred Contact Number**

May we use this number to leave messages regarding your health/health care?

____
SSN **Birth date (mm/dd/yyyy)** ☐ Yes ☐ No

Gender: ☐ Female ☐ Male ☐ Other

Please describe any problems you are currently experiencing.

____
____
____

How long has this been going on? (Please check one): ☐ _______ months ☐ _______ years

Why are you seeking services now? ____

____

What do you hope to gain from this evaluation and/or counseling? ______________________

____
____
____

If you've had difficulties in the past, what have you done to cope? Was it helpful? ____________

____
____
____

Symptoms

Please check any symptoms or experiences you've had in the last month or are related to your visit here:

- ☐ Difficulty falling asleep
- ☐ Difficulty getting out of bed
- ☐ Difficulty staying asleep
- ☐ Not feeling rested in the morning

Average hours of sleep per night: ___________

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving the house
- ☐ Spending increased time alone
- ☐ Outbursts of anger
- ☐ Withdrawing from other people
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Irritability
- ☐ Panic attacks
- ☐ Avoiding people, places, activities or specific things

- ☐ Fear of certain objects or situations (i.e. flying, heights, bugs) Describe: ____________________

____

____

- ☐ Repetitive behavioral or mental acts (i.e. counting, checking doors, washing hands) Describe:

____

____

Feelings of

- ☐ Worthlessness
- ☐ Sadness
- ☐ Fear
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Feeling/acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Excessive exercise to lose weight
- ☐ Use of laxatives
- ☐ Binge eating
- ☐ Are you trying to lose weight?
- ☐ Weight gain: ______________
- ☐ Weight loss: ______________

- ☐ Difficulty catching your breath
- ☐ Unusual sweating
- ☐ Increased energy
- ☐ Tremor
- ☐ Increased muscle tension
- ☐ Easily startled/feeling 'jumpy'
- ☐ Decreased energy
- ☐ Dizziness
- ☐ Physical sensations other's don't have

- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks
- ☐ Thoughts of harming or killing yourself
- ☐ Intrusive memories
- ☐ Large gaps in memory
- ☐ Nightmares
- ☐ Thoughts of harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses or images
- ☐ Unusual visual experiences such as flashes or light or shadows

- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or radio is communicating with you
- ☐ Difficulty problem solving
- ☐ Dependency on others
- ☐ Inappropriate expressions of anger
- ☐ Difficulty or inability to say 'no' to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concerns about your sexuality
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill your own desires
- ☐ Self-mutilation/cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expressing emotions

Stressors

Have your experienced any of the following stressors? (Check all that apply)

- ☐ Recent move
- ☐ Marriage
- ☐ Divorce
- ☐ Substance abuse
- ☐ Change in schools
- ☐ Violence
- ☐ Death
- ☐ Personal/Family health problems
- ☐ Financial problems
- ☐ Job change
- ☐ Other (please explain) ______________________________

Sexual Orientation

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with: ______________________

____

____

Past Psychiatric History

Have you ever met with a mental health professional in the past? ☐ Yes ☐ No

If yes, please list the names of any treatment providers, their specialty (e.g. psychologist), and time period for treatment: ______________________

____

____

*Are you **CURRENTLY** taking **PSYCHIATRIC** medication?* ☐ Yes ☐ No

If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

*Have you been on **PSYCHIATRIC** medication in the past?* ☐ Yes ☐ No

If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If YES, please explain:

Hospital	Dates	Reason

Have you ever tried to harm yourself? ☐ Yes ☐ No

*If YES, please describe the incident, the stressors, and when the incident occurred:*________________________

____

____

____

Medical History

Primary Care Physician

____

Name **Phone Number** **Date of last exam**

Is your primary care physician aware of this appointment? ☐ Yes ☐ No

Preferred Pharmacy

____

Name **Phone Number**

*Do you have any known **ALLERGIES** to any medications?* ☐ Yes ☐ No

If YES, please list all medications that have caused an allergic reaction and describe reaction to each one:

____

____

____

*Are you **CURRENTLY** under treatment for any medical condition?* ☐ Yes ☐ No

If YES, please list: ______________________________

____

____

*Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication?* ☐ Yes ☐ No

If YES, please list:

Medication	Dosage	How long have you been taking it?

*List any **PRIOR** illnesses, operations and accidents:* ______________________________

____

____

Social History

Where were you raised? ______________________________

Were you adopted? ☐ Yes ☐ No

Father: __________ Age: ______ ☐ Living ☐ Deceased Cause of death: __________

Occupation: __________ If deceased, HIS age at time of his death: __________

Health: __________ YOUR age at time of his death: __________

Frequency of contact with him: ______________________________

Describe your relationship with your father: ______________________________

Mother: ________________ Age: ______ ☐ Living ☐ Deceased Cause of death: _______________

Occupation: _________________________________ If deceased, HER age at time of her death: _________

Health: _________________________________ YOUR age at time of her death: _________________

Frequency of contact with her: ____

Describe your relationship with your mother: ____

Did your parents divorce? ☐ Yes ☐ No *If yes, how old were you?* ___________________________

Did your father remarry? ☐ Yes ☐ No *If yes, how old were you?* ___________________________

Did your mother remarry? ☐ Yes ☐ No *If yes, how old were you?* ___________________________

How old were you when you left home? ___________________________

Has anyone in your immediate family ever died? ☐ Yes ☐ No *If so, who and when?* ____________

____

Siblings/Other Family/ Important long-term Friends:

Name	Sex	Age	Relationship	Location	Are you close?

During your childhood, did you live with anyone other than your natural parents for a significant period of time?

☐ Yes ☐ No *If yes, please list name and relationship:*

Name: ____ **Relationship:** ___________________________

Name: ____ **Relationship:** ___________________________

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: ____

____

____

Marital History/Current Family

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Remarried ☐ Cohabitating ☐ Engaged ☐ Widowed

How long in current status: ____________________

Partner's name: ______________________________ *Partner's age:* ______________

Partner's occupation: ____

Describe your relationship with your significant other: ______________________________

____

____

Have you had any previous marriages? ☐ Yes ☐ No *If so, how many?* ______________

Length of each: ____

Do you have children? ☐ Yes ☐ No *If yes, please tell us their names and ages:*

Name	Age

Name	Age

What kind of social activities do you participate in? ______________________________

____

____

Religion

What is your religious affiliation? ____

Please rate the importance of religion or spiritual beliefs in your life:

☐ All Important ☐ Very Important ☐ Important ☐ Somewhat Important ☐ Not Important

Education

Highest grade level completed: ______________________________

Highest degree obtained and major: ______________________________

Did you enjoy school? ☐ Yes ☐ No

What things got you in trouble in school? ______________________________

____

Were you considered hyperactive/ADHD in school? ☐ Yes ☐ No

What kind of grades did you get in school? ______________________________

Military

Have you served in the military? ☐ Yes ☐ No

If yes, please describe briefly including any combat experience or trauma: ______________________________

____

____

What type of discharge (separation) did you receive? ______________________________

____

Employment

Are you currently employed? ☐ Yes ☐ No

If yes, employer's name: ______________________________

What type of work do you do? ______________________________

Please list your previous work and length of employment:

Type of job	Dates	Reason for leaving

Legal

Have you been arrested? ☐ Yes ☐ No *If yes, please explain:* ______________________

____

____

Substance Abuse

Do you use tobacco? ☐ Yes ☐ No *If yes, how often?* ______________________

Do you drink alcohol? ☐ Yes ☐ No *If yes, age of first use:* ______________________

How much do you drink? ______________________

How often do you drink? ______________________

Have you ever passed out from drinking? ☐ Yes ☐ No

How often? ______________________

Have you ever blacked out from drinking? ☐ Yes ☐ No

How often? ______________________

Have you ever had the "shakes"? ☐ Yes ☐ No *How often?* ______________________

Have you ever felt you should cut down on your drinking/drug use? ☐ Yes ☐ No

If yes, please explain: ______________________

____

Other Drugs

Please indicate any drug use below:

Drug	Ever used?	Age of first use	Approx. use in last month	Comments: Effect of drug, drug of choice, bad trips?
Alcohol				
Marijuana				
Inhalants				
Cocaine/Crack				
Methamphetamine				
Heroin				
LSD/Shrooms				
Ecstasy				
Prescribed Pills				
Other				

Family Medical History

*Please check the appropriate box if any have been present in your **biological** relatives:*

	Children	Brother	Sister	Father	Mother	Uncle/Aunt	Grandparent
Anxiety							
OCD							
PTSD							
ADHD							
Bipolar							
Schizophrenia							
Depression							
Substance Abuse							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							

Is there anything else you would like us to know about you? ______________________________

____

____

____

____

____

____

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CLIENT RIGHTS AND RESPONSIBILITIES

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT
Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist
I. Confidentiality With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.
If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be saved electronically to your electronic treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.
- If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be part of the couples

therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

II. Record-keeping I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time, giving me the chance to print it out from my computer. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a electronically secure location that cannot be accessed by anyone else.

III. Diagnosis If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you.

IV. Other Rights You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the MC company as needed.

My Training and Approach to Therapy I have a Master of Social Work degree earned 2011 at Boise State University. I am a Licensed Independent Clinical Social Worker (#LW60512881). My areas of expertise include adults with diverse backgrounds of all ages seeking relief from family life cycle transitions, parenting struggles, infidelity, communication issues, anxiety, depression, anger, among other life challenges. Other areas of expertise include working with complex trauma (sexual assault and domestic violence), historical trauma (Alaska Natives and refugees), PTSD (active-duty sailors, veterans and dependents) and chronic illnesses (dialysis and kidney transplant patients).

I am a Humanistic therapist that practices Client-Centered Therapy. This form of psychotherapy emphasizes the patient's self-discovery, interpretation, conflict resolution, and reorganization of values and life approach, which are enabled by the warm, nondirective, unconditionally accepting support of the therapist, who reflects and clarifies the patient's discoveries.

I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, cognitive reframing, awareness exercises, self-monitoring experiments, visualization, journal-keeping, drawing, reading books and Eye Movement Desensitization Reprocessing

(EMDR). If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. I may suggest that you get involved in a therapy or support group as part of your work with me. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You have the right to refuse anything that I suggest. I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power I have as a therapist.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you use violence to, threaten, verbally or physically, or harass me, the office staff, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I am away from the office several times in the year for extended vacations. I will tell you well in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between-session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 p.m. weekdays or over the weekend), please call the Crisis Clinic at 206-461-3222. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

Your Responsibilities as a Therapy Client

I. You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay $60 for the missed session at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of time to cancellation. I cannot bill these sessions to your insurance. The only exception to this rule is if you are on Medicaid, in such case no fee will be charged. For all patients, if a total of three appointments are missed, you may be removed from my schedule and placed on a waiting list. **II.** You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. My fee for a session is $130.00. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up $10.00 every two years, on the odd year. If a fee raise is approaching I will remind you of this well in advance. I understand that I have individual financial responsibility for services rendered that are not covered by insurance or any other party liable to me. Seaside Psychotherapy LLC reserves the right to impose reasonable financing and late charges as well as reasonable costs, attorneys' fees and expenses incurred in the collection of your account should it become delinquent. Financial responsibility will be reduced or waived if charity care eligibility is determined. I am entitled to a copy of this financial agreement at the time I sign it. **III.** If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means for you once a month. You must provide

me with any forms, completely filled out as needed, your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you, you are responsible for paying me that amount at the time of our next appointment. If the insurance over-pays me, I will credit it to your account or refund it to you if you would prefer that. **IV.** I am not willing to have clients run a bill with me. I cannot accept barter for therapy, nor can I take DSHS medical coupons. I am a Medicare participating provider and accept assignment from them. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency. **V.** I am not responsible for loss or damage of any personal property, including any money, jewelry, documents or other articles of value.

Complaints If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Examining Board for Social Work, Dept. of Health, Olympia WA 98504. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

Client Consent to Psychotherapy I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $130.00 per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I am the patient or am duly authorized by the patient as the patient's legal agent or representative to execute this Consent and accept its terms. If signing as the patient's legal agent or representative, all references in this Consent to "me" or "my" or "I" shall be deemed to refer to the patient, where applicable.

____

Client's Printed Name　　　　Signature　　　　Date

____

Clinician's Signature　　　　Date

275 SE Cabot Drive, Suite B205
Oak Harbor, WA 98277
360-485-0980
seaside-psychotherapy.com
seasidepsychotherapy@gmail.com

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ______________________________
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I,_________________________________, authorize Seaside Psychotherapy LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____

Customer Signature Date