Sunrise Counseling Services

Carlin Harris, M.A., LMHC, NCC

Adult Client Questionnaire Date: _____

Name: _____ Date of Birth: _____ Age: _____
Last Name First Name MI

Address: _____
Street Address City State Zip Code

Phone: _____ _____ _____
Home Phone Cell Phone Email

Social Security Number _____

Occupation: _____ Employer: _____

Marital Status: ☐ Never married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Check all of the above that apply and describe: _____

Religious Preference
☐ Christian
- ☐Catholic
- ☐Protestant
- ☐Non-Denominational
- ☐LDS

☐Buddhist
☐Jewish
☐Muslim
☐Atheist/Agnostic
Other _____

Ethnicity (check all that apply)
☐African American
☐Asian
☐Caucasian
☐Hispanic/Latino
☐Native American/Alaskan
☐Pacific Islander
Other_____

SocioEconomic Status:
(for your household)
☐Under $24,000/year
☐$25,000 - $40,000
☐$40,000 - $80,000
☐$80,000 - $100,000
☐$100,000 - $130,000
☐over $130,000/year

Education
Didn't complete HS _____ HS/GED _____ Some college_____
Degree? What type (AA, BA, etc) in what field? _____

Why are you seeking counseling at this time of your life? _____

_____

_____

_____

What do you hope to gain through counseling? _____

_____

_____

What are your strengths/What do you like about yourself? _____

_____

Who do you turn to for support in your life? _____

How do you usually cope with problems/What coping strategies do you use? _____

_____

Please describe any prior or current legal issues. _____

_____

Please describe any exposure to trauma (childhood abuse, home fire, violence, victim of crime, etc.) and/or grief or other losses. _____

_____

Please describe any family history of mental health issues (Depression, Bipolar, Anxiety, "nervous breakdown", Schizophrenia, Substance Abuse, Suicide, etc) and identify which family member it was and the outcome.

_____

_____

Current Mental Health Symptom Checklist

DEPRESSED MOODS	**Never**	**Occasionally**	**Often**	**Daily**
Poor appetite				
Poor sleep patterns				
Feelings of worthlessness/ hopelessness				
Loss of interest in activities you once enjoyed				
Isolating from others/becoming withdrawn				
Low energy				
Poor memory				
Suicidal thoughts Describe:				
Episodes of unusually "up" moods				
Sadness				
Irritability				
Self critical statements				
Other:				

ANXIOUS MOODS	**Never**	**Occasionally**	**Often**	**Daily**
Difficulty controlling the amount of worry				
Restlessness				
Panic Attacks				
Intrusive Thoughts/Fears				
Obsessive thoughts				
Easily startled or jumpy				
Uncomfortable around people				
Stomach or GI issues				
Other:				

ATTENTION PROBLEMS	**Never**	**Occasionally**	**Often**	**Daily**
Difficulty with focus				
Distractibility				
Forgetfulness				
Disorganized				

OTHER CONCERNS: *(Eating Issues, Compulsive behaviors, Self injury, Phobias, Obsessive Thoughts, Anger Outbursts, Sexual Issues, etc.)*

	Never	**Occasionally**	**Often**	**Daily**

MENTAL HEALTH HISTORY

History of Psychiatric Hospitalization?

Dates_____ Hospital _____ Duration_____ Reason_____

Previous Oupatient Counseling?

Dates_____ Therapist _____ Duration_____ Reason_____

Dates_____ Therapist _____ Duration_____ Reason_____

SUBSTANCE USE:	**Age Started**	**Quantity in Past?**	**How Often?**	**Current Use?**	**Quantity?**	**How Often?**	**Date of Last Use**
Alcohol				Y or N			
Cigarettes / tobacco				Y or N			
Caffeine				Y or N			
Marijuana				Y or N			
Amphetamines				Y or N			
Cocaine				Y or N			
Opiods (misuse of prescription drugs)				Y or N			
Hallucinogens				Y or N			
Other:				Y or N			

HISTORY OF CHEMICAL DEPENDENCY TREATMENT?

Facility _____ Dates of Treatment_____

Drug of Choice at time_____ After Care Plan _____

OTHER COMPULSIONS	**Age Started**	**How Much in Past?**	**How Often?**	**Current Use?**	**How Much?**	**How Often?**	**Date of Last Use**
Gambling				Y or N			
Pornography				Y or N			
Food				Y or N			
Sexual Addiction				Y or N			
Shopping				Y or N			
Internet/Gaming				Y or N			

Describe your current health: □ Excellent □Very Good □Average □ Concerns □ Poor

Describe your nutritional choices: □ Excellent □Very Good □Average □ Concerns □ Poor

Describe your exercise habits: □ Excellent □Very Good □Average □ Concerns □ Poor

Describe your sleep habits: □ Excellent □Very Good □Average □ Concerns □ Poor Comments:

_____

MEDICAL HISTORY Date of last physical examination: _____

Family Doctor: _____ Phone: _____
Other Specialists?_____
Health Issues (list illnesses, injuries, surgeries and dates of each): _____
_____

_____

MEDICATIONS List all for PHYSICAL HEALTH AND MENTAL HEALTH reasons:

Medication	Dosage	Date Started	Used as Prescribed?	Date of Last Use	Purpose of Medication	Describe the Effectiveness
			Y or N			
			Y or N			
			Y or N			

Thank you for your time completing this paperwork, if there's anything that has not been asked here that you would like your therapist to know prior to your session, please mention it here: _____
_____
_____

One final question, how did you hear about Sunrise Counseling Services, and what reason prompted you to pursue counseling here? _____
_____

CONSENT TO TREATMENT

I voluntarily agree to receive mental health assessment, treatment or services and authorize the assigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing below, I the undersigned client, acknowledge that I have read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____
Client Signature Date

ADDENDUM / SIGNATURE PAGE

RECEIPT OF POLICIES AND CLIENT RIGHTS

I acknowledge receipt of

- Therapist Disclosure Statement and Policies and Procedures (in Client's Rights Packet)
- Notice of Privacy Practices (HIPPA) (included in Client's Rights Packet)
- Dept. of Health Counseling and Hypnotherapy Client Information. (optional)

Client Signature_____Date_____

Parent Signature_____ Date _____
If client is under age 18

FINANCIAL POLICY AGREEMENT

I have read the section on Fees and Scheduling and agree to the terms identified. **My fee for therapy is $150 per session unless insurance is being billed**. If using insurance or an alternate funding source for payment, I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. If I am a teenager under 18, I additionally authorize communication between my therapist and parent regarding insurance, payment and scheduling of appointments.

If I cancel an appointment less than 24 hours in advance or no-show, I will be charged $ _50_ for that session. This fee must be mailed in and/or received before another session will be scheduled.

To avoid missed appointments I authorize my therapist to contact me with appointment reminders. I understand that HIPPA is intended to protect my health information including appointments and scheduling. I understand that in compliance with this, my therapist utilizes the best security practices available to her to uphold these standards. However, since this technology cannot be secured unconditionally there is a risk that emails or other electronic communications could be observed by a third party on my devices. For the convenience of receiving appointment reminders and communications via phone, email or text I release my therapist of responsibility for the potential for HIPPA infractions in this context only.

Please indicate your preference for reminders (you can receive both):

____ email: _____@_____

____ text : #_____ Are voicemails okay at this number? Y or N

Client Signature_____Date_____

Parent Signature_____ Date _____
If client is under age 18

EMERGENCY CONTACT

In the event that Carlin Harris, LMHC, reasonably believes that you are a physical danger to yourself or to another person, she has an obligation to warn others of the risk. Therefore, I (the client) specifically consent for the therapist to warn the person in danger and to contact the following person(s), in addition to applicable medical and law enforcement personnel:

Name: _____Relationship to you:_____Phone number:_____

Sunrise Counseling Services

THERAPIST DISCLOSURE STATEMENT, POLICIES AND PROCEDURES
AND NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CARLIN DENETTE HARRIS, M.A., LMHC, NCC
Washington State Licensed Mental Health Counselor #LH 9949
National Certified Counselor

Both State and Federal law require me to provide you with this information that is intended to assist you in making informed choices as you begin your therapy process. This document includes information about your legal rights as a therapy client, including what you should expect regarding privacy and confidentiality. Because you have the responsibility of choosing a clinician and treatment modality that best meet your needs, you will also find information specifically about me, my training and professional experience, my approach to therapy and my practice policies. If you have any questions about this Notice please contact me at 253-445-2441.

TREATMENT PHILOSOPHY

While there are a multitude of reasons why one would seek counseling, we are all essentially looking for a way to improve our lives and to grow into our true selves. I utilize a strength-based approach, focusing on identifying personal values and goals and making healthy choices. Through acceptance and supportive therapeutic skills, I can help you or your child effectively express your experience, challenge your barriers (both real or imagined) and help you make the choices and changes necessary to enjoy your life in a more healthy and fulfilling way. With a foundation of family systems theory, my work has come to include several theoretical approaches including Cognitive-Behavioral, Narrative, and Client-centered.
I will help you or your adolescent look at the past, present and future to identify the problems and solutions. The combination of my education and work experience enable me to use a wide variety of creative and helpful approaches that fit the specific needs of my clients. I truly enjoy the opportunity to assist children in healing and resolving issues before unhealthy coping skills and destructive self-talk take root.

EDUCATION, TRAINING AND EXPERIENCE

I graduated with a Bachelor of Arts in Education from Pacific Lutheran University in 1987 and earned a Master of Arts in Marriage, Family and Child Counseling from the University of San Diego in 1995. As a licensed therapist I participate in ongoing continuing education. My post-graduation training has focused on the areas of art therapy, mindfulness, depression, trauma, grief and anxiety disorders.
I have over twenty years in the human services field including six years as a Mental Health Specialist in various school districts in California, Alaska and Washington. Other experiences include working in the foster care/juvenile justice system, as a sexual abuse counselor at Mary Bridge Hospital, crisis counselor on a suicide hotline, outpatient therapist at a children's psychiatry clinic, in-home behavioral interventionist for developmentally delayed children, a substance abuse educator at a university and seven years as Lead Therapist and clinical supervisor in community mental health agencies. I have been in private practice since 2008.

POLICIES AND PROCEDURES

Dual Relationships

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth

cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts and the realization that you are responsible for lifestyle choices/changes that may result from therapy.
Completion of assignments/readings between therapy sessions will help therapy be more effective. In addition, within a reasonable period of time after beginning treatment, your therapist will discuss her understanding of the problem, and identify treatment goals.
If you have any unanswered questions about the course of therapy, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I can assist you in obtaining those treatments.
After the first few sessions, your therapist will assess if she can be of benefit to you. I do not accept clients whom, in my opinion I cannot help or whose needs are beyond my training and experience. In such a case, I will give you a number of referrals that you can contact. If, at any point during psychotherapy, I assess that I am not being effective in helping you reach the therapeutic goals, I am obligated to discuss it with you and terminate treatment, if necessary. In such a case, I will give you a number of referrals that may be of help to you.

Emergencies

If you are feeling suicidal or homicidal, please call the Crisis Line at 253-798-4443 (1-800-576-7764), call 911 or go directly to the Emergency Room.

When the office is closed, your therapist can be reached for emergencies by calling 253-906-1737.
Emergencies are urgent issues requiring immediate action. If you and your therapist have already completed a Crisis Plan, you will be asked if you are following the strategies identified in session. Please note that your therapist is In a position to provide 24/7 crisis intervention and may not be available when you call.
If an emergency call with your therapist lasts longer than 15 minutes, you will be billed for a therapy session. If you are not in crisis but want to make contact with your therapist a common option is to write an email as this may help you sort out your feelings in the heat of the moment: info@carlinharris.com.

Please acknowledge that, in the event that your therapist becomes physically or mentally incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this information and consent form, you give consent to allowing another licensed mental health professional identified in the therapist's Professional Will to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Appointments

Appointments are available Monday to Thursday between noon and 7pm. To schedule an appointment you may call the office at 253-445-2441 and leave a message, or email at info@carlinharris.com. In the near future a "client portal" will be available on the website and you can schedule your appointment directly.

Appointments will begin on time. If you happen to be running late, our appointment will still need to end at the original time so your therapist may write up your casenote and prepare for the next client.

Cancellations

On the attached Addendum you may select an automated email reminder (48 hours before) and/or a text reminder (24 hours before), however, it is still your responsibility to keep track of your scheduled appointments.
Please call to cancel or reschedule at least 24 hours in advance, or YOU WILL BE CHARGED the fee for the missed appointment. Insurance companies will not reimburse for missed appointments so this will become the client's responsibility. If you "no-show" for an appointment and do not call back within 24 hours, any future appointments will be cancelled and made available for other clients.

The therapist has set a limited number of available appointments for the week, so if you do not show, the therapist is unable to meet with someone else who may need to be seen. Please be considerate of that.

FEES AND SCHEDULING

My fees are as follows:
$175 Initial Intake Assessment 60-75 minutes

$150 Individual Session 50-60 minutes, add'l 30 minutes $75

$250 In person Court Testimony per hour. Other court-related work - $150/hour, letters and other requested documentation preparation - $75/hr.

If it is necessary to raise my fees, clients will be given at least one month notice prior to the increase.

Insurance

Sunrise Counseling Services is In-Network and a "preferred provider" with Premera Blue Cross and Kaiser PPO/First Choice Health Network. I am unable to take clients with Regence Blue Shield or Aetna as I'm in the process of terminating my contract with them. I am therefore not an Out-of-Network provider with them during this transition.
If you choose to use your insurance benefits from a company with which I am not affiliated, you will need to inquire about their reimbursement for an "out-of-network" provider. Out of network clients are responsible for paying for the full fee of sessions up front and seeking reimbursement from their insurance companies or flexible savings accounts themselves.
Clients are responsible for payment of all fees regardless of the how the insurance company chooses to handle the claim. Different co-payments are required by various group coverage plans. Your co-payment is based on the mental health policy selected by your employer or purchased by you. It is recommended that you determine your copayments and deductibles before your first visit by calling your benefits office or insurance company.

- Payment is due at time of services, preferably at the beginning of the hour so we end on time.
- I DO NOT bill secondary insurances. I will provide an invoice to you that you may submit to them.
- Your account is to be kept current - accordingly, all self-pay or insurance co-payments and deductibles will be collected at the TIME OF SERVICE. Payable by cash, check, Visa, MasterCard, or Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- If you fall behind in payments, future appointments may be postponed until your bill is current.
- NO SHOW FEES are charged at a rate of $50 for the session.
- A returned check will result in a $25 service charge and ALL future payments being required in cash or credit card.
- You may receive refunds if you have a credit balance. Refunds will be issued within 4 weeks from the date requested, if there are no pending insurance claims.
- There is a $75/hr prorated charge for the completion of paperwork (ex: disability, FMLA, etc.) Once the fee is determined, this needs to be paid prior to paperwork being submitted.
- Effective November 1, 2010, any unpaid balance of more than sixty days from the last date of service will be charged a 10% late fee per month or $10.00 whichever is greater. This will continue to accrue until the balance is paid. Unpaid accounts older than six months from the last date of service will be sent to collections.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 45 percent of your outstanding balance, court costs and attorney fees.
- If I need to go to court, the fee is $250 per hour. Since court dates are frequently changed the day of the scheduled appearance, and that day's cancelled appointments might not be able to be rescheduled, a retainer fee of $150 may be required up front in addition to the hourly bill while in court.
- If phone calls extend beyond 15 minutes you will be billed a pro-rated rate for a therapy session.
- It is your responsibility to inform us of any address or telephone number changes or changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral forwarded to our office prior to your appointment.
- Not all services are covered benefits with all insurance plans (couples therapy) and it is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit. It is important to understand that insurance companies only quote eligibility and don't guarantee payment over the phone. Therefore, as a client, you are agreeing to make payment in full even if your insurance does not pay for any reason. Your fee for an hourly individual session will be $150.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, PLEASE do not hesitate to ask us. We are here to help you.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes me to do so.
A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached addendum stating that you received a copy of this Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your right regarding health information I maintain about you and a brief description of how you may exercise these rights. This Notice describes my legal duties and privacy practices with respect to your medical information. I must follow the privacy practices that are described in this Notice (which may be amended in time). Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me or can view a copy in my office.

I. USES AND DISCLOSURES OF MEDICAL INFORMATION

A. Permissible Uses and Disclosures without your Written Authorization

In certain situations, which I describe in Section C below, I must obtain your written authorization in order to use and/or disclose your protected health information (PHI). However I do not need any type of authorization from you for the following uses and disclosures (the examples provided in each category are not meant to be complete, but offer a description of the types of uses and disclosures that are permissible under federal and state law):

1. Treatment: I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: if a psychiatrist is treating you, I may disclose your PHI to him/her in order to coordinate your care.
2. Payment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provided to you. Example: I might be required to send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies and others that process health care claims for my office. At this time, I do my own billing and do not use a billing company.
3. Health Care Operations: I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: quality control-I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of healthcare professionals who provide you with those services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws or for use in professional supervision or certification or credentialing activities. I may also use your PHI to contact you between sessions for reminders, etc.
4. Other Health Care Providers: I may disclose your PHI to other health care providers when such medical information is required for them to treat you. Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (For example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
5. Governmental Purposes and other Uses and Disclosures as Required by Law: I may use or disclose your PHI for certain governmental purposes and when I am otherwise required or permitted to do so by law. For example, I may disclose medical information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access medical information; disclosure to judicial and law enforcement officials in response to a search warrant, court order or another lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners and correctional institutions as otherwise authorized by law.

B. Uses and Disclosures When You Have the Opportunity to Object

1. Disclosures to family, friends, or others involved in your care. Unless you object I will use my professional judgment to provide relevant PHI to your family member, friend, or another person that you designate to be involved in your care or responsible for the payment of services. Retroactive consent may be obtained in emergency situations.

C. Other Uses and Disclosures Require Prior Written Authorization.

1. Other Uses and Disclosures. In any other situation not described in Sections IA and IB above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses or disclosures (assuming that I haven't taken action subsequent to the original authorization) of your PHI by me.
2. Use and Disclosure of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information")

II: WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

A. The Right to See and Get Copies of your PHI. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I will charge a fee of $.25 per page of the requested copies. You will receive a response from me within 30 days of my receiving your written request. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
B. The Right to Choose How I Send Your PHI to You. You may request, and I will accommodate if possible, any reasonable written request for you to receive medical information by alternative means of communication (like email) or at alternative addresses.
C. The Right to Accounting of Disclosures. You are entitled to a list of disclosures of your PHI that I have made. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years.
D. The Right to Request Amendment. You have the right to request that I amend your health information. Your request must be in writing and it must explain why the information should be amended. I may deny your request under certain circumstances.
F. The Right to Obtain Notice. You have the right to a paper copy of this Notice.
G. Questions or Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your rights, you may contact my office. You may also file a written complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services or the WA Department of Health. I will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on April 14, 2003.