# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## CLIENT INFORMATION

Name _____ Birthdate _____ Age _____ Male ☐ Female ☐
*Last Name, First Name Middle Name*

Social Security # _____ Single ☐ Married ☐ Couple ☐ Separated ☐ Divorced ☐ Widowed ☐

Spouse's Name (*if applicable*) _____ Marriage Date _____
*Last Name, First Name Middle Name*

Prior Marriages? From _____ To _____ Prior Marriages? From _____ To _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Work Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Cell Phone (_____)_____ OK to call? Y ☐ N ☐ Leave Message? Y ☐ N ☐

Employer _____ Job Title _____

Referred by? _____ Primary Care Physician _____

**People in home** **Children out of home**

| Name | Age | Relationship | Name | Age |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Emergency Contact _____ Relationship to You _____

Phone (____) _____

## INSURANCE INFORMATION

**Primary Insurance Co. Name** _____ **Telephone** (____) _____

Policy Holder's Name _____ Birthdate _____

Social Security # _____ Member ID # _____

Policy Holder's Employer _____ Grp. # _____

**Secondary Insurance Co. Name** _____ **Telephone** (____) _____

Policy Holder's Name _____ Birthdate _____

Social Security # _____ Member ID # _____

Policy Holder's Employer _____ Grp. # _____

*I affirm that the above information is correct and complete.*

Signature _____ Date _____

Signature _____ Date _____

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## CLIENT QUESTIONNAIRE

Name _____

This questionnaire is designed to help you indicate in what ways you might want some assistance. Please circle the most appropriate response to indicate your level of concern. Also specify for how long each issue/symptom has been a problem.

| 1<br>Not a Problem | 2<br>A Mild Problem | | 3<br>A Moderate Problem | 4<br>A Serious Problem | |
|---|---|---|---|---|---|
| **YOUR PHYSICAL FUNCTIONS** | | ***How Long?*** | **YOUR BEHAVIOR** | | ***How Long?*** |
| Sleep too much | 1 2 3 4 | | Difficulty with Daily Routine | 1 2 3 4 | |
| Can't get to sleep or stay asleep | 1 2 3 4 | | Letting Others Take Advantage of You | 1 2 3 4 | |
| Fatigue | 1 2 3 4 | | Hyperactivity (can't sit still) | 1 2 3 4 | |
| Speech (stuttering or stammering) | 1 2 3 4 | | Repeating Certain Acts, again & again | 1 2 3 4 | |
| Appetite Changed | 1 2 3 4 | | Physically Abusing Others | 1 2 3 4 | |
| Weight Gain | 1 2 3 4 | | Using Alcohol to Cope with Problems | 1 2 3 4 | |
| Weight Loss | 1 2 3 4 | | Using Drugs to Cope with Problems | 1 2 3 4 | |
| Sexual Functioning | 1 2 3 4 | | Lying | 1 2 3 4 | |
| **YOUR INNER THOUGHTS & IDEAS** | | ***How Long?*** | Stealing | 1 2 3 4 | |
| Trouble Concentrating | 1 2 3 4 | | Withdrawing from Others Socially | 1 2 3 4 | |
| Thinking about something over & over | 1 2 3 4 | | Attempted to Hurt Self | 1 2 3 4 | |
| Memory Problems | 1 2 3 4 | | Verbally Abusing Others | 1 2 3 4 | |
| Worrying about your Health | 1 2 3 4 | | Dependency (relying on others to make your decisions) | 1 2 3 4 | |
| Believing you are Inferior to Others | 1 2 3 4 | | **YOUR WORK EXPERIENCE** | | ***How Long?*** |
| Believing you are Better than Others | 1 2 3 4 | | General Performance | 1 2 3 4 | |
| Experiencing Confusion | 1 2 3 4 | | General Satisfaction | 1 2 3 4 | |
| Thoughts about Hurting Yourself | 1 2 3 4 | | Lateness | 1 2 3 4 | |
| Thoughts of Hurting Others | 1 2 3 4 | | Absenteeism | 1 2 3 4 | |
| Phobias | 1 2 3 4 | | Negative Feelings about Work | 1 2 3 4 | |
| **YOUR FEELINGS & MOODS** | | ***How Long?*** | Relating to Co-Workers | 1 2 3 4 | |
| Depression/sad a lot | 1 2 3 4 | | Relating to Supervisors | 1 2 3 4 | |
| Euphoria (feeling "high") | 1 2 3 4 | | Relating to Supervisees | 1 2 3 4 | |
| Frequent Crying | 1 2 3 4 | | **PROBLEM AREAS** | | ***How Long?*** |
| Anxiety (Nervousness) | 1 2 3 4 | | Raising Children | 1 2 3 4 | |
| Lack of Energy | 1 2 3 4 | | Relating to your Spouse or Partner | 1 2 3 4 | |
| Feeling Angry or Hostile | 1 2 3 4 | | Death of a Loved One | 1 2 3 4 | |
| Not Liking Self | 1 2 3 4 | | History of Physical Abuse | 1 2 3 4 | |
| Not Liking Others | 1 2 3 4 | | History of Sexual Abuse | 1 2 3 4 | |
| Helplessness | 1 2 3 4 | | Handling Financial Problems | 1 2 3 4 | |
| Excessive Guilt | 1 2 3 4 | | Handling Legal Problems | 1 2 3 4 | |
| Worthlessness | 1 2 3 4 | | Handling Health Problems | 1 2 3 4 | |
| Hopelessness | 1 2 3 4 | | Family Violence (actual or threatened) | 1 2 3 4 | |
| Sudden Changes in Mood for No Apparent Cause | 1 2 3 4 | | Handling Someone Else's Alcohol or Drug Problem | 1 2 3 4 | |
| Feeling Lonely | 1 2 3 4 | | Dealing with Aging Parents | 1 2 3 4 | |

What is the primary problem that has brought you to counseling?

_____

_____

Please list the goals you hope to achieve in counseling. (Be specific)

_____

_____

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

| Current Medications including Dose | When Started? | For What Condition? | Prescribed By? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently under the care of a physician? If yes, please list the name, practice name and phone number of the physician.

For what conditions are you being treated?

Please list additional medical conditions, past and present:

| SUBSTANCE USE HISTORY | Amount used and frequency IN LAST MONTH example: 3 beers per day | Amount used, frequency used and dates WHEN YOU USED IT THE MOST (ex: 6 beers per day in 1991) |
|---|---|---|
| Coffee-tea-caffeinated soda | | |
| Cigarettes | | |
| Alcohol | | |
| Marijuana | | |
| Cocaine | | |
| Amphetamines (uppers) | | |
| Barbiturates (downers) | | |
| Tranquilizers | | |
| Hallucinogens | | |
| Opiates | | |
| Other _____ | | |

| Name(s) of prior Mental Health/ Chemical Dependency provider(s) | Dates | Helpful? *(Y or N)* |
|---|---|---|
| | | |
| | | |
| | | |

List any family history of mental health issues and chemical dependency

Years of education _____ Highest Degree _____

What are your hobbies and leisure time activities?

Does your social support system work for you?

Provide any other information you feel is important.

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## OFFICE POLICY STATEMENT

PLEASE KEEP THIS COPY FOR YOUR RECORDS

**Introduction**

Welcome! The decision to work with a counselor is an important one that only you can make based on the match of your needs and the counselor's skills. Please read the following information about my practice so you will understand more about my background and how we might work together. Please wait to sign the Signature Page until we begin our first session together. I will clarify your fees and you can ask me any questions you have that are not covered in this statement.

**Qualifications**

I received my Masters of Social Work degree in 1975 from the University of Washington. In the years since, I have done psychotherapy in a wide variety of settings and have taught the counseling process to other professionals. I am licensed to do counseling in Washington State (LW #00004257), and am also nationally recognized as a Board Certified Diplomate in Clinical Social Work. I have additional credentialing as a Board Certified Coach.

**Treatment**

The decision to seek counseling is often a difficult one. My goal in working with you is to address the concerns **you** have, tailoring treatment to your personality and needs. Some clients need only a few sessions, while others may benefit from longer term counseling.

Although a successful outcome cannot be guaranteed, I will use my best abilities to help you overcome the difficulties that led you to seek professional help. If you feel you are not receiving what you need from our sessions, please let me know so we can work better together. You have the right to ask questions about what we are doing, to request changes in my approach, and to take a break or end counseling at any time. If your concerns are beyond my areas of expertise, or at your request, I will refer you to another professional.

**Appointments**

When you schedule an appointment, you are asking me to set aside a time especially for you. As a courtesy to me and to others who may wish to schedule, please notify me by **telephone**, giving me as much notice as possible if you need to change or cancel your appointment. **YOU WILL BE EXPECTED TO PAY A MISSED SESSION FEE OF $100 WHEN LESS THAN 24 HOURS NOTICE IS GIVEN**.

Usually, sessions are 45 minutes long unless there is a clinical need to extend the time to 55 minutes. I request your cooperation and assistance in ending sessions on time. If you are paying by check, please have your check written out in advance. If paying by cash, please have the exact change. In consideration to those with sensitivities, please come to appointments FRAGRANCE FREE. Also, as sessions are more productive when uninterrupted, please remember to turn off your cell phone unless there is an emergency situation.

**Fees**

The fee is $175 for the first session, $155 for 55 minute sessions and $125 for 45 minute sessions. Occasional exceptions may be negotiated based on financial circumstances. This fee will be charged on a pro-rated basis for any additional time spent in session, telephone consultation, report preparation, or other activity. In the unlikely event that there would be legal involvement in your situation, you will be billed according to the legal fee schedule and policies current at that time.

A $40 fee will be charged for any check returned unpaid. A bookkeeping fee of $5.00 per month will be applied to any unpaid private balance over sixty (60) days past due. Past private balances must be paid in full within 90 days to avoid being sent to collection. If your account is turned over for collection, you will be charged a collection fee in the amount allowed by law at that time. Additionally, your confidential identifying information will be disclosed. If unusual circumstances make it impossible for you to meet these financial arrangements, please talk to me directly. This will avoid misunderstanding and enable you to keep your account in good standing.

**EVERETT OFFICE**
3101 Oakes Ave.
Everett, WA 98201

**MALTBY OFFICE**
21321 65TH Ave. SE, Suite B
Woodinville, WA 98072

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

**Confidentiality**

Please refer to the Notice of Privacy Practices and the Insurance Billing section below.

**Insurance Billing**

There are advantages and disadvantages to utilizing insurance benefits for mental health services. You need to be aware of what it means to participate in insurance-monitored health care. Insurance companies and managed care plans often require information about your treatment to justify or limit your coverage. This sharing of information can compromise your confidentiality. Occasionally therapist notes are reviewed for auditing purposes. More often, treatment progress or summary information is required for requesting additional sessions. A diagnosis is required on all insurance claim forms. This information becomes a permanent part of your medical record. When this information goes to your physician, it can mean that your health care is more comprehensive. It can also mean that you may have difficulty qualifying for disability or life insurance at a later date.

Federal law mandates that the primary insurance subscriber be informed through an "explanation of benefits" that insurance benefits have been paid on behalf of their covered family members. If you receive insurance benefits under someone else's insurance plan, you have the right to request that your claims information be kept private from the subscriber. To do so, call the insurance company and ask to speak with the privacy officer.

**Communication/Website/Social Media**

**Telephone:**

Please use the telephone to reach me to schedule or cancel appointments or to communicate any therapeutic information that you feel cannot wait until your next scheduled session. The best way to reach me is by leaving a message with my voice message service (**425) 948-4055**. I check for messages multiple times a day on weekdays and I will return your call as soon as I am able (occasionally that may mean the next day). If your call is urgent, please say so.

I make a concerted effort to return calls promptly. To accomplish that, I use an electronic system. Usually, that means I am more accessible. Occasionally, the electronics break, or get updated. When this happens, it is for a very short time period. Therefore, if you have not heard from me within 24 hours, please keep calling back.

**Email:**

I only use Email to occasionally send articles or other information to clients. If you need to communicate with me between sessions, please contact me by phone. That way, I can respond to you more quickly. I request that you not use Email to communicate with me, especially if there is an emergency. If you do so anyway, please be aware that Email communication can be accessed by unauthorized people relatively easilty thus compromising your privacy and confidentiality. My Emails are not encrypted. If you decide to communicate with me by Email anyway, I will assume that you have made an informed decision and I will view it as your agreement to take the risk that such communication might be intercepted. You should also know that any Emails I receive from you and any responses that I send to you become part of your clinical record.

**Website:**

I host a website for the purpose of informing potential clients about my services. Additionally, I post articles that I think might be relevant to current clients. These can be found on the website by going to the menu and selecting "Articles of Interest". As questions arise about recommendations for self-help books, I have collected titles that either I have read or have been recommended by colleagues and/or clients. This collection can be found at www.nancysbookpicks.com. (Any income derived from purchases made from that site defrays the expenses related to the site.)

**Interacting:**

I do not accept friend requests from current or past clients. I am prohibited from responding to feedback left in public forums such as Healthgrades. Please tell me directly if you have any concerns or comments about our work together.

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

**Emergencies**

If you call me in case of an emergency, please make that clear in your message. Since it may be some time before I am able to retrieve and return your emergency call (this could even mean the following day), you are strongly advised to take one or more of the following measures to get immediate help:

1. Call 911
2. Go to the Emergency Room of the nearest hospital
3. Call your primary care physician or psychiatrist and explain that you are in a crisis
4. Call the Care Crisis Line at (425) 258-4357 (Snohomish County) or (206) 461-3222 (King County)
5. In addition to the above, take other appropriate measures, e.g., call a family member or friend

**Ethics and Accountability**

I am licensed in the State of Washington, and am accountable for my work with you. If you have any concerns about your treatment, bring them to my attention immediately. If your concern is not resolved, or if you believe I have been unethical or unprofessional (RCW 18.130.180), you may contact the Department of Licensing in Olympia at the Health Professions Quality Assurance Customer Service Center PO Box 47865 Olympia, WA 98504 Telephone:(360) 236-4700

Ethical guidelines discourage social or business interactions between counselor and client outside the context of therapy.

*Rev 9/24/13*

**EVERETT OFFICE**
3101 Oakes Ave.
Everett, WA 98201

**MALTBY OFFICE**
21321 65TH Ave. SE, Suite B
Woodinville, WA 98072

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## 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 THIS NOTICE CAREFULLY.

PLEASE KEEP THIS COPY FOR YOUR RECORDS

As part of my professional practice, I maintain personal information about you and your physical and mental health. "Protected Health Information" (PHI) is information about you that may identify you and that relates to your past, present or future physical or mental health condition, services provided, or payment for those services. This Notice of Privacy Practices describes your rights regarding that information, how I *may* use and disclose that information and my duties to protect that information in accordance with applicable law and the *Social Work Code of Ethics.*

### How I May Use And Disclose Health Information About You

**For Treatment**. Your health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health provider involved in your care. In case of emergency, a family member may be contacted. In certain circumstances, I may contact you to discuss treatment options, or to provide follow up to a referral.

**For Payment.** Your PHI may be used or disclosed so that payment can be received for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only the minimum amount of PHI necessary for purposes of collection will be disclosed.

**For Health Care Operations.** Your PHI may be used or disclosed in order to support business activities including, but not limited to, quality assessment, licensing, and conducting or arranging for other business activities. For example, your PHI will be shared with third parties that perform various business activities (e.g., billing) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

### Other Uses And Disclosures Also Not Requiring Your Authorization

**Required by Law.** I may use or disclose your health information to the extent that it's use or disclosure is required by law. Examples are: child or adult abuse/neglect reports, law enforcement reports, worker's compensation programs, reports to coroners and medical examiners in connection with the investigation of deaths, government functions, and public safety. Additionally, your PHI will be disclosed if you make a complaint against me to the Washington State Department of Health. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

**Health Oversight.** I may disclose your health information to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me (such as third-party payers).

**Public Health.** If required, your PHI may be used or disclosed for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Fundraising.** Your PHI will not be used in any way for fundraising activities.

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## Other Uses And Disclosures Also Not Requiring Your Authorization

**Threat to Health or Safety**. I may disclose your health information when necessary to minimize an imminent danger to the health or safety of you or any other individual.
**Business Associates.** I may disclose your health information to Business Associates that are contracted by me to perform health care operations or payment activities on my behalf. My contract with them must require them to safeguard the privacy of your protected health information.
**Compulsory Process.** I will disclose your protected health information if I am ordered to do so by a court order or other lawful process.

## Uses And Disclosures Requiring Your Written Authorization

I will make other uses and disclosures of your "PHI" only with your written authorization. You may revoke this authorization in writing at any time. Of course, I am unable to take back any disclosures I have already made with your permission prior to a revocation.

## Your Rights Regarding Your Health Information

You have a right to:

- **Request access to inspect or copy** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy "PHI" that has been maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is competing evidence that access would cause serious harm to you. A reasonable fee is charged for copies. You may also request that a copy of your PHI be provided to another person.
- **Ask me to amend the health information** in your record if you believe it is incorrect or incomplete. Your request must be in writing and must provide the reason for your request. I am not required to agree to the amendment. If it is denied, you have the right to file a statement of disagreement. I may prepare a rebuttal to your statement and will provide you with a copy.
- **Seek an accounting of disclosures** by asking me in writing for a list of the disclosures I have made of your PHI, except for disclosures for treatment, payment and health care operations.
- **Request restrictions or limitations** on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Request communication** with you by another means to preserve confidentiality. For example, if you want me to communicate with you at a different address or telephone number I can usually accommodate your request if it is reasonable. I will not ask why you are making the request.
- **Breach Notification** if there is an unintended disclosure of unsecured PHI. In such case I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Receive a copy** of this notice.

## Changes to this Notice

This notice, effective 9/23/2013, may be changed at any time. Any new Notice of Privacy Practices will be effective for all health information that I maintain at that time. A current Notice will be posted on my website, www.nancyadlerjones.com.

## Complaints

If you believe your privacy rights have been violated, you may contact me, the Privacy Officer at 425-948-4055, or submit your complaint in writing to Nancy Adler-Jones, MSW, Privacy Officer, 3101 Oakes Ave. Everett, WA 98201. If I cannot resolve your concern, you may also contact the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

# NANCY ADLER-JONES, MSW, LICSW

Counselor/Psychotherapist | 425-948-4055 | www.nancyadlerjones.com

## AGREEMENT

| FEES | |
|---|---|
| EAP Sessions | $ 0 |
| Intake (first session) Fee | $ 175 |
| Co-Payment* | |
| 45 Minute Session Fee | $ 155 |
| Co-Payment* | |
| 55 Minute Session Fee | $ 125 |
| Co-Payment* | |
| Report Writing, Telephone Calls | $2.50 per minute |
| **Late cancellation/no show** | **$ 100** |

*For other fees refer to office policy statement*

*Occasionally the co-payment may be different if insurance benefits change of if the deductible has not been met.

I authorize Nancy Adler-Jones, MSW to provide counseling services to me. The fee arrangements are clear. I have read and understood the Office Policies and have been given a copy of the Notice of Privacy Practices. I have been given the opportunity to ask questions about those policies.

Client Signature Date

Therapist's Signature Date

## Authorization for use or disclosure of protected health information to Third Party Payers

I,_____ (birthdate), _____ authorize NANCY ADLER-JONES, MSW to obtain and/or disclose the following protected health information: benefits, eligibility, demographic information, billing information, diagnosis, treatment plan, current treatment update, discharge/transfer summary and/or progress notes.

The purpose of this disclosure of information is to bill and receive payment from your insurance company, managed care organization or other third party payer. Only the minimum necessary information to obtain benefit eligibility and coverage information as well as to submit claims for payment and to comply with medical necessity and utilization review purposes will be disclosed.

## Recipient of Protected Healthcare Information

Name of Insurance Co., EAP or Other Third Party Payer: _____

**Revocation.** It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.
**Duration.** If not previously revoked, and provided there are no obligations imposed by my insurer in order to process or substantiate claims made under my policy, this authorization will expire when benefit claims are no longer pending and my account has been paid in full.
**Signature.** Signature below authorizes use and/or disclosure of protected health information for the above purpose.

Client Signature Date

**EVERETT OFFICE**
3101 Oakes Ave.
Everett, WA 98201

**MALTBY OFFICE**
21321 65TH Ave. SE, Suite B
Woodinville, WA 98072