Selin E. Caka, MA, LMFT

Client Information Form

(please provide one information form for each partner)

Name: _____ DOB:_____ Pronouns:_____

Street Address:_____ City: _____ State: ____ Zip: _____

Cell: _____ Home : _____ Office: _____

OK to send postal mail? _____ OK to leave voice mail on: Cell ____ Home: _____ Office: _____

Primary Care Provider:_____ Date last seen _____

Psychiatrist _____ Date last seen _____

What brings you to therapy?

Current symptoms (please rate severity):

0 *= Not present at this time*

1 *= Impacts quality of life, but day-to-day functioning is not impaired*

2 *= Significant impact on quality of life and/or day-to-day functioning is impaired*

3 *= Profound impact on quality of life and/or day to day functioning*

	0	1	2	3		0	1	2	3		0	1	2	3
depressed mood					bulimia					hyperactivity				
anxiety					anorexia					losing track of time/place				
appetite disturbance					laxative abuse					somatic complaints				
sleep disturbance					diuretic abuse					significant weight change				
elimination disturbance					paranoid ideas					a medical condition				
fatigue/low energy					racing thoughts					emotional trauma				
slow movements					delusions					physical trauma				
poor concentration					visual hallucinations					sexual trauma				
poor grooming					audio hallucinations					domestic violence				
mood swings					aggression					self-mutilation/self-harm				
agitation					sexual dysfunction					suicidal thoughts				
emotionality					grief					other_____				
irritability					hopelessness					other_____				
panic attacks					social isolation					other_____				
phobias					guilt					other_____				
obsessions					feeling worthless					other_____				
compulsions					elevated mood					other_____				

Where did you learn about me?

Informed Consent for Partner and Family Therapy Services

Starting counseling is a major decision, and you may have many questions. This document is intended to inform you of the policies, state and federal laws and your rights. If you have other questions or concerns, please ask, and I will do my best to give you all the information you need.

Your Therapist: I hold a Master's degree in Psychology and Couple and Family Therapy from Antioch University Seattle, and a Bachelor's degree in Psychology from the University of Washington. I am a Licensed Marriage and Family Therapist in the state of Washington, (credential #LF60820305).

I provide counseling services to individuals and families age 13 and older, and partners age 18 and older. I work within the general conceptual framework of Emotionally Focused Therapy and family systems theory, but employ techniques and interventions from multiple disciplines, and feel that a collaborative relationship between clients and myself is the key to successful therapy.

Partner and Family Therapy Services: Change is often not easy. In fact, meaningful change can be one of the most difficult things people can tackle. You have decided, however, that you are ready for change, and I am honored to have the opportunity to support you in what changes you wish to make.

While I believe I can help you on your journey to change, it is, in the end, a journey you will have to make for yourselves. I can provide insight, make observations and teach behavioral techniques, but I cannot do the work for you, nor guarantee that the work will provide the change or results you desire. Therapy can be emotionally intense, even painful, at times. We will be challenging long-held assumptions and beliefs, and this may make you angry, uncomfortable, upset, even confused. These reactions are entirely expected, and are a part of healing, and I encourage you to explore them together as they come up.

Number of Visits: The number of sessions depends on many factors, including the nature of your situation and your level of participation in the therapeutic process. Standard partner and family sessions are 85 minutes in length, though longer sessions are available, should they be appropriate. We will discuss this change before it is made.

Payment for Services: 85-minute partner and family session are billed at $165. By signing this consent for treatment, you understand that you are financially responsible for the cost of treatment. Co-payment for insurance billing is due at the time of service. If you do not use insurance, full payment is due at the time of service, and includes a $25 time-of-service administrative discount. I accept credit cards, cash, or checks as payment. If you have any concern about your ability to meet your payment for service, please discuss it with me.

Insurance

Insurance does not cover partner or family therapy, except to assist in mental health treatment of an individual member of the partnership or family. This person must be covered by insurance for the service to be covered. We will discuss at your first appointment whether using insurance is appropriate. If you do use insurance, I will need to provide your insurer a diagnosis, and your insurer will have access to your records.

Missed Sessions: You are responsible for keeping your scheduled appointment. Appointment no-show or cancelation within 24 hours of session incurs the full session fee, which is not billable to insurance. Late arrival of 20 minutes or more will be considered a no-show.

Termination of Services: In most cases, our time together will end as a natural result of you completing your treatment goals. However, therapy is entirely voluntary, and you are free to refuse any suggested intervention or treatment, and to terminate therapy at any point. If you're thinking about ending therapy, I encourage you to discuss it with me, and, if you desire, I would gladly provide you with referrals to other providers in the area, and will do all I can to be helpful in the transition process. During our work together, if I assess that I am not being effective in helping you achieve your desired goals, I will discuss this with you and, if appropriate, terminate therapy. In this rare instance, I will also provide referrals to other providers who might better suit your needs.

Confidentiality: Your records are confidential. They are stored in a locked, limited-access area. However, there may be times when disclosure of your records will be compelled by law. By law, confidentiality is waived for reporting purposes:

- if I believe one or more of you are an imminent danger to yourself or others,
- if I know of or suspect current child or elder abuse,
- if I believe that one or more of you have been infected with HIV, or are putting a sexual partner at risk for possible transmission of HIV,
- if one or more of you bring a negligence suit against me or file a complaint with the WA licensing board,

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the HIPPA Notice of Privacy Practices you were given along with this form, and to discuss with me any questions or concerns you may have. By signing this form, you are giving me your consent to share confidential information with all persons mandated by law, and with the insurance carrier responsible for providing your mental health care service, if applicable.

Professional Records: Your clinical record will contain Protected Health Information, including contact information and reasons for seeking therapy, and may also include a description of the ways in which your problem affects your lives, the goals for treatment, your progress toward those goals, your medical and social histories, your treatment histories, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that, at your request, have been sent to any outside providers. You may examine and/or receive a copy of your Clinical Record – it is yours. I will ask that you sign and date a release form that will be added to your Clinical Record before doing so. In addition, I may also keep a set of therapy notes that are for my own use, and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record, and are not released to others with your Clinical Record, except in rare legal circumstances.

Risks of Therapy: *"An examined life is painful" - Malcolm X*. As I mentioned before, the therapeutic process can be stressful, and can evoke feelings of sadness, anger, anxiety or fear. Your relationships may shift as you explore new ways of interacting with each other and with your lives. You may feel worse about your situation before you begin to feel better. These

experiences are common and normal, and, as your therapist, it is my job to help support you through the bumpy road toward your goals.

Secrets: Therapy is a journey that invites us to learn new skills and gain new perspectives so that we can build honesty and trust in our relationships. The process takes courage, patience and openness. Due to the collaborative nature of partner and family therapy, it is imperative that the therapist maintain a neutral stance toward partners and families. This can only be achieved in the absence of secrets within the treatment group. Therefore, please refrain from asking me to keep secrets from other members in treatment. This applies to all forms of communication (verbal, email, phone and written correspondence).

Emergencies: I am unable to provide emergency services. If you are experiencing a psychiatric or medical crisis, immediately contact 911, the King County Crisis Clinic (206.461.3222), or go to your nearest hospital emergency room. Emergencies are urgent issues requiring immediate action - do not be afraid to ask for help.

* *

____ We have read, signed and received a copy of the HIPPA Notice of Privacy Practices

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Please sign on the following signature page:

We, the undersigned, have read and discussed this Informed Consent Document, and have been given the opportunity to ask any and all questions we have, and have received acceptable answers, and understand that we will be given copies. I have also been given a copy of, and the opportunity to discuss, the HIPPA Notice of Privacy Practices. I give my voluntary consent for Selin Caka, MA, LMFT to provide me with mental health services as her experience and licensure allow. I understand that I must be an active participant in my care, and that I have the right to end or refuse care or treatment at any time.

_____
Client Name (please print)

_____ _____
Client Signature Date

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Client Name (please print)

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Client Signature Date

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Client Name (please print)

_____ _____
Client Signature Date

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Client Name (please print)

_____ _____
Client Signature Date

_____ _____
Selin Caka, MA, LMFT Date

Notice of Privacy Practices

Effective April 14, 2003

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. Please review it carefully.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used by me and others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, as necessary. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided, with your written permission, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services, should you choose to seek reimbursement from an insurance company.

Business Operations: I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Disclosures: Under the law, I must make disclosures to you upon your request.

Abuse or Neglect: I may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or elder abuse or neglect. In addition, I may disclose your protected health information if I believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: I may disclose protected health information in the course of any judicial or administrative proceedings in response to an order of the court or administrative tribunal (to extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful legal process.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that I have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action proceeding, protected health information restricted, by law, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – this means you may ask me not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations.

You have the right to request to receive confidential communications – You have the right to request confidential communication from me by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from me, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to request an amendment to your protected health information – If I deny your request for amendment, you have the right to file a statement of disagreement with me and I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to obtain a paper copy of this notice from me even if you have agreed to receive the notice electronically. I reserve the right to change the terms of this notice and I will notify you of such changes on the following appointment. I will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS
You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with me by notifying me in writing. I will not retaliate against you for filing a complaint.

I am required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. I am also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please speak to me, and I will work to have your questions answered.

_____ _____
Client Name (please print) Date

_____ _____
Client / Legal Authorized Representative Signature Relationship to Client

Statement of Personal Financial Responsibility

FEES

- Fees are $125 per 55-minute individual session, and $165 per 85-minute partner or family session. If we arrange a longer session, the hourly rate is prorated to determine your fee.
  - A $25 administrative discount is extended to clients who self-pay at the time of service.
- You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services.
  - If using insurance, you are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance.
    - It is your responsibility to be aware of what services and providers are covered, both in and out of plan network. You agree to pay for any service deemed to be non-covered or not authorized by the plan.
    - Chakabox Therapeutic Services, PLLC will bill your insurance carrier as a courtesy. Once your insurance carrier processes your claim, you will be billed for any remaining patient responsibility deemed by your insurance carrier.
    - If your insurance carrier does not remit payment on your claim within 180 days of claim submission, you will be responsible for payment of the charges.
- Phone contact that extends beyond 15 minutes will be billed based on the standard hourly rate, in 15-minute increments.
- Session cancelation within 24 hours of the scheduled session time incurs the full session fee, which is not billable to insurance.
- If this Statement is signed by multiple people, the co-signatures remain in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt and shall apply only to those services and charges thereafter incurred.
- Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, Chakabox Therapeutic Services, PLLC reserves the right to disclose to an outside collection agency or attorney the relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection.

PAYMENT

- Insurance co-payment is due at the time of service. For self-pay clients, the full fee is due at the time of service.
- I accept cash, credit/debit cards, personal checks, or cashier's checks as payment. Checks are to be written to *Chakabox Therapeutic Services*. Returned checks will incur a $25 fee.

ACKNOWLEDGEMENT

By signing this form on the next page, I acknowledge that I have read and understand this Statement of Personal Financial Responsibility, I have discussed any questions or points of concern, and I agree to the terms and conditions contained herein.

SIGNATURE(S)

_____ _____
Client Name (please print) Date

_____ _____
Client Signature Date

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Client Name (please print) Date

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Client Signature Date

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Client Name (please print) Date

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Client Signature Date

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Client Name (please print) Date

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Client Signature Date

_____ _____
Selin Caka, LMFT (for Chakabox Therapeutic Services, PLLC) Date