Natika Dawn Counseling, LLC

Natika Dawn Shewry, M.A., LMHC
Ph: **360-551-2060**

Adult Intake Form

Referral Source: _____ Date: _____
(Website, friend, family, therapeutic referral, etc.)

Identification Data:

Name: _____ Phone: _____

Address: _____ Zip Code: _____
Street City State

Birth Date: _____ Gender: M F (Circle One) Preferred Pronoun:_____

Occupation: _____ Work Phone: _____

Employer: _____

Number where you would like me to contact you? _____

Is it okay to leave voicemails? _____ Send text reminders for appointments? _____

Emergency Contact:

Name:_____

Phone:_____ Relationship:_____

Marital History and/or Significant Relationships:

1. Are you currently married? Yes ___ No ___ For how long? _____

2. Are you in a significant relationship? Yes ___ No ___ For how long? _____

3. Number of marriages? _____

4. If you have children, how many and are they living with you?

5. Others living at this address:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

6. In your life, are you experiencing or have you experienced: (Please check if applicable)

Past	Present	Past	Present
( )	( ) Financial Difficulties	( )	( ) Physical Abuse
( )	( ) Emotional Problems	( )	( ) Emotional Abuse
( )	( ) Alcohol Abuse	( )	( ) Sexual Abuse
( )	( ) Drug Abuse	( )	( ) Neglect
( )	( ) Chronic Pain	( )	( ) Sexual Dysfunction

7. How would you describe your current friendships? (Please check one)

( ) Deep friendships ( ) Few friends

( ) Many friends, few deep ( ) No friends

8. In the past, have you ever attempted suicide? _____

a. How many previous attempts and methods used?:_____

_____

b. Do you often think about death or killing yourself?_____

_____

9. In the past, have you ever intentionally harmed yourself? (Examples include cutting, burning, binging/purging, etc.) _____

_____

Do you currently practice any of these behaviors? If yes, please explain:

_____

_____

_____

Family of Origin/Psychosocial History:

10. Is your mother living? Yes _____ No _____

11. Is your father living? Yes _____ No _____

12. Are they still together? Yes _____ No _____

13. Where were you raised? _____

14. Did you ever live away from your parents during your childhood? _____

With whom? _____ For how long? _____

15. Did your family move frequently? Yes _____ No _____

16. How many children in your family? _____

17. Of all family members, to whom were you closest? _____

_____

18. Has/does anyone in your family suffered from:

Depression Yes _____ No _____ Who: _____

Anxiety Yes _____ No _____ Who: _____

Other psychological problems? Yes ____ No ____ Who: _____

_____

_____

_____

Education, Employment, and Legal History:

19. Academic Education _____

_____

20. Occupational Training

_____

_____

21. What is the length of time at your current or last job? _____

22. Have you served in the military? Yes _____ No _____

a. What type of discharge did you receive? _____

23. Have you ever been arrested? _____

List charges: _____

_____

_____

Health Data

Rate your physical health (check one)

Very Good _____ Good _____ Average _____ Poor _____

List important illnesses, surgeries, or injuries, which may have caused you serious difficulty:

_____

_____

_____

Date of last medical exam (approximate): _____

Medication(s)

Please list all prescription and non-prescription drugs used **currently**

Medication Name	Dosage	Reason	Start date

Previous counseling, psychotherapy, psychiatric services: (Circle**)** **YES** **NO**

If YES, list name(s) of counselor, therapist, or psychiatrist: _____

_____

Dates and length of time spent in counseling:

_____

_____

_____

List problems you would like to discuss in counseling: _____

_____

_____

_____

_____

List your goals for counseling: _____

_____

_____

_____

Any other info you would like me to know:

_____

_____

_____

_____

_____

Natika Dawn Counseling, LLC

Natika Shewry, LMHC
WA State License # LH60848162
(360) 551-2060

Disclosure Statement/Informed Consent/Financial Agreement

Welcome! The following is my disclosure statement for Natika Dawn Counseling, LLC per Washington State Law. The purpose of this document is to inform you about my background, treatment approaches, client rights, my confidentiality statement, as well as my office procedures and policies. If you have any questions of concerns please feel free to let me know.

Approaches to Treatment and Educational Background:

I have a B.A. in Psychology and Expressive Art Therapies from The Evergreen State College and a Master's degree in Counseling and Transpersonal Psychology from Sofia University. I have over 13 years experience in case management and human services. My experience includes agencies such as Kitsap Community Resources, South Sound Family Services, Kitsap Mental Health, and the Kitsap Sexual Assault Center. I have worked with individuals of all ages from a variety of different cultural and religious backgrounds. I have experience treating depression, anxiety, grief/loss, trauma, sexual assault/abuse, PTSD, domestic violence, and many other issues. My foundation is Mindfulness Based Cognitive Behavioral Therapy and Acceptance and Commitment Therapy (ACT), but I draw from many other approaches such as Emotionally Focused Therapy, body/mind approaches, and expressive art therapies.

I believe in a holistic, eclectic approach that fits each unique individual, couple, and family. I believe that people are unique and no single treatment approach can be effective for everyone. We will work collaboratively to set goals and find solutions.

Licenses:

I am a Licensed Mental Health Counselor (LMHC) in the State of Washington. License # LH60848162

Confidentiality:

You have the right to confidentiality. I hold what you discuss during our sessions in the strictest confidence. I will never disclose either the fact that I do, or do not, see you as a client, or the content of your therapy, with any person or any kind of legal agent. By law, information concerning your treatment may be released only with your written consent with the following exceptions:

- If there is suspected abuse or neglect of a child, dependent adult or developmentally delayed person.
- If your give strong indications that you are likely to harm yourself or someone else.
- If you reveal the contemplation or commission of a crime
- If your records are subpoenaed by court of law.

- If you bring a complaint against me with the state or with a local regulatory agency.
- If it becomes necessary to turn an account over to collections.
- If you are involved in a life-threatening emergency, in which case information pertinent to that emergency may be released.
- If an involuntary commitment for mental health services assessment seems necessary.
- If the insurance company that is covering your visits requests client information such as if I am audited or a diagnosis is needed for payment. *(I do not give any details of session content and keep my notes brief and simple for your benefit.)*

Consultation:

To ensure I am giving you the best treatment possible, I do consult with other professionals in consult group format or one on one with an approved clinical supervisor who is ethically bound to the same confidentiality as I am. Please know that your identity remains protected during these consultations.

Ethical and Professional Standards:

- You have the right to receive appropriate care and to be fully informed about your therapy.
- You have the right to participate in the development of your treatment plan and to refuse any proposed treatment.
- You have the right to receive care that does not discriminate against you and that is respectful of your gender, race, religion, national origin, language, age, disability status and sexual orientation.
- You have the right to contact the state of Washington Department of Licensing to lodge a grievance if any of these rights are violated, or if you feel that you have been treated in an unprofessional or unethical manner.

If you have and concerns or complaints about your therapy please let me know as I will be happy to discuss them with you.

Fee and Payment:

Check my website, natikadcounseling.com, for my standard fee. If you are unable to pay the standard fee, I do have a sliding scale. Please let me know and we will discuss this during our initial phone consultation. **Payment is due at time of service. This includes Copays if you are using Insurance.** Check with your insurance before our first session to make sure mental health services are covered, if you need prior authorization, if there is a Copay, and how many sessions are allowed. I accept cash, personal check, and Major Credit Cards. I reserve the right to stop services if payment has not been made for two consecutive therapy sessions. I will discuss this with you in advance. *Please discuss any financial situations that may impact services as soon as you can so that if needed I can refer you or adjust payment.*

Appointments and Cancellations:

For counseling services to be effective, it is important to have a level of consistency. Exceptions will be made for major holidays, serious illness, and anything we discuss that may affect such constancy. If there is a need to cancel our weekly appointments or previously scheduled appointments, please let me know and I will reschedule to the best of my abilities. **I have a 24-hour cancelation policy**. If you are unable to attend the session, please let me know as soon as possible. **If given less than 24-hour notification, I require payment for a full session.** In the event that payment is not received after ninety (90) days, please be advised that your account may be turned over to collections. Before this happens, please call and make arrangements for a payment plan. *More than three missed appointments or late cancelled appointments may result in a termination of therapy services.*

Crisis:

If you ever feel that you are in a crisis and cannot reach me due to the time or nature of the crisis, you can call the 24 hour crisis hotline at: **1-800-843-4793** or dial **911.**

Email:

Please be aware that I cannot guarantee confidentiality when using email. **For this reason, I will not discuss clinical content using e-mail or text.** If you choose to use email as a means of setting and confirming appointments, you accept that confidentiality cannot be guaranteed.

Professional Standards:

At all times, I try to adhere to the highest possible professional standards of competence and ethics. If you have any questions with the treatment you are receiving, I encourage you to please contact me. However, if you are not satisfied you may contact the WA Department of Health at (306) 664-9098.

Therapy is *your* choice. You have the right to stop treatment or to be referred to another therapist who may better suit your needs. If this does come up, please know that I am open to discussion and to finding you the best help possible. This is your right as a client and mine as a therapist.

Receipt of Disclosure Statement:

I hereby certify that I have read, understood, agreed to, and received a copy of the "Welcome and Disclosure Statement/Informed Consent." These documents have informed me of the policies of Natika Dawn Counseling, LLC and of my rights as a client. They have also acquainted me with the education, training, identity, therapeutic orientation, and professional certifications of my therapist.

Furthermore, I understand that all of my (our) counseling communication (including any information stored or retrieved by any written, oral, or electronic means) is entirely protected, private, and confidential and that it will not be disclosed to anyone outside Natika Dawn Counseling, LLC. I (we) must jointly agree upon any exception to this agreement.

I understand the amount of my fee for counseling and I agree to pay the fee at each counseling session unless other arrangements have been made. If I "no show" or fail to cancel an appointment within 24 hours of its scheduled time, I will be responsible for the entire fee for that session.

_____

Client Date

_____

Client Date

_____

Parent/Guardian Signature (If a minor under 13) Date

_____

Natika Dawn Shewry M.A., LMHC Date

HEALTH INSURANCE CONSENT

Your health insurance may pay for part or all of your therapy, but the benefits cannot be paid until your health insurance authorizes this. **Check with your insurance before our first session to make sure mental health services are covered, if you need prior authorization, <u>if there is a COPAY</u>, and <u>how many sessions are allowed in a calendar year</u>.** If you choose to use your health insurance to pay for therapy, you must allow your therapist to communicate with your health insurance company about your treatment recommendations, progress during therapy, and about how you are doing in many areas of your life. This information is considered Protected Health Information (PHI). All of this information will become part of the health insurance records.

Your health insurance may set limits on the kinds of therapy your therapist can provide to you and can refuse to pay for services. You can appeal the health insurance's decisions on payment and number of sessions. The health insurance will approve therapy aimed at improving the specific symptoms that brought you to therapy. It may not agree to more sessions, even if you and I feel they are needed to fully relieve your presenting issues. The health insurance company in charge of your medical and mental health benefits can change during the course of therapy. If this happens, I may have to go through the authorization process again. It is possible that the benefits or coverage for your therapy may change and your part of the costs may change as a result. **It is your responsibility to let me know when your benefits change.**

In some cases, I will be required by your health insurance to contact your physician. This PHI is allowed to be shared under HIPAA and state regulations without consent (RCW 70.02 Medical Records).

By signing this form, you give Natika Dawn Counseling, LLC permission to submit PHI in order to secure payment for mental health services. You agree to have payment from the health insurance be sent directly to Natika Dawn Counseling, LLC. You are aware that this may include faxing, sending encrypted PHI through Office Ally (my billing software vendor).

If you are concerned with any of the above, you have the option to pay directly and not use your mental health benefits. This means your PHI will not be shared with your health insurance. By signing below you indicate that you understand the issues described above and willingly enter therapy accepting these limits.

Insurance Information

Primary Insurance:_____

Subscriber Name:_____

Relationship to Subscriber:_____

Client Date of Birth:_____ ID #:_____

Employer:_____

Policy#:_____ Group#:_____

Insurance Company Phone Number: _____

Name of Physician:_____ Physician Phone:_____

Copay Amount: _____

_____

Signature Date

No Show, Late Cancellation, Co-payment Policy

If I fail to give **24-hour notice** prior to my appointment, I understand that I will be charged the **full amount** for the cost of a 60-minute session for a LATE CANCELLATION or NO SHOW. This amount will be charged to the credit card below.

Co-payments are due at the time of the session. If you are not using insurance, full payment is due at the time of the session.

If I decide to use my insurance to pay for counseling sessions, I understand that I am responsible for knowing my co-payment amount and deductible amount. My **co-payment amount per session is** _____. My **deductible amount** per year is _____. Have you met your deductible this year? **YES**_____**NO**_____. If no, how much more do you have to pay towards you **deductible** _____? **I am allowed** _____ **number of sessions per calendar year.**

I understand that I am responsible for fees associated with not attending appointments, canceling appointments with less than 24 hours notice, unpaid therapy appointment fees, sessions not covered/denied by my insurance, or fees associated with checks returned for non-sufficient funds. I also understand that Natika Dawn Counseling, LLC will store this document in a locked file cabinet with other confidential records and that this form will be shredded after I am no longer receiving counseling services. I understand and agree that I am responsible for these payments as part of my contractual obligation as outlined in the disclosure agreement that I have signed and agree to without exception.

Credit/Debit Card Information

I authorize Natika Dawn Counseling, LLC to bill for the fees listed above to my credit or debit card. I have read and understand this policy. I verify that my credit card information is accurate. If this information is incorrect or fraudulent, or my payment is declined, I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

_____

(Signature) (Date)

Name on the Card: _____

Card Number: _____ Expiration Date: _____

CVV (three-digit code on the back): _____ Zip Code: _____

Visa: _____ Mastercard: _____ Discover: _____ American Express: _____

YOUR VALUES: *What really matters to you, deep in your heart? What do you want to do with your time on this planet? What sort of person do you want to be? What personal strengths or qualities do you want to develop?*

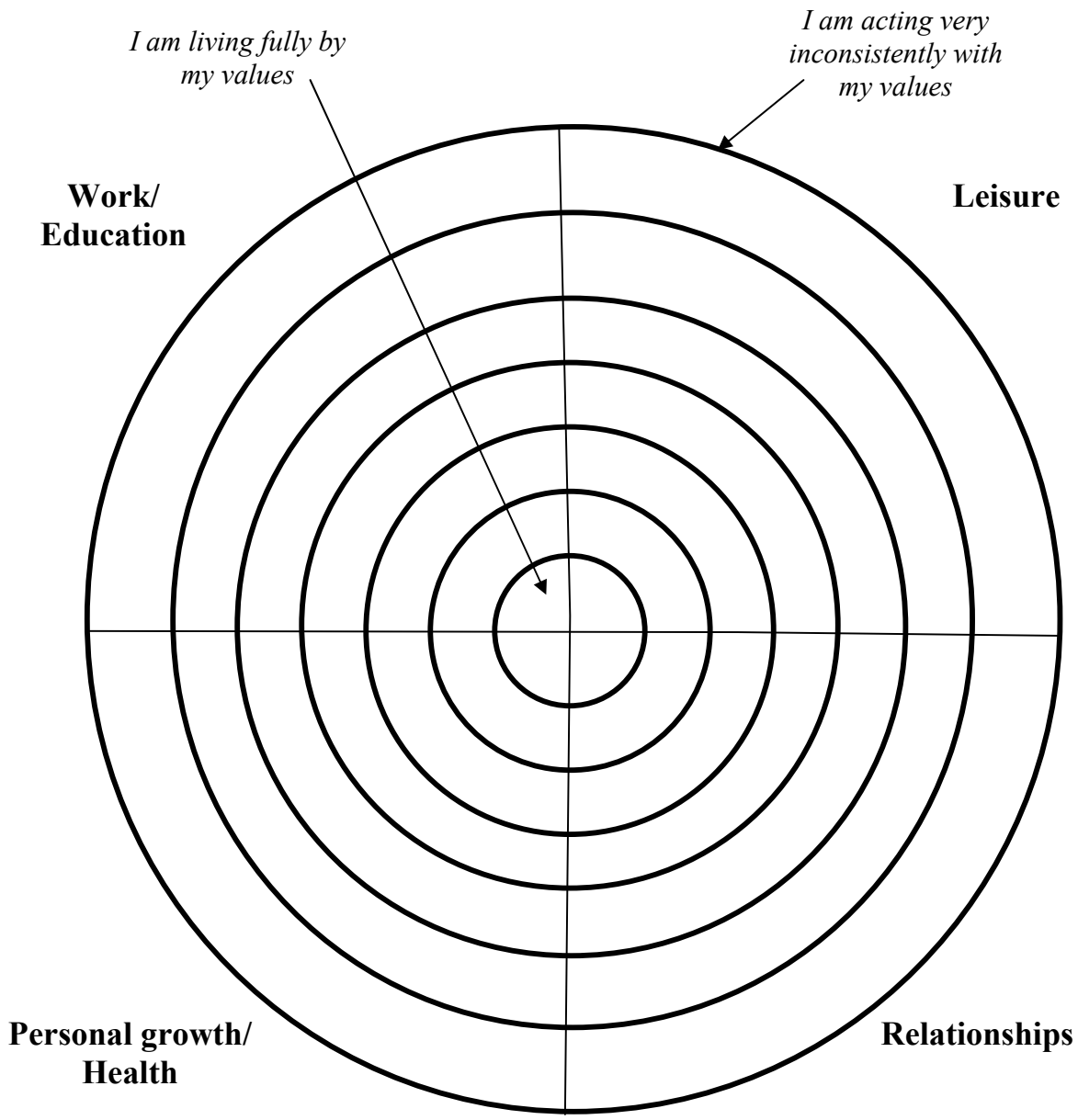
1. Work/Education: includes workplace, career, education, skills development, etc.

2. Relationships: includes your partner, children, parents, relatives, friends, co-workers, and other social contacts.

3. Personal Growth/Health: may include religion, spirituality, creativity, life skills, meditation, yoga, nature; exercise, nutrition, and/or addressing health risk factors like smoking, alcohol, drugs or overeating etc

4. Leisure: how you play, relax, stimulate, or enjoy yourself; activities for rest, recreation, fun and creativity.

THE BULL'S EYE: make an X in each area of the dart board, to represent where you stand today.



Dissecting The Problem

This form is to help gather information about the nature of the main challenge, issue, or problem facing you. First, please summarize, in 1 or 2 sentences, what the main issue or problem is:

Second, please describe, in 1 or 2 sentences, how it affects your life, and what it stops you from doing or being:

Regardless of what your problem is – whether it is a physical illness, a difficult relationship, a work situation, a financial crisis, a performance issue, the loss of a loved one, a severe injury, or a clinical disorder such as depression - when we dissect the problem, we usually find four major elements that contribute significantly to the issue. These are represented in the boxes below. Please write as much as you can in each box, about the thoughts, feelings and actions that contribute to or worsen the challenge, problem or issue facing you.

Entanglement With Thoughts What memories, worries, fears, self-criticisms, or other unhelpful thoughts do you dwell on, or get "caught up" in, related to this issue? What thoughts do you allow to hold you back or push you around or bring you down?	**Life-draining Actions:** What are you currently doing that makes your life worse in the long term: keeps you stuck; wastes your time or money; drains your energy; restricts your life, impacts negatively on your health, work or relationships; maintains or worsens the problems you are dealing with?
Struggle With Feelings What emotions, feelings, urges, impulses, or sensations (associated with this issue) do you fight with, avoid, suppress, try to get rid of, or otherwise struggle with?	**Avoiding Challenging Situations:** What situations, activities, people or places are you avoiding or staying away from? What have you quit, withdrawn from, dropped out of? What do you keep "putting off" until later?