Alta Vista
Integrated Life Services

Mental Health | ABA Therapy | Education | Respite | Family Services

Client Information Form

Name: _____

Preferred Name: _____ Pronouns: _____

Date of Birth: (____/____/_____)

Address: _____

_____

_____

Mobile Number: _____ (Voice Messages okay: Y/N)
Home Number: _____ (Voice Messages ok:ay Y/N)
Work Number: _____ (Voice Messages okay: Y/N)

Gender at Birth: ☐Male ☐Female

Gender Identity: ☐Male ☐Female ☐Transgender Male/Trans Man/FTM
☐Transgender Female/Trans Woman/MTF
☐Gender-queer, neither exclusively male/female
☐Additional gender category or other, please specify
☐Choose not to disclose

_____

_____

Sexual Orientation: ☐Lesbian, gay, or homosexual ☐Straight or heterosexual
☐Bisexual ☐Unknown
☐Something else, please describe ☐Choose not to disclose

_____

_____

Race/Ethnicity: _____

Languages:

_____

_____

Marital Status: ☐Married ☐Single ☐Other

Employment: ☐Employed ☐FT Student ☐PT Student ☐Unemployed

Alta Vista
Integrated Life Services
Gig Harbor . Port Orchard . Poulsbo . Telehealth
Phone: (253)858-5846 | Fax: (253)858-4063 | www.AltaVistaLife.com

Client History Form

Client Name _____ DOB_____

Why are you seeking help now?

What is happening or is it different? What stressors do you have? What do you hope will be different from seeking help?

_____

_____

_____

Please give more details about the issue you mentioned above:

When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?

_____

_____

_____

Have you ever experienced similar or other mental health symptoms before?

If so, what was your experience like?

Has anyone in your family ever sought help for mental health or substance use issues?
If so, who was it? Did they seek help or get a diagnosis? What was it like for them? What was it like for you? When did it happen? Did you get help?

Do you have any current or prior medical issues?
If so, what was/is it? Have you seen a doctor or other healthcare professional for it? What recommendations or treatment did you have? Is there any family history of disease?

Are you currently prescribed any medications?
If so, please list the name, dosage, how often you take it, and the prescriber for each medication.

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed?
If so, which? When did you start, how often did/do you use and, how long did this occur? Please list each substance separately.

Who is in your family? What is your relationship with them like?

Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

What social activities and relationships do you engage in?

What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

What spiritual practices and cultural influences are important to you?

Do you belong to a religion, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

What was life like as you were growing up, both at home and in school?

Did you meet developmental milestones on time or experience any delays? What were your friends like when you were younger? What was school like for you?

What significant education and work/volunteer experiences have you had?

What is the highest level of education you have completed? Are you currently employed? If so, where and for how long? What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)? Are you satisfied with your current employment and education?

Do you have any current or prior legal issues

Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

_____

_____

_____

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?

What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

_____

_____

_____

Client(s) age 13 and older, please sign. For client(s) 12 and under, responsible party please sign.

_____ _____

Printed Name of the Responsible Party Relation to Client

_____ _____

Signature Date

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Client Contacts Form

Name: _____

DOB: (____/____/_____)

Telephone Number: _____

Address: _____

_____

_____

Email Address: _____

Contact Type: ☐Guardian ☐Emergency Contact
☐Primary Care Physician

Relationship:

☐Spouse	☐Husband	☐Wife	☐Partner
☐Mother	☐Father	☐Stepmother	☐Stepfather
☐Guardian	☐Child	☐Sibling	☐Grandparent
☐Aunt	☐Uncle	☐Friend	☐Psychiatrist
☐Psychologist	☐Guidance Counselor		☐Physician
☐Therapist	☐Pharmacist	☐Attorney	

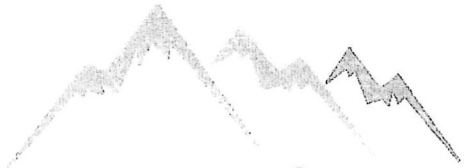
If Contact is a Business:

Company's Name: _____

Telephone: _____

Fax: _____

Email: _____



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RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Alta Vista Integrated Life Services is authorized to contact the following:

Provider / Organization / Name: _____

Relationship to Client: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Please select the type of information you want to be received, provided and or, exchanged.

☐Lab Work	☐Immunizations	☐Medical Records
☐Evaluation	☐Progress Notes	☐Treatment Coordination
☐Discharge Records	☐IEP / 504	☐Licensing
☐Education Records	☐Substance Abuse	☐Billing
☐Psychiatric Records	☐Scheduling	☒Other Join Session

This consent expires:

☐ in one year ☐ when revoked ☐ end of treatment ☐ on date: _____

By signing this form, I offer my consent to the release of the above information including mental health records, drug/alcohol related treatments, and/or evaluations and HIV/AIDS related information obtained during my receipt of services. I have been informed of what specific type of information is being requested, and the reason that it is being requested. I have been informed that the services I receive are not conditional upon my decision to grant this release. I consent to the release of this information voluntarily. If the client is 13years or older, the client is required to sign this form.

_____

Signature of Client/Responsible Party Relationship to Client Date

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DISCLOSURE FOR PROVIDERS AND ADMINISTRATION

Directors

Ashley Ruiz, MSW, LICSW - Licensed Independent Clinical Social Worker
Executive Director, Board Member
INN Network Medicaid, Regence, Premera, Tricare and, First Choice.

I received my Master of Social Work from Our Lady of the Lake University in 2016 and have a BA in Human Services from Western Washington University. I hold a professional certification in the Strengthening Families Program, and I am a Certified Behavior Technician with Washington State. I have more than 18 years working with diverse family systems, promoting optimal outcomes for youth. My experiences in body health, conditioning, and naturopathic approaches have shaped my belief that an integrated mind-body-soul approach is essential in therapy. I offer formal assessments of cognitive, mental and emotional, physical, spiritual/soul, and social functioning. I offer services to empower people to identify goals and to access inner strengths needed to meet both individual and family goals.

My scope of therapeutic practice includes play therapy, behavioral therapy, family therapy, solution focused therapy, mindfulness, sensory integrative therapy, applied behavioral analysis, functional behavioral assessments, and cognitive behavioral therapy. My focus is working with children, adolescents, and adults and family systems on many issues relating to the mental health, parenting, behavior and social problems, depression, anxiety, stress, anger management, as well as recovery from physical, sexual, and/or emotional abuse. I also specialize in offering assessments, support, and training for youth and families with disabilities.

Kristin Andrew, MEd, BCBA, LBA - Board Certified Behavior Analyst, Licensed Behavior Analyst ABA Supervisor - Port Orchard
INN Network with Regence, Premera, Tricare, First Choice and Medicaid

Kristin has worked with people with disabilities since 2004 in various settings. Her focus has been students with Autism, particularly supporting transitioning to adulthood and independent living skills. Other passions include ADHD support and parent, family, and caregiver training. Kristin has worked closely with occupational therapists and physical therapists at a therapeutic riding center, utilizing hippotherapy (horseback riding) as a therapeutic tool for sensory regulation. Additionally, she has experience working both for the school, and for the parents, on IEP's, school transitions, and educational support.

While working at Alta Vista, Kristin focuses on life skills for older clients, and school readiness skills for younger clients within the preschool. Applied Behavior Analysis (ABA) is used to increase functional skills and decrease problem behavior. Kristin works with Behavior Technicians (BT's) on implementing behavior change protocol, including adjusting the environment to support clients. She has a bachelor's in Health Sciences from Boston University, and a Masters of Education from University of Washington; and is credentialed as a Board-Certified Behavior Analyst (BCBA) and a Licensed Behavior Analyst (LBA).

Clinical Staff

Allison Landes-Stordahl, MA, LMFT, NBCC - Licensed Marriage and Family Therapist, National Board-Certified Counselor
Clinical Supervisor - Gig Harbor
INN Network Medicaid, Regence, Premera and, First Choice.

I obtained my Bachelor of Arts Degree in Psychology from Arizona State University in 1992 and my Master of Arts Degree in Marital, Family, and child Therapy from Chapman University in 1996. I am a Licensed Marriage & Family Therapist in California (2001), as well as Washington state (2018), working in the field since 1996. I am also a Nationally Board-Certified Counselor. I have held various positions in the mental health field, ranging from residential treatment facilities for children & day treatment school sites to outpatient mental health settings, and Private Practice.

I have provided clinical supervision as well as administrative supervision to clinical teams and have also played a lead role in Utilization Review throughout my Agency work. I have had the privilege of providing clinical supervision to practicum as well as masters level therapists who are gaining hours towards their state licensure. I have been responsible for ongoing treatment planning for clients, clinical documentation, legal and ethical issues and chart compliance. I was also an adjunct faculty member at University of Phoenix in their Counseling and Therapy Master's Program. I have taught classes including practicum, law and ethics and advanced treatment planning.

I have worked with clients presenting with concerns in the areas of; Depression, Anxiety, PTSD, Trauma, Addiction, Recovery, LGTBQ+, families, divorce, custody, and parenting. As a psychotherapist and healing arts practitioner, I am extensively trained to assess, diagnose, and treat individuals, couples, families, and groups to achieve more adequate, satisfying, and productive marriages, family, and social adjustments. The treatment modalities I utilize are eclectic in nature and are tailored to the client's individual, developmental, and presenting needs of each client.

Anthony Abastilla, LMHCA - Licensed Mental Health Counselor Associate
Gig Harbor, Poulsbo, Telehealth
INN Network Medicaid and Premera.

I have worked with children, teenagers, and adults since 2003 as a clinician, mental health counselor, case aid, and school counselor. The companies I have worked for include Kitsap Mental Health Services, Crisis Clinic of the Peninsulas, The Washington Youth Academy, and the Moses Lake and Central Kitsap School Districts. I hold a Bachelor's degree in Human Services, Master's Degree in Psychology, and a Master's degree in Education. I have completed supplemental training in Cognitive Behavioral Therapy, Motivational Interviewing, Dialectical Behavioral Therapy, Solution Focused Therapy, Problem Solving, and Applied Suicide Intervention Skills Training (ASIST}. I was a school counselor for 9 years and worked in the Mental Health field 9 years before that.

I believe in building trusting relationships that are client centered, solution focused, and relational with a nonjudgmental approach. I use play therapy to build relationships and develop rapport with my youth clients. One of my main goals is to help you identify not only what you are doing and thinking, but the reason and rationale behind it. The hope is that we can then figure out strategies and ideas to help you understand yourself and create goals and solutions. Most importantly, I want to develop a trusting relationship with you where you can trust me and know that I care about your wellbeing. Nothing gives me greater satisfaction than to see you grow, improve your quality of life, and to be a small part of that success.

Heather Mclellan, Certified Counselor, LSWAIC - Licensed Social Work Associate and Independent Clinical - Gig Harbor, Telehealth
INN Network Medicaid and Premera.

I am a graduate of Pierce College, Pacific Lutheran University (1994, BSW), and the University of Washington, Tacoma (2004, MSW). I am a Tacoma native and have enjoyed engaging with numerous individuals and a variety of large and small social service agencies in Pierce County during the last 20+ years of Social Service employment. My experience includes veteran community outreach programs, Inpatient and Outpatient Substance Abuse treatment and Social Work interning at the PTSD program at VA Hospital at American Lake. Child Welfare Services in Tacoma for seven years, and Case-managing at a private foster care agency and later becoming the Program Manager. I wanted a change and to work more closely with clients and took providing in-home counseling and parenting services to diverse families but, found myself driving across three counties and spending more time in traffic than with clients. I am very excited to be working for and with individuals young and old, individually, and/or in small groups, and families at Alta Vista Integrated Life Services in Gig Harbor where I too live!

I often make the statement, "Social Work is not just what I do for a living, it best fits who I am". My service delivery is client centered, holistic, and eclectic, utilizing many pieces from my vast array of theoretical modalities learned (addictions treatment, Motivational Interviewing, Cognitive- Behavioral-Therapy, Mindfulness, Trauma Informed Therapy, Play Therapy, Level 1 Thera play, Grief Therapy, to name just a few), always checking in for shared understanding of the problems and the proposed or desired solutions/outcomes. Therapy treatment will begin with a shared assessment of the clients' needs and hopes for desired outcomes, and specific ideas of how we'll get there, together.

Steven E. Thomas, LMFTA- Licensed Marriage and Family Therapist Associate
Gig Harbor, Port Orchard, Telehealth
INN Network Medicaid and Premera.

I graduated from Hope College in Holland Michigan ready to teach Elementary and Middle School with a Math/Science BA. I then taught English as a Second Language in Japan. From there I went to Asbury Theological Seminary and received a Master's in Education. I then was a director of Education and Youth in a private institution. After the towers in New York were hit in 9/11, I joined the Army as a Chaplain. A major part of my job was providing mental health/counseling services. I worked with depression, anxiety, grief, family issues, work issues as well as trauma. Then in the process of retiring I earned a Master of Arts from Brandman University in Marriage and Family Therapy. I now have a Family and Marital Therapy Associates license and teaching certificate in the State of Washington.

I practice primarily from a Positive Psychology lens believing that often concentrating on our strengths over problems is the most beneficial. Solution-Focused Therapy model is my main model. I also use Play Therapy, which especially helps children within developmentally appropriate ways, Cognitive Processing therapy for trauma, and Narrative Therapy because if people can understand they are the hero oftheir own story they can learn their own significance and superpowers. I also use Cognitive Behavioral Therapy because beliefs, actions and feelings can work together for change. I believe all people are more than an island and I am committed to being part of a team letting anything that is helpful be part of the process needed for growth. I work with individual clients of all ages as well as family systems.

"'Associate licensed clinicians and interns are practicing under the close supervision of a Washington State Approved Clinical Supervisor"'

I have read and understand the details of this group disclosure statement.

_____

Client Name printed

_____ _____

Responsible Party Printed Name if different from client **Relationship to Client**

_____ _____

Responsible Party Signature **Date Signed**

_____ _____

Clinician Signature **Date Signed**

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I certify that my current household income is insufficient to cover monthly expenses and therapy at the full rate of $125/session. Therefore, I understand that the fee for services with Alta Vista Integrated Life Services will be (please circle the amount you can feasibly pay for each session).

$50.00/Session **$80.00/Session**

I recognize that the amount circled above will be payable at the time of services (unless other arrangements are made in advance).

By signing this form, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I recognize that my insurance will not be billed and that I am choosing to pay independently for services. I confirm that I am the patient or the patient's duly authorized representative.

Patient Printed Name _____

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify your relationship to the patient:

Representative Printed Name _____

Relationship to patient _____ Date_____

Alta Vista Staff Printed Name _____

Alta Vista Staff Signature _____ Date_____

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CONSENT TO TREATMENT AND CLIENT RIGHTS

Name of Client(s)_____

I consent to and am voluntarily seeking treatment at Alta Vista Integrated Life Services (hereafter known as Alta Vista ILS). In the event that a client is a minor, I represent that I have the right and authority to authorize and hereby authorize Alta Vista's staff to provide services to that minor.

I understand the following:

- Information is considered confidential and my right to privacy shall be respected by the staff of Alta Vista ILS.
- It is the client's right to be informed of procedures and any applied medications which may be used in the course of treatment. The treatment effects and side effects for the prescribed medication will be reviewed and discussed with the client by the primary physician.
- Client involvement is encouraged and welcomed in the treatment process.
- Termination of treatment is ideally an agreement between the therapist and client; however, the client has freedom to discontinue treatment at any time.
- Promises and/or guarantees cannot be offered regarding the outcome of treatment.
- I understand that treatment may include utilization of medication like tranquilizers, antidepressants, stimulants, medication to assist in sleeping and medication that may be necessary to counteract the side effects of prescribed medications indicated.
- I understand the nature and purpose of treatment, possible methods of treatment, risks involved and possibility of complications.

I agree to the following:

- Respect the rights and privacy of the other clients at Alta Vista ILS.

It is a therapist's legal obligation as a mandated reporter under the laws of the State of Washington to inform CPS (Child Protective Services) of any allegations of abuse/neglect of a child or dependent adult (Adult Protective Services). A therapist also has a "duty to warn" if you tell me of any plans to harm another individual or yourself.

MASTER'S LEVEL LICENSED COUNSELORS: EXCEPTIONS TO CONFIDENTIALITY

The full extent of confidentiality is provided in RCVW 18.19.180 and 18.225.105

Under the laws of the State of Washington, Alta Vista, LLC cannot disclose any Automation given to me by you except in certain situations: 1) With the written authorization of the client, or the client's parent 2) If the client waives the privilege by bringing charges against me 3) In response to a subpoena from the Secretary of Health, in response to a complaint 4) As required under chapter 26.44 or 74.34 RCW or RCW 71.05.250 (abuse/neglect of dependent children/ adults, or harm to self/others) 5) "to any individual if the person licensed under this chapter reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the individual or another individual; however, there is no obligation on the part of the provider to do so Also note that federal HIPPA policy allows for other uses of your information. You may request a copy of the federal HIPPA policy.

PHONE MESSAGES/EMAIL

_____I give Alta Vista ILS permission to leave a phone message at this number:

_____

_____I give Alta Vista ILS permission to email me at this address:

_____

(Note: message left will only be appointment time with therapist's name and/or therapist's name and phone number.)

Alta Vista Integrated Life Services provides evidence based clinical assessment and psychotherapy for children, adolescents and adults. Alta Vista also provides stress management, consultations, and psycho-education.

All clients are provided with clinically efficacious skills to achieve an optimal level of functioning. It is our hope clients seen at Alta Vista reach a level of social and emotional functioning acceptablefor both the client and their family.

- I agree to pay Alta Vista ILS the co-pay/deductible amount due per insurance at the time services are rendered.

- I am being seen via an Employee Assistance Program (EAP) for sessions and understand obtaining authorization from my primary insurance and/or payment for services beyond my EAP sessions is my responsibility.

- I acknowledge that all payments and information of benefits are sent directly to me, and agree to be responsible for and to pay Alta Vista ILS the full rate or contracted portion for every session at the time services are rendered.

- I agree to pay Alta Vista ILS the sum of $_____per_____until all charges are paid in full.

We are moving to a paperless system and would like to email your statement and/or invoices. Please provide us with an email address that we may send them to. We appreciate your helping usconserve our environment.

Email address:_____

- Should you prefer your statements/invoices to be postal mailed, please initial here ____

I understand that if I fail to make payments as indicated and fail to make other arrangements with Alta Vista ILS, the balance owing may be placed with Alta Vista ILS's appointed collection agency and additional collection fees may be assessed. Balances over 30 days outstanding will be subject to an additional 1.5% monthly finance charge.

NO-SHOW AGREEMENT

Alta Vista ILS maintains a 24-hour cancellation policy. To avoid being assessed a no-show/late cancellation fee, please contact Alta Vista at least 24 hours prior to your scheduled appointment time.

I agree to pay $60* for those scheduled appointments which are not kept or cancelled at least 24 hours prior to the appointment time.

*Fee is subject to change**

CONFIDENTIALITY AGREEMENT

Mandated Reporting:

- Work with the assigned therapist in developing my treatment plan and following the treatment plan.
- Keep scheduled appointments or, if necessary, cancel appointments at least 24 hours prior to the appointment.

AUTHORIZATION FOR BILLING

I agree to the following terms and conditions:

- I understand that payment, co-pays and/or deductibles for services are due at the time services are rendered.
- I authorize direct payment of any third-party insurance benefits to Alta Vista ILS for services rendered to the above-named patient. If the party insurance benefits are not paid directly to Alta Vista ILS, or are paid in an amount which is less than the agreed upon charges, the balance will be my responsibility.
- I hereby authorize Alta Vista ILS to release information acquired in the course of my examination or treatment, which is required to obtain reimbursement for services, or to obtain benefits for which I may be eligible.
- I acknowledge that I have been informed and am aware Alta Vista ILS charges for services rendered and I agree to pay, or authorize the third-party insurance to pay, those rates of their contracted portion
- I understand that there is a charge for scheduled appointments that are not kept or cancelled at least 24 hours prior to the appointment time. I understand and acknowledge that I am personally responsible for this charge and that it is not covered by any third-party insurance benefits.
- In case the third-party insurance refuses to acknowledge the obligation for the payment of charges for services rendered by the clinic, I agree to be responsible for and to pay the charges for those services. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with the insurer.
- In addition to charges established for professional services, Alta Vista ILS may charge for the performance of certain clerical work requested. Work for which additional charges are made includes, but is not limited to: duplication of billing statements, completion of sick leave authorization, and completion of patient's INS form(s).
- In the event that the above-named patient is a minor, I represent that I have the right to authorize treatment and authorize Alta Vista ILS to provide services to that minor and bill on their behalf.

FINANCIAL AGREEMENT

Please check one or more of the following:

- I agree to pay Alta Vista ILS the amount of $_____per session at the time services are rendered.

All psychotherapists have a master's degree or higher with five years of direct clinical experiencelicensed to practice psychotherapy within the scope of their professional training and expertise.

All interns are supervised by Alta Vista's clinical director. Interns are enrolled in a credited university/ college.

UNPROFESSIONAL CONDUCT: RCW 18.130.180

You can contact the Dept. of Health Counselor Program Division to request a copy of this section of law.

Contact Information: Health Profession Quality Assurance Customer Service Center PO Box 47865 Olympia, WA. 98504 Email: hpqa.cssfiaoh.wa.gov
Phone: (360) 236-4700 Fax: (360)236-4818

Printed Name of Client/Responsible Party	Relationship to Client
Signature of Client/Responsible Party	Date Signed