CLIENT INTAKE FORM

Dr. Jennifer Dean-Hill, MSW, LICSW

PERSONAL CLIENT INFORMATION

Full Name _____ Today's Date _____

Address _____ City _____ St. _____ Zip _____

Primary Phone # _____ ❑ check box if you are able to receive text messages at this #

Secondary Phone # _____ Age _____ Sex _____ Date of Birth _____

Referral source _____ E-mail _____

Employer _____

If under 18, give names of parents or guardian _____

If student: School _____ Grade _____ Teacher _____

Highest grade completed or degree received _____

Religious preference _____ Church _____

FAMILY INFORMATION

List others living in your home (check box if they will be in counseling with you)

Name		Date of Birth	Relationship
_____	❑	_____	_____
_____	❑	_____	_____
_____	❑	_____	_____
_____	❑	_____	_____

Marital Status: (circle one) Single Married Separated Divorced Widowed

If married: Date married _____ Name of spouse _____

If previously married, give name(s) of previous spouse(s), and date marriage(s) began & ended:

_____

CLIENT MEDICAL INFORMATION

Physician's Name _____ How long _____

Date of last physical exam _____ Current medication(s) _____

Current or past medical problem(s) _____

Please list any alcohol or drug use or abuse _____

Any difficulties in normal childhood development? ❑ Yes ❑ No If yes, please explain _____

Personal or family medical history: (please check all that apply)

❑ Epilepsy	❑ Seizures	❑ Depression	❑ Mental Retardation	❑ Suicide
❑ Autism	❑ Schizophrenia	❑ Bipolar	❑ Anxiety Disorders	❑ ADHD
❑ Alcoholism	❑ Stroke	❑ Thyroid	❑ Obsessive Compulsive	❑ _____

(over)

COUNSELING INFORMATION

Prior counseling received:

Therapist _____ Dates _____ Reason _____

Therapist _____ Dates _____ Reason _____

Briefly describe the current problem that brought you here today? _____

_____

_____

_____

Have you previously experienced this same condition? ❑ Yes ❑ No If yes, give date(s) _____

What do you hope to accomplish through therapy? _____

_____

_____

_____

Impressions of family strengths and support networks _____

_____

Any additional information that may be helpful _____

_____

Treatment Plan (for Therapist use only) _____

_____

_____

PAYMENT INFORMATION

Responsible Party _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Employer _____

Relationship to Client _____

Insurance Company _____ ID # _____

Ins. Co. Phone # _____ Group # _____

TERMS & CONDITIONS: Dr. Jennifer Dean-Hill, MSW, LICSW is a private, clinical service provider. Clinical service fees are provided by private payment. Jennifer will electronically bill primary insurance providers only, and most insurance providers will reimburse you directly. Payment is expected at the time of service. Jennifer accepts cash, check or credit/debit cards. If your personal check is returned for non-sufficient funds (NSF), a **service fee of $35.00** will be added to the face value of the NSF check. If this account should become delinquent, it will be **subject to collection** with any costs or fees resulting there from to be paid by you, including, but not limited to court costs and attorney fees. Jennifer reserves the right to charge her full clinical fee for any session that you cancel with less than **24 hours notice**, unless prior arrangements have been made. Preparation of legal documents and special reports; Attendance at meetings; and Phone calls over 30 minutes will be billed at normal clinical hour fee. My signature below acknowledges that I have read and agree to the above terms and conditions.

Normal clinical hour fee is $190.00 **. Intake fee is** $215.00 **.**

Signature of Responsible Party _____ Date _____

Dr. Jennifer Dean-Hill, MSW, LICSW

1950 KEENE RD. BLDG H · RICHLAND, WA 99352

PHONE: (509) 366-9399 ● FAX: (509) 735-4971

JenniferDeanHill.com

CLIENT AGREEMENT

Dr. Jennifer Dean-Hill, MSW, LICSW

Please read and initial each agreement, then sign at the bottom.

_____ (initials) I authorize Jennifer Dean-Hill, MSW, LICSW to provide counseling and therapeutic services. No guarantees have been given by Jennifer Dean-Hill, MSW, LICSW as to the results that may be obtained. I indemnify and hold harmless the therapist or mediator from any and all claims arising directly or indirectly from the services rendered by said therapist under this agreement. Such indemnification shall include reasonable attorney fees and costs.

_____ (initials) I understand that Jennifer Dean-Hill, MSW, LICSW does not offer services related to court or legal proceedings, such as verbal testimony, written statements, or affidavits, unless subpoenaed by a judge.

_____ (initials) I give Jennifer Dean-Hill, MSW, LICSW permission to collaborate and seek consultation regarding my case with the other therapists on site.

Payment Policies:

_____ (initials) I agree to make full payment at time of service, unless other arrangements have been made.

_____ (initials) I agree to pay a $10 late fee on all payments not received on day of service.

_____ (initials) I agree to pay a $35 fee on all checks returned for non-sufficient funds.

_____ (initials) I agree to pay the full clinical fee on all sessions no-showed or canceled with less than 24 hours notice, except in case of emergency.

_____ _____
Signature of Client (If client is 13 years of age or older, he/she must sign consent) Date

_____ _____
Parent/Guardian Signature (for minors) Date

_____ _____
Witness Signature Date

THERAPEUTIC DISCLOSURE STATEMENT

Dr. Jennifer Dean-Hill, MSW, LICSW, DMin

Jennifer Dean-Hill received her Bachelors of Art in Liberal Studies from Azusa Pacific University, and went on to become a CA/WA certified teacher. She taught several years before receiving her Masters in Social Work from Walla Walla College in Washington, then went on to receive her Doctorate of Ministry in Global Leadership at George Fox University in Oregon. She has worked with Lourdes Counseling (formerly Carondelet) as an Education Specialist, Kennewick School District as a program facilitator, Sunderland Family Treatment Services as a family therapist, and currently a marriage and family therapist in private practice for over 20 years.

On a micro level, Jennifer specializes in family/marriage therapy, and individual therapy for men, women, and adolescents. Jennifer's counseling style is to involve the client's support system throughout therapy in order to help facilitate change and gain a broader perspective of the client. She comes from a strength's perspective with the intent of empowering the client to reach his/her fullest potential. The therapeutic modalities most favored by Jennifer include: cognitive therapy, behavioral therapy, solution-focused therapy, attachment therapy, emotional focused therapy, and some psychotherapy. Talk therapy is Jennifer's preferred style as she partners with the client to create a safe, loving, and caring environment to cultivate personal and relational growth.

On a macro level, Jennifer specializes in developing healthy community through volunteer work, presentations, keynotes, trainings, and workshops. She utilizes her travel experiences and education as a teacher, counselor, and leadership expert to help organizations cultivate healthy, psychologically safe cultures for leaders to be developed, led, and mentored. Jennifer has authored a children's book, self-growth manual for women, on-line couples curriculum, One Kingdom and more. She is the founder of NuShu Sisters and a consultant for Gender Synergy.

Confidentiality: All information disclosed within session doors is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in any of the following circumstances: where there is a reasonable suspicion of child or elder abuse, where there is a reasonable suspicion that the client presents a danger of violence to others, or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding (ref. RCW 18.19.180).

Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. *Washington State Licensure #LW0007724*

My signature below acknowledges that I have been provided a copy of the required disclosure information, and I have read and understand the information provided.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Dr. Jennifer Dean-Hill, MSW, LICSW

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI 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. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment 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, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request to us in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI. that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to. Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our office or with government authorities. We will not retaliate against you for filing a complaint. The effective date of this Notice is December 15, 2006.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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