Bridges Behavioral Health

10102 Meridian Ave
Everett WA 98208

DISCLOSURE STATEMENT

I, Christopher R. Sturgeon, am a private individual doing business by providing mental health services to the general public as a Certified Counselor in the State of Washington. The current fee for a fifty minute session is _______. Services offered include therapy, clinical assessment and testing. Fees for clinical testing and assessment are available as per the schedule of fees charged by Bridges Behavioral Health. Fees for services are due at the time of service; unpaid fees are your personal responsibility even if billed to a third party, if they remain unpaid, the bill may be turned over to a third party for collection. Account arrangements may be provided with my consent in advance, in writing, for the services to be provided.

Washington State Law requires that counselors practicing for a fee must be certified by the state. Certification of an individual with the Department of Health does not denote recognition of standards by the department. Further, certification does not imply effectiveness or quality of treatment.

The purpose of the law as it relates to regulating counselors is to offer protection to the public as to health and safety and therefore to provide a complaint process against any counselor who acts in an unethical or unprofessional manner.

COUNSELOR CREDENTIALS

Christopher R Sturgeon PhD (cand.)
Certified Counselor # CL 60155102
Agency Director

Therapy services are offered to individuals, couples, families, and groups. Treatment includes therapy for individual's pathology, also couple, marital, and relationship issues. Orientations of treatment primarily include Cognitive Behavioral Therapy, Solution Focused Therapy, and Narrative Therapy.

Records of services provided to you will meet Washington State Law. Unless otherwise requested, written case notes will not be kept, but we will keep date and time of appointment, fees charged and procedure codes. By law you may request to view and copy these records for personal or third party use for a fee. I will not disclose your records without your written direction and consent unless I am compelled to by law. Your records may be seen at the address above.

I will accommodate a change in appointment times; however, changes must be made 24 hours prior to your appointment. A standard hourly fee will be charged for appointments missed or changed with less than 24 hours' notice.

By signing this document you, the client, state that you have read and understand the information provided and that you have been offered a copy of this disclosure statement for your own records

Client Signature ____ **Date** ________________

Therapist Signature____ **Date** ________________

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OFFICE POLICIES & PROCEDURES

Please read the following information carefully. Washington State law requires that you be informed concerning the following information. By signing this form you are acknowledging that you have read, understand and agree to these policies and procedures.

Ethics & Standards

I follow the code of ethics and professional standards set forth in the provisions in the law of the State of Washington. I further adhere to the standards espoused by the American Psychological Association. The standards outlined by the State of Washington are available at www.state.wa.us or 360 236- 4022. The standards outlined by the American Psychological Association are available at www.apa.org and 800 374 – 2721. Additionally, you may contact the Washington State Psychological Association's professional ethics and standards review committee at 206 363 – 9772. However, if you have any questions or concerns about the treatment you receive through this office, please feel free to contact me in order to discuss the issue personally with me.

Theoretical Orientation

My approach to treatment is from a narrative social constructivist and cognitive behavioral perspective. The narrative approach means when we see our lives disconnected, fragmented, or dysfunctional we can explore and discover the talents, abilities and capacity of our lives in order to reassemble, unveil and construct a life of substance and value. The cognitive behavioral approach means our personalities are developed from schemas of our lives which cultivate core beliefs we have about ourselves. These schemas guide our focus, direction, and the qualities of our daily lives. Cognitive therapy works to reduce symptomology in our lives and modify inferred beliefs which are causing behavioral dysfunction in our lives. With both perspectives: thoughts, stories, moods, emotions, behaviors, biology, and environment are assessed to understand you, the client, and implement proven and well researched interventions and treatments.

Course of Counseling

A typical course of treatment will involve detailed discussion of the problematic situations and identifying life patterns which are associated with the current issues. This is to enable you to work through impediments to a more satisfactory coping style, and to integrate new understanding into you, the individual, or your marriage or your family. The process of therapy often brings out a variety of intense feelings and can be emotionally stressful. Success in therapy depends to a large degree on the willingness and motivation of the client to work through the process. Each course of therapy is unique to those who participate in it. My goal is to facilitate and assist people to become healthy and independent as soon as possible.

Clients Rights in Psychotherapy

As a client starting therapy you have the right and responsibility to choose your therapist and insure a good fit between you and your therapist. You always have the right to ask questions about your therapist's treatment and approach. The information in the sessions belongs to you and you may discuss your treatment with anyone you choose, including another therapist. Finally, it is your right to make decisions concerning taking a break from therapy, to end therapy, or to see another therapist at any time.

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Confidentiality

All of the information that comes out of a session with your therapist belongs to you. You are in control of who you want to know what was discussed while in session. This is strongly protected by the State of Washington. I will only disclose information to whom I have expressed written consent. There is a form available for you to sign if you so choose. Your wish to disclose or not is a personal issue and receiving services is not contingent on your being required to release information to anyone. However, there are provisions in the law that require confidentiality be broken: 1) If the therapist has reason to believe that there is a danger that the client may cause themselves or any other person harm, I am a mandated reporter. 2) If there is evidence of abuse by physical or emotional means or by neglect to a minor child or an infirmed adult, I am a mandated reporter. 3) If you are a party to a civil litigation or criminal court proceeding and I am directed and obligated by law to disclose I will do so.

Emergency Calls

In the case of a person's emergency, and we are unavailable please call the crisis hotline at 206-461-3222 or 911. If a serious medical condition occurs while you are on sight, we will call for emergency medical attention and contact whatever legal authorities as necessary.

Appointment and Fees

Therapy sessions are 50 or 70 minutes in length. The fee for a 50 minute session is _________. The fee for a 70 minute session will be prorated by your 50 minute rate. The therapy time scheduled for you is set aside just for you. If you miss an appointment or cancel with less than 24 hours notice, you will be billed in full for the session. If you are late for a session, you will be seen for the time remaining and charged the full session. Accounts not paid according to arrangements and which remain unpaid are both a business and therapy concern. If your account is overdue, I will discuss this with you and make every effort to arrive at a mutually agreeable outcome. If further collection action is required, your account may be turned over to a third party. If you need to reschedule an appointment, I am pleased to do so. However, rescheduling the appointment needs to be done 24 hours before your appointed time. If not, the scheduled appointment will be billed to you. I do not accept insurance as a form of payment. You are personally responsible for all charges incurred. I will provide you with a statement monthly with date of service, service codes, tax ID numbers, and diagnostics as you require if you wish to present a claim to a third party for reimbursement.

Client Consent to Treatment:

I have read these office policies and procedures and understand them. I have asked any questions that I had about this statement regarding fees and payment polices. Your signature below indicates agreement and your informed consent with these policies. You understand your signature constitutes your agreement to all these conditions with your therapist and you agree to pay for all services and charges that you incur.

___________________________________ _____________

Client Date

___________________________________ _____________

Therapist Date

Treatment Goals

Have you had any previous mental health treatment, psychotherapy or counseling:

Agency	Psychologist/Therapist/ • Counselor	Date: To/From	Reason/Outcome
		/	
		/	
		/	

Please list issues to discuss in therapy which are of primary concern to you at present:

1.
2.
3.
4.
5.

Please list any specific goals or changes you would like to accomplish:

1
2.
3.
4.
5.

I understand that it is my responsibility to reimburse my service provider for any services provided on my behalf. In the event that my service provider agrees to accept any third party payer who does not cover costs for services rendered, I agree to pay any and all costs of therapy. Costs may include any fees for missed appointments, fees for written reports, fees for time on phone calls on my behalf, or any other costs of providing services on my behalf. I understand that third party payers may require me as your service provider to exchange information with them or your referring and/or primary care physician. They may also require me as your service provider to provide confidential diagnostic information in order for you to process your claim(s). You have the right to notify me your service provider in writing to limit communication with your physicians(s). You may also make arrangements to pay for therapy privately to avoid confidential information being released to any third party payer.

• I certify all the information given by me is accurate to the best of my knowledge:

Signature	**Signature (if other than client)**
______________________ ________ Date	______________________ ________ Date

Personal Information Intake Questionnaire

NAME				DATE
Address				Home phone
City	State		Zip Code	Work Phone
Date of Birth	Gender	Social Security Number		Cell Phone
Is it ok when we call you to leave a message			YES	NO
Marital Status Single Married Separated Divorced Remarried		Education Highest grade completed _______Degree held_______		
Employer		Occupation		FT PT RETIRED
Religious Orientation (optional)		Ward/Diocese Bishop/Priest/Minister		

Emergency Contact

Name				Home Phone
Address	City	State	Zip Code	Work Phone
Relationship to Client				Cell Phone

Spouse / Partner / Parent Information if Client under 18 years of age

Name			Home Phone	
Address			Work Phone	
City	State	Zip Code	Cell Phone	
Date of Birth	Gender		Social Security Number	Marriage Co-Habit date

Children's Information

Name	Birth date	Live at Home	Name	Birth date	Live at Home

Medical History

Doctor (primary care physician)	Clinic	Phone Number

What is your Height ___________	What is client's Weight __________
Has there been any current weight gain/lose Y N	If yes, amount of gain or loss + - __________
Date gain/loss began ___________	Date of your last physical __________
How is your appetite? Good Fair Poor	How is your energy level? Good Fair Poor
How well do you sleep? Good Fair Poor	Rate your general health Good Fair Poor

List all doctors or medical specialists you see now or have seen in the past two years:

Doctor's Name	Phone Number	Reason

Describe any current medical problems or recent changes in your physical condition:

Problem	Treatment

List all medications you are currently taking and in the past five years. Include non-prescription drugs and health supplements:

Drug Name	Currently	Dosage	# per day	Drug Name	Currently	Dosage	# per day
	y/n				y/n		
	y/n				y/n		
	y/n				y/n		
	y/n				y/n		

Do you have any allergies to these or any other medication (if yes please specify)

1
2
3
4
5.

Client Name: ____________________

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RELEASE OF INFORMATION / AUTHORIZATION TO DISCLOSE

I VOLUNTARILY AUTHORIZE AND GIVE PERMISSION FOR DISCLOSURE OF MY MENTAL HEALTH INFORMATION TO THE INDIVIDUALS AND ORGANIZATIONS BELOW

This covers your mental health records held at Bridges Behavioral Health regarding your psychological diagnosis and treatment. This remains in effect for 90. You may renew this authorization for an additional 90 by initialing this form. You are authorizing release of the following information: time and dates of office visits, personal phone calls, hospital visits (inpatient & outpatient care), topics of discussions during sessions, financial issues with third party payers, current therapy issues, diagnostics of your current mental health, treatment plans and future prognosis.

All regulations regarding HIPPA will be adhered to.

Name____________ Address____________ Phone____________	Name____________ Address____________ Phone____________
Name____________ Address____________ Phone____________	Name____________ Address____________ Phone____________
Name____________ Address____________ Phone____________	Name____________ Address____________ Phone____________

____________________ ____________________
Individual authorizing disclosure Date signed

Therapist

Renewed

Date	Int	Date	Int