Marriage & Family Life

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www.Success4Couples.com
Licensed Mental Health Counselor #: LH60174444
Provider NPI: 1235890880

Welcome,

We are pleased to serve you. Our goal is to offer hope and healing to those who seek guidance and counsel. Through the grace of God, we believe everyone may experience a more purposeful, peace-filled life. Our services focus on the whole person by providing professional counseling, coaching, and mental health therapy to enhance individual lives, relationships with couples, and parents needing assistance with their children.

Financial obligations are based on insurance coverage or utilizing our discounted fee schedule when paying out of pocket. If insurance is used, we need copies of both sides of your card prior to services being rendered.

To serve you best, please complete the enclosed paperwork, which is held in strict confidence.

Hope, Peace, & Joy,

Updated for 2023

Robert Olsen, MS, LMHC, CTT+, CPLP
Owner & Clinical Director

Client Information: (please print or type)

For marriage, couples, and live-in partnerships, your spouse or significant other must complete their own disclosure form when both engage in counseling together.

Full Legal Name: _____ Today's Date: _____

Birthdate: _____ Mobile Phone#: _____ Email: _____

Home Address: _____

Living Status: Single Married Widowed Divorced Separated Living w/Partner **(circle one)**

Number of Previous Marriages/Live-in Partnerships: _____

Your Children's Gender at Birth – Male or Female – and Age **(circle N if not living with you):**

_____ Age: ____ N _____ Age: ____ N _____ Age: ____ N

_____ Age: ____ N _____ Age: ____ N _____ Age: ____ N

_____ Age: ____ N _____ Age: ____ N _____ Age: ____ N

How did you hear about our services? Friend Family Online Search Other **(circle one)**

Have you received counseling in the past? Yes No If Yes, where and when:

Counselor / Agency? _____ Approx End Date: _____

Counselor / Agency? _____ Approx End Date: _____

Was your counseling experience a positive one? Yes No

Are you currently taking medication(s)? Yes No If Yes, list all medication and condition below:

Medication: _____ Medical Condition: _____

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Are you currently in **PHYSICAL PAIN** or have unresolved **MAJOR** medical conditions? Yes No

If Yes, explain: _____

_____

Have you ever been hospitalized for Behavioral/Mental Health reasons? Yes No

If Yes, explain: _____

_____

What is your occupation **(whether employed now or not)**? _____

Employer: _____ Address: _____

Work Phone #: _____ Work Email: _____

What Faith do you practice? None Catholic Christian Jewish Muslim Other: _____

I attend Church Services: Never Occasionally Regularly

If attending, Church/Parish/Synagogue Name: _____

Do You... **(circle answer)**

Wake up feeling like you never slept?	Yes	No	Feel sad & hopeless?	Yes	No
Feel like hurting yourself?	Yes	No	Stay awake over 24 hours frequently?	Yes	No
Believe your depressed?	Yes	No	Struggle with intimate relationships?	Yes	No
Feel joy/happiness/peace frequently?	Yes	No	Think others take advantage of you?	Yes	No
Drink alcohol regularly?	Yes	No	Experience peace and calm frequently?	Yes	No
Feel self-confident?	Yes	No	Have uncontrolled or racing thoughts?	Yes	No
Feel guilty or ashamed?	Yes	No	Believe you're in-control of your life?	Yes	No
Believe life is what you make it?	Yes	No	Think you are a successful person?	Yes	No
Use illegal drugs or abuse pharmaceuticals?	Yes	No	Feel uncomfortable answering these questions?	Yes	No
See yourself as intelligent?	Yes	No	Feel stressed & burdened frequently?	Yes	No
Yell at your partner/kids/family?	Yes	No	Believe your life will get better soon?	Yes	No
Feel joyous/hopeful frequently?	Yes	No	Feel like exploding with anger?	Yes	No
Disappoint yourself or others frequently?	Yes	No	Believe in a higher power or a supernatural god?	Yes	No
Worry a lot about your future?	Yes	No	Obsess over little matters frequently?	Yes	No
Over-think about most things?	Yes	No	Feel overwhelmed most of the time?	Yes	No
Feel confident that your problems will be resolved?	Yes	No	Believe most people do not care whether you live or die?	Yes	No
Believe opinions of others have little to no value?	Yes	No	Think most people seek happiness, yet never find it?	Yes	No
Desire more social interaction?	Yes	No	Experience suicidal thoughts?	Yes	No
Believe overly-emotional people are not intelligent?	Yes	No	See yourself as trustworthy and honest?	Yes	No
Use Marijuana in any form regularly?	Yes	No	Believe others are in-charge of you?	Yes	No

High School Graduate, GED, or Equivalent? Yes No Have you attended College? Yes No

If yes to college, what degree(s)? _____

OR-- State primary subjects: _____

Believe counseling/therapy is the 'last chance' to resolve your struggles? Yes No

Please explain your Yes -or- No answer: _____

_____

State your expectations in seeking counseling/therapy (be specific): _____

_____

_____

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

CONFIDENTIALITY STATEMENT

All counseling/therapy sessions are considered highly confidential, with no information given to anyone without your knowledge AND written permission. There are a few exceptions, however.

Exceptions below are most reasons a counselor 'might' share information without your permission:

1. A client considered gravely disabled &/or unable to care for his/her basic human needs.
2. A client who is suicidal or who is going to harm him/herself seriously.
3. A client who shows serious intent in harming another individual.
4. A client, or other person revealed, who has already abused/seriously harmed another individual.

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

BEHAVIORAL/MENTAL HEALTH CARE AUTHORIZATIONS & FINANCIAL AGREEMENT

I am requesting and authorizing behavioral/mental health evaluation and treatment for myself or for my minor child. I have read and agree to the following:

HEALTH CARE INFORMATION RELEASE:

I authorize the release of any behavioral/mental health information to other care providers to coordinate/facilitate my treatment. I authorize the release of any information deemed appropriate concerning my physical condition, treatment, and services to any insurance company, attorney, or adjuster to process any claim for reimbursement of charges incurred by me at Marriage & Family Life (MFL).

FINANCIAL RESPONSIBILITY & GENERAL BILLING POLICY:

I understand I am personally responsible for the cost of my evaluation, treatment, and behavioral/mental health services at MFL. Payment is due at the time of services are rendered. Insurance will be verified and billed as a courtesy. Billing and/or administrative fees may apply to any service unpaid at the time it is rendered. All balances billed but unpaid may be subject to a rebilling fee. A 5% fee will be applied to all unpaid balances after 60 days from date of billing. A $35 fee, or greater as allowed by law, will be applied to any Non-Sufficient Funds (NSF) check payment or charge back. Balances unpaid by insurance companies, within 60 days, are the client's responsibility and are due immediately. I understand continued/future services by MFL may be limited or discontinued if financial obligations are unmet. Upon discontinuation of services, outstanding balances are due immediately.

DIRECT PAYMENT AUTHORIZATION & ASSIGNEMENT OF BENEFITS:

For any amount owed for service rendered to me, I authorize direct payment to MFL by any insurance companies/legal representatives paying for services rendered by MFL. Regardless of my insurance/third party benefits, I am personally responsible for all costs related to services rendered. I am personally responsible for any remaining balance owed after third party processing. I authorize direct payment to MFL from my current/future attorney out of proceeds of any settlement for any case related to my behavioral/mental health or for which I have received treatment services. Payment of my bill is not dependent on the outcome of any settlement. I will not rescind these direct payment instructions for any current/future attorney, representative, or insurance company. If my attorney/representative does not agree to uphold this authorization, I will be immediately responsible for payment in full.

INSURANCE PROCESSING & INDIVIDUAL RESPONSIBILITY IN EVENT OF INSURANCE DENIAL:

Attempts in determining insurance eligibility/benefits are a courtesy and are not a guarantee of insurance coverage. I understand it is my responsibility to confirm coverage before receiving services from MFL. I understand my insurance may deny coverage/payments even with efforts made to determine benefits prior to services. In the event of delay or denial from any insurance company, it is my responsibility to make appeals and/or otherwise intervene. There may be delay in determining residual balances owing after third party/insurance reimbursement due to processing or other unforeseen delays. Once MFL determines balances owed and billed to me, I will make payment accordingly. I understand whatever amount MFL is unable to collect from insurance coverage, I personally owe. Any amount not paid by insurance 60 days after initial billing will be paid by me. Any further billing for all additional amounts owed, after 60 days, is strictly as a courtesy and I will make personal payment to MFL. I understand insurance companies may unilaterally determine services unnecessary or charges to be excessive, however, by receiving services from MFL I am authorizing such services and I will be responsible for payment of all charges incurred. I acknowledge MFL does not bill secondary/supplemental insurance.

LATE CANCELLATIONS & MISSED APPOINTMENTS:

I agree a missed appointment fee may be applied to cancellations with less than a 12-hour advance notice or if I miss a scheduled appointment. Late cancellations with less than a 12-hour advance notice will be considered a missed appointment. Multiple missed appointments may cause denial of future services.

COLLECTIONS:

I agree to pay all related attorney/collection fees related to the collection of my outstanding account balances if MFL must employ an attorney/collection agency to secure outstanding balances. I agree the legal venue for collection activity will be in Pierce County or as set forth by collection representatives of MFL.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA):

I have reviewed, or had the opportunity to review, the HIPAA policies for MFL.

I will not rescind these direct payment instructions for any current or future attorney, representative, or insurance company. I understand financial policies may be changed by MFL without notice. I agree to these terms for any services provided to me as a client at MFL. A printed copy or electronic document of this signed agreement shall be considered as effective and valid as the original. I confirm that I have provided accurate information related to my health history, current health status, and regarding my insurance information to the best of my knowledge.

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

NON-COVERED SERVICES WAIVER

I understand proprietary 3rd party evaluation fees charged to MFL in scoring/analyzing my behavioral/mental health evaluations are not covered by insurances. I agree to pay MFL all 3rd party evaluation fees related to my evaluation services at MFL. These 3rd party charges will be specifically noted in my billing statements from MFL.

On occasion, insurances will deny a specific MFL charge that they normally cover/pay for. I agree to pay for insurance-denied charges.

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

CONSENT TO RECEIVE TEXT, EMAIL, AND/OR VOICE MAIL NOTICES/REMINDERS

Marriage & Family Life utilizes text, email, and/or voice mail as a courtesy to clients. Given these are electronic communications it is impossible to guarantee assurance against risks of corruption, interception, or reaching an untended recipient. We strive to ensure all texts, emails, and voice mails are sent to you, the intended client.

Check the appropriate agreement statement:

_____ I agree to receive texts, emails, and/or voice mails from Marriage & Family Life and their Providers.

_____ I do not agree to receive texts, emails, and/or voice mails from Marriage & Family Life and their Providers.

***NOTE**: If you check "I do not agree…" no appointment reminders or correspondence will be provided by MFL except when allowed by HIPAA and/or WA State laws/policies/regulations.*

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

AUTHORIZATION TO RELEASE BEHAVIORAL/MENTAL HEALTH INFORMATION

I grant/authorize my full consent to Marriage & Family Life to release AND receive health-related information from the agencies/individuals listed below ensuring my health/well-being is of the highest regard. I grant/authorize my full consent to release ONLY the information considered reasonably necessary for the best possible outcome in my behavioral/mental health treatment/evaluation/care at MFL.

Add Agency's Full Name *(if applicable)* and at least 1 Individual's/Provider's Full Name & Title.

Phone and Email are Mandatory.

1. Agency \ Individual Name: _____
   Address: _____
   Phone: _____ Email: _____
2. Agency \ Individual Name: _____
   Address: _____
   Phone: _____ Email: _____
3. Agency \ Individual Name: _____
   Address: _____
   Phone: _____ Email: _____
4. Agency \ Individual Name: _____
   Address: _____
   Phone: _____ Email: _____

I fully understand I am **NOT** required to sign this **Release & Authorization** to receive services from Marriage & Family Life. I understand it is my right to inspect/copy/ receive information to be disclosed under this signed form. I may revoke this **Release & Authorization** at any time, in writing, by sending such to Marriage & Family Life: 4901 Center St, Tacoma, WA 98409

I fully understand when behavioral/mental health information is disclosed to a person/agency, those parties may re-disclose it, which may mean your privacy is at risk. Please discuss this signed authorization with agencies &/or persons listed above. Health-related agencies may require you to sign their authorization release form, which offers further information-sharing protection.

Client Name: _____ Today's Date: _____

Client Signature: _____

Print Parent/Responsible Party Name if Client is a Minor: _____

Parent/Responsible Party Signature: _____

Release & Authorization expires 1 year after the date signed – complies with RCW 70.02.030.