

Brien R. Wood, M.A. LMHC
3123 Fairview Ave East, Suite C
Seattle, WA 98012
(206) 571-3069

BACKGROUND INFORMATION FORM

Name (s) _____ Date _____

Home Phone (s) _____ Cell Phone (s) _____

Home Address (s) _____

Briefly describe what you hope to accomplish in therapy:

Occupation (s) _____

Date (s) & Place (s) of Birth _____

How were you referred (please list name of contact or referral source):

- | | |
|--|---|
| <input type="checkbox"/> Crisis Clinic | <input type="checkbox"/> Google Listing |
| <input type="checkbox"/> Friend/Family: _____ | <input type="checkbox"/> MSN Search |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> CounselingSeattle.com | |

DISCLOSURE STATEMENT

Washington State law requires that all mental health professionals present to new clients a disclosure statement that specifies the therapist's background, experience, theoretical orientation, and approach to therapeutic services. This disclosure statement is intended to help you become an informed consumer about these aspects of my clinical practice and your rights as a client.

THERAPEUTIC APPROACH

In our sessions you can expect to be treated with respect and care. I will focus my attention to the process of what you are doing and how you are doing it. Together we will explore the benefits and limitations of your habitual ways of responding to the environment and experiment with increasing your power to choose behavior and ability have deeper and more meaningful interactions with your self and others.

My work as a Licensed Mental Health Counselor is influenced by Gestalt psychotherapy, the research of John Gottman, Susan Johnson's Emotionally Focused Family Therapy, Dan Wile's Non Traditional Approach,

Buddhist mindfulness, and Family Systems Therapies. I work collaboratively and respectfully with couples, helping them to develop mutual support and understanding.

PROFESSIONAL TRAINING AND CREDENTIALS

- Post graduate training in Gestalt therapy from Gestalt Associates Training, Los Angeles
- Masters Degree in Clinical Psychology from Antioch University
Seattle, WA
- Bachelors of Arts from The Evergreen State College, Olympia, WA
- Licensed Mental Health Counselor LH60071756

CLIENT RIGHTS

As a client, you have the right choose a therapist who best suits your needs and goals. If you work with me, you have a right to raise questions about my therapeutic approach and to request a referral if you believe you might make more progress with another therapist. If you believe I have engaged in unethical or unprofessional conduct, you also have the right to report your concerns to the department of health by calling 360-236-4902.

You have the right to confidentiality. I am bound not to release any information to anyone without your written permission. The main exceptions to this are consultations with other clinicians, and if you (1) are about to commit a crime, (2) are involved in child or dependent adult abuse, (3) are a danger to yourself or others, or (4) are unable to meet your own basic needs in taking care of yourself.

If I see you together with your partner or with other family members, confidentiality extends to all those involved in therapy and I will not release to third parties any information without first obtaining signed releases from everyone involved. However, I will not necessarily be bound by confidentiality in joint sessions with information I have obtained in individual sessions and discussions. This means I reserve the right to discuss in joint sessions information that you have shared in individual sessions and discussions if I believe it helps facilitate the achievement of the goals set forth in therapy.

"Counselors practicing for a fee must be registered or certified with the Department of Licensing for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment." (RCW 18.19)

ACKNOWLEDGEMENT OF DISCLOSURE

I (we) understand the information and agree to the terms set forth in the above disclosure statement.

Client(s) Signature

Date

INSURANCE: If Brien Wood is a participating provider with your insurance plan, his billing coordinator will submit the claim to your insurance company. To do this we must have *complete and accurate* insurance information.

Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding *pre- authorizations, obtaining required referrals, etc.*** Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay.

All co-payments must be paid at the time of service.

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Brien R. Wood, MA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named practitioner may use my health care information and may disclose such information to the insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Client, Parent or Guardian

Please print name of Client, Parent or Guardian

Date

Brien R. Wood, MA LMHC
3123 Fairview Ave E
Seattle, WA 98102

INSURANCE CLIENT REGISTRATION:

(For office use only) DSM IV: _____

Name: _____ Age: _____ Date of Birth: _____

Address, City, State, Zip Code: _____

Phone: _____ May I call you at this number Y N Leave a message at this number Y N

Person Responsible for this bill: _____ Social Security #: _____

Address: _____ Phone: _____

Employer Information:

Employer: _____ Occupation: _____

Address: _____

Work phone: _____ May I call you at this number Y N Leave a message Y N

Insurance & Health Care Information:

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____

Identification Number (include alpha numerical #): _____

Group Number: _____

Address of insurance company: _____

Phone: _____ Co-pay Amount: _____

PRACTICE STANDARDS AND FINANCIAL POLICY

My fee for service is:

Individual Counseling

- \$110.00 for a fifty minute session
- \$160.00 for an eighty five minute session

Couples Counseling

- \$125 for a fifty minutes session
- \$175 for an eighty five minute session

Regarding payment, I would like to make therapy as accessible as possible; situations in which my fee would lead to economic hardship I offer a sliding scale and/or barter. Unless there is a prior arrangement, full payment is required at the end of each session.

Since regularly keeping appointments is essential to effective therapy, I emphasize the importance of attending all scheduled sessions.

There is no charge for appointments that are cancelled at least **24 hours** in advance. **Except for emergencies and illnesses, your regular fee will be charged for missed or cancelled appointments with less than 24 hours notice.**

In the event of an emergency, you may try to reach me day or night at (206) 571-3069. Since I am frequently unavailable directly, leave a voice mail and I will return your call promptly. If you need immediate attention and I am unavailable, please call The Crisis Clinic at (206) 461-3222 (24 hours).

Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Signature of Client, Parent or Guardian

Please print name of Client, Parent or Guardian

Date