



Welcome to Eastside Counseling & Coaching!

Personal Bio: Mrs. Lamb received her Masters of Arts in Mental Health Counseling from Northwest University in Washington in 2009, after undergraduate studies from University of Reno, Nevada in Social Work. Mrs. Lamb's practice includes the treatment of couples conflict, depression, anxiety and issues related to life transitions and spirituality. Mrs. Lamb is licensed in the field of counseling in the state of Washington (#60147081).

Disclosure Statement & Informed Consent

Nature of Counseling: Counseling is a relationship between the therapist and client; whereby trust is the fundamental premise. The therapist's role is to provide understanding, compassion, and challenge for change; accepting and valuing the client. The client's role is to be a partner in the change process, to work toward his/her goal, and to be committed to his/her own growth. _____ **(Initial Here)**

Confidentiality: Your relationship with Monica Lamb is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law. a) In the event of a medical emergency, emergency personnel or services may be given necessary information. b) In the event of a threat to harm oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made. c) In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported. d) If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed. e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released. f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena. g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure. h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities. i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities. _____ **(Initial Here)**



Record Keeping: The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity. The therapist will have broad discretion to release any information she deems relevant in situations where she believes the client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect. The client may request a copy of the clinical record (there is a per page copying fee). The client may also ask the therapist to correct record data. If at any time the client desires record release to a third party, it is strongly advised to review the notes before release.

Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. Eastside Counseling and Coaching will not use or disclose your health information for any purpose not described in this notice without your written authorization.

_____ (Initial Here)

Professional Standards: If you have any questions or concerns about any respect of the professional relationship, Mrs. Lamb would welcome an opportunity to discuss them with you. A review process for unresolved problems is available through: Department of Health, Counselor Programs, P.O. Box 47869
Olympia, WA 98504-7869. Phone: 360.664.9098.

Fees: Fees are discussed before or during your first session. The standard fee for a 50-minute session is \$75.00. You are asked to pay at the time service is rendered. Mrs. Lamb does not accept insurance but will provide you with receipts for you to file with your insurance company if you chose to do so.

I agree to pay Eastside Counseling and Coaching at the rate of \$75 per 50-minute session. Initials_____

Use of Credit Cards: Eastside Counseling and Coaching permits payment with credit card, cash or check. If you chose to pay with a credit card, please submit the number and expiration date below. Your credit card will be charged after your session and a receipt will be e-mailed to you.



Card # _____ Exp Date:

I agree to remit payment by credit card for counseling services.

Signature

Date

Legal Requests: If Mrs. Lamb is requested by her client or subpoenaed by any attorney to testify in any court-related proceeding as a result of the therapeutic relationship, she will produce the requested information because she is required to do so by law. Mrs. Lamb may be required to show the court her records and/or testify in court. The client will be required to reimburse Eastside Counseling & Coaching in advance at the rate of \$230/hr for the following applicable records: production of any form or report pertaining to records, preparation/review time concerning depositions, preparation time for court, travel time to/from depositions and court, waiting time at deposition and court, time in deposition and court. There is also a retainer fee of \$2000. I have read the previous statement and agree. Initials_____

Cancellations: Sessions are generally scheduled for 50 minutes. The appointment is reserved for you. You will be billed the full amount for missed appointments and cancellations of less than 24 hours notice. If Mrs. Lamb is not available to take a call, you may leave a confidential voice mail at 425-945-6533, which will be time stamped for delivery verification. Please do not e-mail notification of cancellation or rescheduling. After two consecutive absences, Mrs. Lamb may, at her discretion, refer you to another counselor. I agree to pay for missed scheduled appointments if I do not give at least 24 hours notice by phone of my wish to cancel or reschedule. Initials_____

Counseling Relationship: During the time you work together with Mrs. Lamb, you will meet regularly for approximately 50 minutes per session. This is the time you will be billed for. Mrs. Lamb sometimes does allow consultation by phone for short amounts of time; however, time in excess will be billed. Although our session may be very intimate psychologically, we have a professional relationship, not a social one, as a social relationship might lead to exploitation of clients and impair objectivity in the professional role. Mrs. Lamb's services will be rendered in a professional manner consistent with accepted legal and ethical standards. If you have problems with your counseling relationship, it is encouraged that you speak directly with your counselor. While benefits are expected from counseling, specific results are not guaranteed. As a client, you have the power to refuse or discuss modification of any of her counseling techniques or suggestions. Both the client and Mrs. Lamb have the right to withdraw from the therapy process. If the



counseling process is withdrawn from, Mrs. Lamb will provide appropriate referrals upon the client's request. Therapists are expected to provide services to clients only within the boundaries of their competence. They are also expected to acknowledge, be sensitive to, and respect the diversity of values, attitudes, opinions, and culture of clients and to avoid engaging in any behavior that is discriminatory, harassing, or demeaning to others.

Initials_____

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and /or your understanding of yourself. Some of these changes may be temporarily distressing. The exact nature of these changes cannot be predicted. Together, you can work with your therapist to achieve the best possible results for you. **Initials**_____

Emergency/Crisis Situations: Your counselor has voice mail at 425-999-9470 if you need to get in touch with her. Mrs. Lamb does **not** provide a 24 hour crisis counseling service. If in a life threatening situation, always call 911 before contacting your counselor. You may also contact the Crisis Hotline # at: 800.244.5767 or 425-999-9470 . Please notify Mrs. Lamb if an "after hours emergency" has occurred so that a follow-up session may be scheduled if as soon as possible. **Initials**_____



Consent to Treat

I do hereby seek and consent to take part in the confidential treatment by Monica Lamb, MA, MHCA. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that after the final session or in the event that I have not attended a therapy session in three months that the client/therapist relationship will be considered closed unless I initiate further contact. I understand I have the right to refuse treatment at any time. **Initials**_____

*Your signature here indicates you have read, understand and accept this document (**Disclosure Statement** and **Informed Consent Policies**) and that any questions you had about this document were answered to your satisfaction, and that you were furnished a copy of this document. By your signature, you issue consent for Mrs. Lamb to provide counseling, you understand you financial obligations and acknowledge your commitment to conform to these documents specifications.

Print Name _____ Fee _____

Client Signature, Parent/Guardian _____ **Date** _____

Client Signature, Parent/Guardian _____ Date _____

Counselor Signature _____ Date _____

Monica Lamb, M.A., MHCA

Insurance Benefits: I authorize my insurance benefits to be paid directly to Monica Lamb for the services provided. I understand that I am financially responsible for my bill with Monica Lamb and that any balance not covered by my insurance benefits is my responsibility. I consent to the release of diagnostic information in authorizing treatment from my managed care company, and to the release of information necessary to complete the billing process with my insurance company.

Signature

Client Information Form

Personal Information:



Child's name: _____ Today's

Date: _____

Date of Birth: _____ Address: _____

Home Phone: _____ Mom's Cell Phone: _____ Dad's Cell
Phone: _____

Where would you prefer to be called? _____ E-
mail: _____

Can Eastside Counseling & Coaching send you a monthly e-newsletter?

Mother's Occupation and

Where: _____

Father's Occupation and Where:

Religious Faith: _____ Church: _____

Is your religious faith something you would like to talk about?

Please List Your Children:

Name Gender Age Comments

Who is currently in your household: _____

Please list any medications that your child is taking:



Any emergency names and numbers besides you:

Please describe your child's personality:

Please describe your child's interests:

Please circle any difficulties that have applied to your child in the past or do apply currently:

- | | | |
|---|--|---|
| <input type="checkbox"/> Engaging Peers | <input type="checkbox"/> Tolerating Separation | <input type="checkbox"/> Playing Cooperatively |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Academic Trouble | <input type="checkbox"/> Violent Temper | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Animal Cruelty | <input type="checkbox"/> Assault others | <input type="checkbox"/> Non-Compliant |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Bizarre Behavior | <input type="checkbox"/> Self-injurious |
| <input type="checkbox"/> Threats | <input type="checkbox"/> Frequently Tearful | <input type="checkbox"/> Frequently Daydreams |
| <input type="checkbox"/> Lack of Attachment | <input type="checkbox"/> Often Sad | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Breaks Things | <input type="checkbox"/> Isolates Self |
| <input type="checkbox"/> Very Shy | <input type="checkbox"/> Dominates Others | <input type="checkbox"/> Biting |
| Fingernails | | |
| <input type="checkbox"/> Nervous Tics | <input type="checkbox"/> High Intelligence | <input type="checkbox"/> Learning Problems |
| <input type="checkbox"/> Fearful or Anxious | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Phobias | <input type="checkbox"/> Associates with Acting-Out |
| Peers | | |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Problems with Authority | <input type="checkbox"/> Sibling Rivalry |

Other:-----

-

Please name Child's ethnicity:

Please describe any cultural issues that contribute to current problem:

Please describe your parent style:-----



Please describe any current stressful situations that you think has caused problems for your child.

Please list any additional information that you think would be helpful:

Important Info For Your Records

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Unprofessional Conduct: If you suspect unprofessional conduct, contact the Department of Health at the following address and phone number: Department of Health, Counselor Programs, P.O. Box 47869, Olympia, WA 98504-7869 or call at 360.664.9098.



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