



# New Client Intake Form

*Puyallup Psychotherapeutic Alliance (PPA) is committed to protecting your information.*

## Client Information

Client Name	Birthdate	SSN
Gender Identity	Age	Marital Status
Address	City	State Zip
Email	Cell Phone	Landline

PPA may contact me in the following ways to coordinate and provide health care services:

*(Select all that apply.)*  Mail  Email  Text  Phone

Employer	Estimated Annual Household Income
Workplace Address/City/Zip	

Client's Emergency Contact
Phone Number(s) Relationship to Client

*For clients who are under the age of 18:*

Client's Parent/Guardian
Email Cell Phone Landline

## Household Information

Please select all that apply and list how long/how many years for each description. Are you:

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Previously Married
<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<input type="checkbox"/> Coupled, not married	<input type="checkbox"/> Other	

Please share any concerns you may have with your current romantic relationship, home environment, or living situation:

Please use the following to describe who currently lives with you:

First Name	Relationship	Age	Gender
First Name	Relationship	Age	Gender
First Name	Relationship	Age	Gender
First Name	Relationship	Age	Gender
First Name	Relationship	Age	Gender

No additional people reside with me.

## Family Mental Health History

Please select all that apply and indicate the relationship (*child, sibling, parent, aunt, grandparent, etc.*) in the space provided for each selection. Has anyone in your family experienced difficulties with any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Learning Disabilities   |
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Alcohol/Substance Abuse |
| <input type="checkbox"/> Panic Attacks    | <input type="checkbox"/> Trauma History          |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Eating Disorder(s)      |
| <input type="checkbox"/> Schizophrenia    | <input type="checkbox"/> Suicide Attempts        |
| <input type="checkbox"/> Other            |  |

## Client Health History

Please make one selection to rate your current physical health:

- Poor       Unsatisfactory       Satisfactory       Good       Very Good

Please list any prescription medication you're currently taking and why:

Please describe your current health issues, and if you are being treated for any physical or psychological illness:

Name of Physician

Date of Last Exam

Are you currently receiving psychiatric services elsewhere?

Please list any recreational substances you use and the age you were when you started. Do you smoke cigarettes, vape, drink alcohol, or use other substances (*marijuana/cocaine/etc.*)?

How often do you use recreational substances?

- Daily       Weekly       Monthly       Rarely       Never

How often do you have 4 or more alcoholic beverages within a 24-hour period?

Does your spouse/partner/household member use prescriptions or recreational substances?

Please briefly describe what substances and how often they are used:

To help your therapist understand what you're dealing with, please select all the items that describe your experience over the past few weeks:

### 1. Mood & Emotions

- Feeling sad, down, or discouraged
- Feeling emotionally numb or flat
- Frequent tearfulness
- Feeling hopeless or pessimistic
- Feeling irritable or easily frustrated
- Feeling unusually confident or "up"
- Rapid mood swings

### 2. Anxiety, Stress & Worry

- Excessive worry
- Feeling tense or on edge
- Trouble relaxing
- Rapid speech or shakiness
- Tight chest or upset stomach
- Panic attacks
- Anxiety interferes with daily life

### 3. Energy, Activity & Motivation

- Low energy or fatigue
- Difficulty getting started on tasks
- Loss of interest in usual activities
- Increased energy or restlessness
- Feeling driven or unable to slow down
- Needing much less sleep than usual

### 4. Thoughts, Focus & Organization

- Difficulty concentrating
- Easily distracted
- Forgetful or disorganized
- Trouble finishing tasks
- Thoughts feel slowed or foggy
- Racing thoughts

### 5. Stressful or Impactful Experiences

- Recent major life change or stressor
- Ongoing stress affecting mood or functioning
- Past event that still causes distress
- Avoiding reminders of a difficult event
- Strong emotional or physical reactions to reminders
- Feeling jumpy, watchful, or easily startled

### 6. Sleep

- Difficulty falling asleep
- Difficulty staying asleep
- Restless or unrefreshing sleep
- Sleeping too little
- Sleeping too much
- Disturbing dreams

### 7. Relationships & Social Environment

- Ongoing conflict with a partner
- Ongoing conflict with a household/family member
- Relationship separation or divorce
- Loss of a close relationship
- Feeling unsupported or isolated
- Stress related to caregiving or family roles

### 8. Daily Functioning

- Loss of appetite, eating less, or restricting food
- Increased appetite, overeating, or bingeing food
- Difficulty at work or school
- Difficulty in relationships
- Difficulty managing daily responsibilities
- Others have noticed changes in me

Are you experiencing:  Repetitive behaviors or thoughts       Unexplained memory lapses/loss of time  
 Hallucinations       Homicidal thoughts       Suicidal thoughts or attempts

How long have you been experiencing the items you selected?

- <1 month     1-3 months     3-6 months     6-12 months     >1 year     >2 years

How much are these selections affecting your life?

- (Not at all)  0     1     2     3     4     5     6     7     8     9     10 (Severely)

Have you ever had thoughts of killing yourself? If so, when and how frequently? Did you form a plan?

Have you ever made a suicide attempt? If so, when and what method was used?

Please describe any prior therapy you've received. Include dates, name(s) of therapist, the reason(s) for seeking care, previous diagnoses, and what was helpful or unhelpful:

Please share the reasons you are seeking therapy and what you hope to accomplish:

### Additional Information

What is your religious or spiritual background, and are you experiencing any conflicts or struggles regarding those beliefs?

Please describe any spiritual or religious practices you currently follow, their importance to you, and if there are any specific practices or restrictions that may affect how therapy is provided:

Please describe any community, group, or supportive gatherings you participate in:

Please share effective coping strategies you've learned, what you consider to be your strengths, and what you like about yourself:

I attest that all the information provided in this document is accurate and complete.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Printed Name of Client/Guardian

\_\_\_\_\_  
Date of Signature



# Client Disclosure & Informed Consent Form

*For the provision of mental health services in Washington State.*

## Practice/Provider Information

Puyallup Psychotherapeutic Alliance (PPA)

Mailing Address: PO Box 731271, Puyallup WA 98373

Service Location: 13610 108<sup>th</sup> Ave Ct E Suite B, Puyallup WA 98374

Website: [www.PsychotherapeuticAlliance.com](http://www.PsychotherapeuticAlliance.com)

Business Phone: (253) 686-1319

Business Email: [AFArminLMHC@gmail.com](mailto:AFArminLMHC@gmail.com)

Provider Name: Anahita Armin, Supervising LMHC & Owner

WA State License #: MHC.LH.60305323

**Please read the entirety of this document carefully and save a copy for your records.** This form explains important information about your rights; the nature of psychotherapy services and PPA policies; billing information; confidentiality and the Health Insurance Portability and Accountability Act (HIPAA); and who may legally sign this form to acknowledge you have read and understand this information.

For your convenience, all areas that require acceptance, acknowledgement, or completion to authorize health care services have been indicated by a yellow tab in the left margin.

## Nature of Services

Psychotherapy involves provider/client discussions of personal issues, emotions, and behaviors. It may involve risk as well as benefit. You may experience uncomfortable feelings as part of the process. Your therapist will explain goals, methods, risks, and potential benefits.

I understand that mental health services offered by this practice include therapeutic assessment and counseling; I have the right to discuss treatment alternatives and risks/benefits with my provider; I may ask about the methods, modalities, and orientation used as well as the expected course/duration of treatment.

I understand that therapy is collaborative; that I am encouraged to participate in discussions honestly and openly; that I will help define my treatment goals and practice skills or strategies discussed in sessions; that I may share relevant thoughts, feelings, behaviors, and experiences; and that I may provide feedback about what is or isn't working.

I understand I have the following client rights: I may refuse or discontinue treatment at any time without penalty; I may choose my provider and treatment modality; I may ask questions and receive clear explanations before providing consent; and I have the right to receive a copy of this disclosure and understand it.

PPA provides outpatient individual, child/adolescent, couple, family, and group therapy services in-person and/or virtually by secure electronic telehealth. PPA's telehealth services

use Zoom, Teams, Simple Practice, or other qualifying platforms to deliver interactive health care services remotely.

I consent to receive telehealth services, and I understand this mode of care; that telehealth technology may contain risks, benefits, and privacy limitations; and that I may decline or discontinue telehealth at any time.

The frequency of therapeutic services is based on the unique needs and goals of each client. Appointments are typically scheduled for 60 minutes on a weekly basis unless an alternative schedule is arranged in advance.

I understand that I must commit to a regular schedule and arrive to my appointments on time; that I will be offered a selection of available therapists and recurring appointment times to choose from; that I may select the options that are best suited for my needs; and that PPA will provide updated availability and assistance with modifying my selections at my request.

Our therapeutic team is comprised of licensed mental health counselors (LMHCs), licensed mental health counselor associates (LMHCAs) and student interns whose approved Washington State Licensed Supervisor is Anahita Armin. Behavioral health consultants, including a psychiatrist and a licensed clinical social worker (LCSW), help PPA provide confidential comprehensive behavioral health care for our clients.

I understand that I have the right to make an informed choice regarding my provider; that PPA will disclose my therapist's credentials (*i.e.*, *intern/pre-licensed/LMHCA/LMHC*) during my intake appointment scheduling discussion and any time I request this information; and that I have the right to ask about their training, experience, and how supervision works.

I understand that intern therapists are not independently licensed; that intern therapists receive regular supervision from a licensed supervisor that oversees my care; that my case may be discussed with the supervisor to improve treatment quality; and that confidentiality is maintained during supervision.

I consent to receiving services from an intern therapist and I understand that my care must meet Washington State and professional board requirements; that I will receive the same ethical and professional standards, rights, and protections; and that I may withdraw my consent at any time.

I agree to interact respectfully with PPA therapists and staff; make no threats, harassment, or violence; participate in safety planning if needed; and attend my sessions sober from alcohol/mind-altering recreational substances.

## Billing & Payment Information

PPA strives to offer affordable services, accepts many types of insurance, and offers rates on a sliding scale for qualifying clients. Additional fees may be waived for established clients experiencing hardships. Client Billing Statements/Invoices are generated monthly, and clients may choose to complete a credit card authorization for their convenience.

### Out-of-pocket Fees

Individual Session: \$150

Couples' Session: \$175

Family Session: \$200

No Show Fee: \$45\*

### Missing a Scheduled Session Without Notice

A no show fee is assessed when a client either: (1) does not adjust their appointment time a minimum of 48 business hours in advance, or (2) does not attend their scheduled appointment within the first 15 minutes of the appointment time. *\*Exceptions include documented extenuating circumstances, medical emergencies, sudden illness, family emergencies, and severe weather.*

I understand clients are asked to cancel or reschedule an appointment 48 business hours in advance; that I may incur a No Show Fee for missing a scheduled session without notice; that if I accumulate three No Shows I may be referred for a scheduling assessment before I can continue services; and that three or more No Shows without adequate communication may lead to being discharged.

### Client Contact and Billing Information

Clients are expected to provide timely communication of changes to their therapist. If you experience a hardship during your course of treatment, PPA will do all that we can to prevent your necessary services from being interrupted. Please contact Anahita Armin to discuss available options.

I agree to notify my therapist of any changes to my contact and billing information; I understand that accepting health care services without notifying PPA of changes to my contact and billing information may be considered fraudulent; and I understand I may choose to contact Anahita Armin directly with my contact and billing information updates, questions, or concerns.

### Insurance Billing

Clients must complete an Insurance Release of Information form for each insurance plan held. Once received, PPA will verify your eligibility and the acceptance of your insurance plan for billing purposes. Insurance may not cover the entire fee for your service.

I understand insurance plans provide an explanation of benefits (EOB) to the primary subscriber/member and to the provider of each health care service; that the EOB details any amount the insurance paid for the service and any patient responsibility portion; and that PPA Billing Statements/Invoices use these EOBs to reflect deductibles, copays, or coinsurance amounts owed by the client.

### Confidentiality and Privacy

PPA follows federal and Washington State rules and regulations by using the minimum amount of personal health information (PHI) necessary to provide services and by adhering to the following Notice of Privacy Practices.

## Notice of Privacy Practices (HIPAA)

\*\*\* THE FOLLOWING 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.

### 1. OUR RESPONSIBILITIES

We are required by federal law (HIPAA) and Washington State law to:

- Maintain the privacy of your protected health information (PHI).
- Provide you with this Notice of Privacy Practices.
- Follow the terms of this Notice.
- Notify you following a breach of unsecured protected health information.

PHI includes records of your mental health condition, treatment, diagnoses, and payment information, whether written, spoken, or electronic.

### 2. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

We will not use or disclose your information for purposes outside treatment, payment, or operations without your written authorization, except as required or permitted by law.

- Psychotherapy notes are given special protection under HIPAA and Washington law.
- We will not release psychotherapy notes without your specific written authorization, except as allowed by law.

You may revoke an authorization in writing at any time, except to the extent it has already been relied upon.

### 3. WASHINGTON STATE CONFIDENTIALITY PROTECTIONS

Washington law provides additional privacy protections for mental health information.

Special protections include:

- Mental health treatment records may not be disclosed without authorization except as permitted by law.
- Minors under age 13: parents or legal guardians generally control consent and access.
- For minors age 13 and older, the minor controls access to their mental health records unless disclosure is otherwise permitted by law.
- Parents or guardians may not automatically access records of minors age 13+ without the minor's written consent.
- Special rules may apply in cases involving safety, court orders, or dependency proceedings.

### 4. HOW WE MAY USE AND DISCLOSE YOUR PHI

We may disclose information without your authorization when required or permitted by law, including:

#### **a. Treatment**

We may use and disclose PHI to provide mental health services, coordinate care, or refer you to other providers. Example: sharing relevant information with another clinician/supervisor to assist with your care.

#### **b. Payment**

We may use and disclose PHI to bill and collect payment for services provided to you. This includes disclosures to insurers (*e.g., Medicaid, Medicare, private insurance*) for claims and eligibility.

**c. Health Care Operations**

We may use or disclose PHI for practice operations, such as quality assurance, training, and compliance with licensing requirements.

**d. Required by Law**

We may disclose PHI when required by federal, state, or local law, including reporting to comply with HIPAA, workers' compensation rules, or other legal processes.

**e. Public Health and Safety**

We may disclose PHI to appropriate authorities for public health activities and reporting requirements, such as responding to communicable disease reports or public health investigations.

**f. Serious Threat to Health or Safety**

We may disclose PHI if necessary to prevent or lessen a serious and imminent threat to your health or safety or that of others (*e.g., suspected abuse or neglect of a child, dependent adult, or vulnerable adult*).

**g. Judicial and Legal Proceedings**

We may disclose PHI in response to a court order, subpoena, or other legal processes as permitted by law.

**h. Business Associates**

We may share PHI with third-party service providers who support our operations (*e.g., billing services, electronic record vendors*). These "Business Associates" are required to protect PHI in accordance with HIPAA.

Only the **minimum necessary information** will be disclosed.

**5. YOUR RIGHTS UNDER HIPAA AND WASHINGTON STATE LAW**

You have the right to:

- Inspect or obtain a copy of your PHI (with limited exceptions)
- Request an amendment to your PHI if you believe it is incorrect.
- Request confidential communications (*i.e., alternative contact methods*)
- Request restriction on how PHI is used or disclosed (subject to legal limitations)
- Receive a copy of this notice at any time.
- Receive an accounting of certain disclosures of your PHI.

If you have questions about this notice, your privacy rights, or wish to file a complaint please contact our Privacy Officer:

**Privacy Officer:** Anahita Armin

**Phone:** (253) 686-1319

**Email:** AFArminLMHC@gmail.com

You may also file a complaint with the U.S. Department of Health and Human Services, information on how to do so is available upon request. You may contact appropriate state privacy authorities if state law applies. Filing a complaint will not affect your access to services or treatment.

**6. CHANGES TO THIS NOTICE**

We reserve the right to change the terms of this Notice at any time and apply the changes to all PHI we maintain. A revised Notice will be available upon request and in our office.

I acknowledge that I have received, read, and understand this Notice of Privacy Practices.

## Emergency & Crisis Information

Please use this resource list if you or a loved one experience an emergency, thoughts of suicide, self-harming behavior, extreme agitation, or an inability to care for basic needs.

1. Go to your local Emergency Room or **Call 911**
2. Emergency Suicide and Crisis Lifeline 24/7: **Call or Text 988**
3. Crisis Counseling 24/7: **Text HOME to 741741**
4. Common Ground 24/7 Crisis Phone Line: **1 (800) 231-1127**
5. 24-hour Pierce County Crisis Line: **1 (800) 576-7764 or Text "HEAL" to 741741**

## Changes in Service Delivery/Discharge

Clients experience significant improvements in health outcomes when transitions in and out of health care services are planned with their provider. Health insurance plans, providers, and socioeconomic situations sometimes change, which can suddenly affect your access to care. Completing treatment or changing your level of care without planning can feel destabilizing. PPA offers transitional planning with your therapist and/or another PPA clinician/team member. **Simply speak with your therapist or call (253) 686-1319 to request transitional planning.**

## Authorization of Care & Consent

Please review the following statements thoroughly and click each checkbox to signify each statement has been read. All statements must be selected prior to providing signature(s) to authorize PPA mental health services.

- I acknowledge that **clients age 18 and older who have legal capacity** must personally sign this form to authorize mental health treatment and related disclosures.
- I acknowledge that when a **client age 18 or older has a court-appointed guardian** or has been legally determined to lack decision-making capacity, the guardian must sign this form and provide documentation of legal authority (*e.g., letters of guardianship or court order*).
- I acknowledge that **clients under the age of 13** require the signature of a parent or legal guardian to legally authorize outpatient mental health treatment.
- I acknowledge that in Washington State, **minors age 13 and older** may independently consent to outpatient mental health treatment and may sign this form on their own.
- I acknowledge that a **parent or guardian of a minor age 13 or older** may only receive information or access records if the minor has authorized such disclosure in writing or if disclosure is otherwise permitted by law.
- I acknowledge that **individuals who are not a biological or adoptive parent** (*e.g., grandparents, relatives, caregivers*) must provide legal documentation of authority to sign on behalf of a minor client.
- I acknowledge that **foster parents or state-appointed caregivers** must provide placement or authorization documentation demonstrating their authority to consent to mental health treatment.





# Insurance Coverage Information Form

*This form is required for clients to use their insurance coverage as a form of payment.*

## Insurance Coverage Information

Please ensure the information you provide matches the insurance policy record.

Client's Full Legal Name: \_\_\_\_\_

Client's Relationship to the Policyholder:  SELF  CHILD  SPOUSE  OTHER

Client's Insurance Company: \_\_\_\_\_

Insurance Policy Number / Member ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Coverage Effective Date: \_\_\_\_\_

### If different from the client:

Policyholder Name: \_\_\_\_\_

Policyholder DOB: \_\_\_\_\_ Policyholder Phone Number: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_

### Secondary insurance, if applicable:

Client's Insurance Company: \_\_\_\_\_

Insurance Policy Number / Member ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Coverage Effective Date: \_\_\_\_\_

I understand that I am responsible for providing accurate and current insurance information; I must notify the provider/clinic of any changes to my insurance coverage; and I may be asked to provide a copy of my insurance card at any time.

I understand that I am entitled to receive mental health services regardless of my insurance status and that I may choose to self-pay if I do not wish to use insurance.

I understand that my insurance policy is a contract between me and my insurance company; the provider/clinic cannot guarantee that my insurance will cover services; I am responsible for all charges not paid by my insurance including deductibles, copayments, coinsurance, and non-covered services.

I authorize PPA to bill my insurance company directly for mental health services provided to me and I understand that my protected health information may be disclosed to my insurance company as necessary for the purpose of payment. I assign payment of insurance benefits directly to the provider/clinic.

By signing below, I certify that the information provided is accurate and complete and I confirm that I have read and understood this form and agree to its terms.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Printed Name of Client/Guardian

\_\_\_\_\_  
Date of Signature