# Westwinds

## Behavioral Health

*1812 Hewitt Ave Ste 101*
*Everett, WA. 98201*

# Disclosure Statement

I, Christopher R. Sturgeon, am a private individual doing business by providing counseling services to the general public as a Certified Counselor in the State of Washington. The current fee for 45-to-50-minute session is _____. My service offered includes counseling under the consultation with Dr. Mark Yamada PhD. Clinical assessment and testing are available by referral to Dr. Mark Yamada PhD. Fees for services are due at the time of service. A schedule for fees is available upon request. 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 payment arrangements may be provided in advance by securing consent in advance and are made and replied to in writing.

Washington State Law requires that counselors practicing for a fee must be credential by the state. certification of an individual with the Department of Health does not denote recognition of standards by the Department of Health. 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 CREDENTIAL**
**Christopher R Sturgeon PhD (C)**
**Certified Counselor # CL 60155102**
**Agency Director**

Counseling services are offered to individuals, couple, families and groups. Treatment includes counseling for individual's current life challenges. Orientation and principles to treatment primarily include the orientation of Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution Focused Therapy, and Narrative Therapy. Records of service provided to you will meet Washington State Law. Unless otherwise requested by the client, written case notes will not be kept, but we will keep: a) Date and Time of Appointment, b) Fees charged, c) Procedure codes. By law you may request to view to view and copy these records for your or a 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 above address.

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

By signing this form, 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 and the office policies and procedure form which also are part of this disclosure statement.

Client Signature_______________________________ Date _____________

Counselor Signature. ___________________________ Date _____________

# OFFICE POLICIES & PROCEDURES

***Westwnids Behavioral Health***
*1721 Hewitt Ave*
*Everett WA 98201*

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.

# 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<br>Single Married Separated Divorced Remarried | Education<br>Highest grade completed ________Degree held________ |
|---|---|
| Employer | Occupation FT PT<br>RETIRED |
| Religious Orientation (optional) | Ward/Diocese<br>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 physican) | 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. | |