Jason P. T. Geibel, MA, LMHC
214 N. Commercial, Ste 300, Bellingham WA 98225
Phone (360) 602-1764

CLIENT INTAKE FORM

Please complete all pages of form.

Client's Full Name:_____
Social Security#:_____
Date of Birth: _____ Age:
Gender at Birth: _____ Current gender identification:_____.
Identified Pronouns:_____
Referred by: _____ Primary Care Physician: _____
Client lives with☐:Mother ☐Father ☐ Both ☐ Other: ___
Mothers Name: _____
Social Security#: _____
Fathers Name: _____
Social Security#:_____
Client's Address: _____
_____
Home Phone: _____☐day ☐ evening OK to leave msg? YES NO
Work Phone: _____ ☐ day☐ evening OK to leave msg? YES NO
Cell Phone: _____☐ day☐ evening OK to leave msg? YES NO

COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

MEDICAL HISTORY

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Briefly describe your primary concerns and why you have sought counseling at this time:

_____
_____

When was your last comprehensive medical evaluation?

_____

Have you ever been hospitalized for psychological reasons? ☐ Yes ☐ No
If yes, when and where?

_____

_____

Please check whether you currently have, or have ever had any of the following:

__drug/alcohol abuse
__running away
__disturbing thoughts
__memory problems
__irritability
__bowel problems
__suicidal ideations/attempts
__sexual concerns
__chronic illnesses
__phobias:_____
__physical abuse or neglect
__racing thoughts
__broken bones
__problems with coordination
__gender issues

__sleeping problems
__frequent headaches
__lack of interest
__low self-esteem
__emotional abuse
__irregular heartbeat
__feelings of hopelessness
__difficulty managing anger
__family/relationship issues
__hormone disorder
__panic attacks
__frequent stomachaches
__school/work difficulties
__frequent or uncontrolled crying

__changes in appetite
__epilepsy or seizures
__sexual abuse
__speech problems
__hearing problems
__visual problems
__homicidal thoughts
__mood swings
__communication problems
__difficulty concentrating.
__serious infection
__feelings of paranoia
_blood pressure concerns
__self-destructive or self-injurious behavior

__flashbacks
__ulcers
__depression
__confusion
__seizures
__bedwetting
__weight loss
__asthma
__stress
_anxiety
__allergies
__head trauma

__Other physical or emotional issues (please describe):

_____

_____

Are you currently taking medication? Yes No
Medication: _____ Dosage: _____
Date Started: _____
Medication: _____ Dosage: _____
Date Started: _____
Medication: _____ Dosage: _____
Date Started: _____

List any serious illnesses for which you have required hospitalization or surgical operation:

Illness	Year	Doctor	Hospital

Has you ever received psychological, substance abuse, or psychiatric services?

Service	Year	Doctor	Issue at Time

FAMILY SITUATION

Relationship Status (if under 18 parents): Single, married, divorced, separated, co-habituating , widowed

Names and ages of other individuals residing in the home:

Name	Age	Relationship to Client

Client's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation:

_____

Employer: _____

For how long? _____

Father's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation:

_____

Employer: _____

For how long? _____

Mother's-

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation:

_____

Employer: _____

For how long? _____

Are there any family members who have experienced significant medical problems, mental health problems or substance abuse?
(Please indicate relationship to child):
Medical Problems-
Past: _____
Present:
_____
Alcohol Use-
Past: _____
Present:
_____
Drug Use-
Past: _____
Present:
_____
Tobacco Use-
Past: _____
Present:
_____
Caffeine Use-
Past: _____
Present:
_____

GOALS FOR THERAPY

What would you like to see happen as a result of your work here? _____
_____
_____

Jason P. T. Geibel
214 N. Commercial St., Ste 300
Bellingham WA 98225
(360) 602-1764
Licensed Mental Health counselor (LH 60589036)

DISCLOSURE STATEMENT

Welcome to my practice! Washington State Law requires that all therapists provide clients with written information about their qualifications, treatment philosophy and methods, and service policies. It is your right and responsibility to choose the provider and treatment that best suits your needs. To help you make your choice and to help facilitate our work together, here is some basic information about me and my therapy practice. Please read this information carefully and ask me to explain anything that you don't understand. This statement, in its entirety, serves as our agreement to our respective rights and responsibilities as therapist and client. You will be asked to sign it after reading it and before we begin our therapy together.

EDUCATION:

Master of Arts, Applied Behavioral Science - Systems Counseling
September 2007 - June 2009
Leadership Institute of Seattle (Bastyr University)

BA, Major in Psychology, Minor in Children in Social Policy
September 2003 – September 2006
Antioch University of Seattle

MY APPROACH TO COUNSELING:

My overall approach to treatment is through genuine and deliberate interpersonal communication. I believe that the responsibility for the process is a shared endeavor between the patient and the therapist. I may utilize cognitive behavioral models, dialectic behavioral models, and experience interpretation, play therapy, mindfulness & reality therapy. I believe that regardless of the method or approach taken; the foundation for a successful treatment experience is based upon the therapeutic relationship. Therefore, my style of therapy remains grounded in psycho-analytic models that give the interplay between therapist and patient the highest priority.

Therapy may be offered to an individual, couple or family. I will also collaborate with any medical providers involved in a client's treatment as seen necessary, and with a client's consent. We will evaluate our progress towards treatment goals to allow for adjustments to the therapy process and/or individual goals. My intent is to provide a respectful, holistic and relationship-based approach to therapy, rather than one that in narrowly focused and/or impersonal.

CONFIDENTIALITY:

You have the right to choose a counselor who best suits your needs and purposes and if ever you or I feel that our therapeutic relationship does not suit your needs, I would be happy to provide information for other practitioners in the area. You also have the right to a confidential relationship to the extent as provided for by RCW 18.19.180(1) through (6).

Continued on back →

I will keep all information about you confidential, including the fact that you are my client.
With teens age 13 and over: I will keep your individual information confidential, even from your parents/guardians. I may need to communicate with your parents regarding appointment scheduling and payment, or if I am worried that your life is in danger.
When I am required to release information:
If I suspect that a child or dependent person is being abused; if you intend to seriously harm yourself or someone else; to consult with my confidential clinical team regarding my counseling work; or if a judge subpoenas my records.

I have been provided a copy of the required disclosure information the "Notice of Practices Regarding Protected Health Information" and read and understand the information provided. Initial here to acknowledge receipt_____

BILLING PRACTICES:
Payment for services will be due at the beginning of each session. My basic individual counseling rate is $125.00 per 55-minute session. In some cases, your insurance company may pay a percentage of the cost of your therapy per session. In this case, your co-pay becomes your fee, while I collect the remainder of your fee from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company.

APPOINTMENTS:
Your appointment times are reserved for you alone. I try very hard to begin and end on time, out of respect to both of our schedules. If you need to cancel an appointment, please notify me by voice mail at least **48 hours in advance**. If you do not show for an appointment, you will be charged a **"No Show Fee"** at your full regular session rate. If you cancel with less than 48 hours notice, you will only be charged a **"Late Cancellation Fee"** at half your regular rate. (There will be no fee if you have to cancel due to an emergency.) I will adhere to the same policy if I need to change your appointment.

PHONE CONTACT:
If there is an emergency between sessions, I can be reached by phone at 360-602-1764 during clinic hours, however if it is an emergency and you can not reach me call:

Care Crisis Line at 1-800-584-3578 (24 hours a day, 365 days a year, toll free)
If life-threatening, call **911** or go to the nearest **Emergency Room**.

CLIENT RIGHTS:
As a client, you have the right to refuse treatment, and the right to choose the provider and type of treatment which best suits your needs.

COMPLAINTS:
If you are ever dissatisfied with my services, I encourage you to talk to me about your concerns. Your thoughts provide very important feedback for me, and may be growth for you as well. If I am not able to resolve your concerns, you may write to the WA Department of Health, Health Professions Quality Assurance Division.

TREATMENT CONSENT:

I have been informed of the type of counseling I will receive from Jason P. T. Geibel, MA, LMHC, the methods and techniques used, his education, training and experience and the cost of counseling services. Furthermore, I have received this information in writing.

Counselors practicing for a fee must be registered with the Department of Health for the protection of public health and safety. Registration of practice standards does not necessarily imply the effectiveness of any treatment.

_____

I have read and understood these policies, have received my own copy of this Disclosure, and consent for treatment with Jason P.T. Geibel, MA, LMHC:

_____ _____

Client Signature(s) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Counselor Signature Date

Addendum to, Jason P. T. Geibel, MA, LMHC counselor disclosure statement:

Use of social media: I do communicating with clients via social media. Therefore, I cannot friend clients on Facebook, Linkedin, Instagram and the like.

Texting: I do allow for texting on my emergency number, 360-602-1764, for the purpose of scheduling changes only. I **will not** use texting for clinical issues and request you call if clinical support is needed.

Credit cards: I do accept credit cards and therefore need to inform you that to process your card I will be disclosing a minimal amount of information during the processing of the credit card which will limit your confidentiality.

I have read and understand the above addendum to Jason P.T. Gebel, MA, LMHC's counselor disclosure.

_____

Client Signature

_____

Therapist Signature

Jason P. T. Geibel, MA, LMHC
214 North Commercial Street #300
Bellingham, WA 98225
360-602-1764

Client Information

Date: _____

First, Middle initial, and Last Name: _____

Date of Birth: _____Male: _____Female: _____

Email:_____

Address, City, & Zip: _____

Home Phone: _____ Work Phone: _____Cell: _____

Emergency Contact: _____Phone: _____

Address of where you would like statement sent to if different from client address:

_____

Insurance Information

Please make a copy of the front and back of the insurance card.

Name of Insurance Provider: _____

Policy or ID Number: _____

Group Number: _____

Insurance Claims Address: _____
(Found on the back of the card)

Insurance Phone number: _____

First and Last Name of Insured: _____
(If different from Client's name)

Date of Birth of Insured: _____

All information is needed to secure reimbursement from your insurance company. The claim may be denied if this information is not included.

☐ Check benefits

Jason Geibel, LMHC
214 N. Commercial Suite 300
Bellingham, WA 98225
360-602-1764

Billing Practices / Financial Agreement

Patient Name: _____ Date of Birth: _____

Financially Responsible Party:_____

As the Financially Responsible Party for the patient, please carefully review this information and sign below:

Insurance information
For those with insurance, your insurance company may pay a portion of the cost of your office visits. In this case, your patient responsibility becomes your fee, which may include a deductible; co-pay (a fixed amount specified by insurance companies for certain services); or coinsurance (a percentage of costs specified by insurance companies for certain services), while I collect the remainder of your fees from the insurance company. Please remember, however, that you are ultimately responsible for payment of your costs, not your insurance company. **You are responsible for obtaining any authorization your insurance requires prior to treatment.**

Changes in Insurance Coverage:
As a reminder, it is the patient's/responsible party's responsibility to inform service providers of any changes in insurance coverage. Your insurance company will only inform service providers about any changes in insurance coverage after a bill for services has been submitted to the insurance company.

"No show" and Cancelled Appointments:
If appointments are missed without notification, **you, not your insurance company**, will be charged a no show fee of **125.00.** If you need to cancel your appointment for any reason, please do your best to cancel 48 hours in advance. If you cancel with less than 48 hours notice, you will only be charged a **"Late Cancellation Fee"** at half your regular rate. (There will be no fee if you have to cancel due to an emergency.) I will adhere to the same policy if I need to change your appointment.

Non-Sufficient Funds (NSF) Check Returns:
Checks that are returned as NSF will incur a reprocessing fee of $10.00 per occurrence.

_____ _____
Signature of Responsible Party Date

JASON P.T. GEIBEL, MA LMHC
214 N. Commercial St., Suite 300
Bellingham, WA 98225
360-602-1764

Credit Card Authorization

Client Name: _____

Responsible Party (if different): _____

Credit Card #: _____

Exp. Date: _____ CCV (on back of card): _____

Billing Address: _____

City, State, Zip: _____

I understand that payment is due upon receipt of billing statement. I also understand that if payment is not received within 60 days of date of billing statement, my credit card listed above will be charged for the full amount. I authorize my credit card listed above to be charged for my full balance due to JASON P. T. GEIBEL, MA LMHC if payment is not received within 60 days of date of billing statement.

_____ _____
Cardholder Signature Date