ROBERT E. DEEBLE, MA, LMHC

FOLKTOWN
COUNSELING • COMMUNITY • ART MENTORING

1900 Dock Place #3, Seattle WA 98107

To new clients:

Thank you for contacting me for therapy.

This packet includes forms for you to fill out for your first session. It also includes a disclosure form to give you a little bit more about how I practice as your counselor. My purpose in providing these forms in advance is to preserve our first session from unnecessarily paperwork. If you are unable to complete the paperwork I have copies in my office that you can complete during the session.

Regarding forms: the intake form is a "protected" word document, open it as a read only file, fill it out, then save it under your own name and email it back. The disclosure form is a pdf file and requires Adobe Acrobat software on your computer.

I look forward to working with you,

Robert Deeble

Robert E. Deeble, MA, LMHC
Licensed Therapist & Clinical Supervisor
1900 Dock Pl., Ste. 3, Seattle, WA 98107
Email: Robert@folktowncounseling.com
www.folktowncounseling.com • (206) 274-5889

THIS PACKET INCLUDES:

Attachment One: ***Welcome Letter & Disclosure Statement*** provides you with basic information about me and my counseling practice, rates and policies.

Attachment Two: ***Credit Card Authorization*** (optional) allows me a backup form of payment for missed sessions or for amounts not covered by insurance payments.

Attachment Three: the ***Intake Form (attached separately)*** provides me with basic information about you.

CHECKLIST FOR COMPLETING PAPERWORK:

- Read, sign and date the **Disclosure Form** and bring it with you for your first appointment.
- Complete the **Intake & Credit Card Form** (in MS Word) to email it to: Robert@folktowncounseling.com

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DISCLOSURE STATEMENT

General: Asking for counseling can be difficult. I would like to help you in this process by letting you know what you can expect from me as your counselor and the services I provide. I also wish to clarify my administrative policies to avoid misunderstandings. The State of Washington also requires counselors to provide their clients with certain information. You will find all of this information in this statement.

Please read through all the material provided and let me know if I can answer any questions for you. Counseling will be provided on the condition that the counselee (client/patient) understands and accepts these conditions.

Robert E. Deeble, LMHC, Counselor | Clinical Supervisor:
Licensed Mental Health Counselor: LH60090293
National Provider Identification Number (NPI): 1124257795
Bachelors of Liberal Arts, Azusa Pacific University, 1989
Masters in Counseling Psychology, The Seattle School of Psychology and Theology 2006

Contacting me: Please enter **206-274-5889** into your phone; this is my office number and simultaneously dials my cell phone. If in Crisis: call 911, Seattle Crisis Center (206) 461-3222, or the King County Crisis Clinic: (800) 244-5767 ***then*** alert me to your situation. If I do not pick up please leave a message. I prefer to keep Email correspondence to scheduling concerns.

Therapeutic Approach and the Counseling Process: My psychotherapy practice is based on a psychodynamic modality (sometimes referred to as existential or humanistic psychotherapy) that examines the relationship between client and therapist as the primary agent of change for the client. This approach relies heavily on analyzing transference and counter-transference in therapy and at times may include some self-disclosure by the therapist for the benefit of the client. I attempt to use those encounters to help a client better understand their self within a relational context. It is these relational patterns that develop in the counseling relationship that I believe allow a patient to gain a better awareness of him or herself and develop greater insight into the nature of their problem(s). As your counselor I try to *explore* your concerns, assist you in uncovering deeper issues that may be of influence in your life and to discover with you relational patterns that occur as you interact with me on a consistent basis. I strive to view the lives of my clients with a sense of curiosity over any one clinical or scientific position, having said that, my counseling approach is based off psychodynamic, existential and modern psychoanalytic theory.

Choosing a counselor: You should choose one counselor who best suits your needs within a season of time. As professional ethics dictates I do not knowingly counsel clients who are in multiple counseling relationships. Please advise me if you are currently in treatment or wish to pursue treatment with a different professional.

Confidentiality: As your counselor I am committed to the strictest ethical standards of confidentiality. Your identity and ongoing therapy will be kept strictly confidential with the following exceptions:

1. Child Abuse: If I have reasonable cause to believe a child has suffered neglect or abuse, I am required by law to report it to the Washington Department of Social and Health Services. The requirement does include current and past offenses committed. It does include past abuse you suffered if children are currently in danger from the same offender that abused you.
2. Threat of harm to self or others by law may need to be reported to family and or appropriate mental health or law enforcement professionals. I may disclose your confidential mental health information to any person if I reasonably believe disclosure will avoid or minimize imminent danger to your health or safety, or that of any other individual. I may seek hospitalization for you, contact someone else who can provide protection, and/or contact the potential victim or the police.

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DISCLOSURE STATEMENT

- *Confidentiality continued*

3. Adult and Domestic Abuse: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I am required by law to report it to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must report it to the appropriate law enforcement agency and DSHS.

4. Case records and testimony may be subpoenaed by court order.

5. Periodic professional consultation (described below).

Scheduling of Appointments: I work, at the minimum, on a weekly basis with clients. Once we agree to a regular day and hour this will become your hour that I reserve for you each week. You are responsible for payment of that hour. No-shows or late starts are charged at the full hourly rate.

Fees: I accept cash, check or credit card at the time service or with a monthly fee paid on the first session of each month. At times I can offer a sliding scale for clients who demonstrate financial hardship to afford therapy. As an out of network provider my services are available for reimbursement by most insurance carriers.

• Standard fee for individual or couples counseling (53 min.) is $125, paid at the time of service,
-or-
• $450 per month pre-paid on the first session of each month. Please note, the monthly option, which has a built in discount, does not allow for cancellations. The fee amount is paid each month regardless of sessions attended or cancelled. Should therapy end prior to the end of the month the unused portion of the monthly fee will be refunded.

Initial consultations. I do not offer free initial consultations. Your first session will be charged at the rate we agree to in our first visit. An initial consultation will not commit you towards further sessions.

Canceling and rescheduling: As a part of a mutual commitment to therapy I require 48 hours in advance to cancel an appointment and request that you make a reasonable attempt to reschedule within the week. Cancellations under 48 hours are charged at the full rate. I offer phone or Video sessions when transportation or health issues are factors.

Duration and Termination: our work is considered an ongoing relationship unless you state upfront a specific time frame to be in therapy. The duration of the work depends on when you feel ready to transition out of therapy. Often clients feel anxious about telling their counselor that they are ready to discontinue, please feel free to discuss this with me even if you see it as a temporary pause. Ending treatment is as important as starting treatment so I encourage you to discuss this in session. I am also happy to provide referrals to further your treatment.

Professional Consultation: To maintain a clearer perspective for the clients I serve; I keep regular clinical consultation with other professionals. Currently I contract with Dr. Roy Barsness, PHD for clinical consultation. "Identifying information" is not shared in these consultations except under a crisis situation. Your agreement to this disclosure grants me permission to disclose information for the purpose of clinical consultation.

Medications: I aim to be holistic in my practice and believe that certain psychological problems have a physical component. I may advise my clients to seek medical consultation in addition to our work. Despite having a clinical familiarity with medications and natural remedies, I cannot prescribe or provide medication. I can, at your discretion, work in cooperation or refer other medical providers and professionals for you in your best interest.

1. **CONFIDENTIALITY**: I understand and accept the statement on confidentiality.

   INITIAL ___

2. **FEES: (check one)**.
   - ☐ Individual / Couples Counseling – Session Rate $125 per session (Payment at time of service)
   - ☐ Individual / Couples Counseling - Monthly Rate (Pre-paid each month) $ 450 per month
   - ☐ Other arrangement:

Payment at the Time of Service is made at the end of each weekly session. I provide a statement at the end of each month for clients to submit to insurance for partial reimbursement. 48 hours advance notice is required to cancel an appointment.

Monthly Pre-Payment is paid on the first session of each month. This is designed to consistently budget for therapy and fosters a better environment for ongoing work. The monthly fee remains the same regardless of a 4-week or 5-week month and allows therapist and client to use vacation or sick leave without a cancellation fee or refund. Should counseling terminate mid-month, the unused portion of your payment will be refunded. A statement is provided at the end of each month to submit to insurance.

Insurance: it is your responsibility to know "how much your insurance will pay for counseling and whether you have met your deductible." Clients are responsible for payment regardless of insurance reimbursement.

3. THIS DISCLOSURE: I (we) have read this disclosure form and have been provided a copy of these counseling policies as mandated by the State of Washington. I understand its terms, and agree that my counseling with Robert E. Deeble, will be subject to such terms and conditions.

   INITIAL ____

4. EMAIL CORRESPONDENCE: If you wish to have me communicate via electronic mail (email), please initial below. Be aware that I do not have encrypted email software and cannot guarantee that information transmitted by email will not be intercepted or read by other parties. By initialing and signing this form you are agreeing not to hold Robert E. Deeble / Folktown Counseling LLC responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from him.

   INITIAL ____

5. RECORDING: With your permission I may, on occasion, audio record for the purpose of note taking. Recordings are erased following notation. I do not provide tapes back to clients. Please initial if you are comfortable with this practice otherwise leave blank:

   INITIAL ____

_____ _____
Client Date

_____ _____
Client (couples) Date

_____ _____
Counselor Date

Credit Card Payment Authorization Form

Sign and complete this form to authorize Robert E. Deeble / Folktown Counseling LLC. to debit your credit card as listed below. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

This is permission for therapeutic treatment fees accrued while in treatment with Folktown Counseling LLC and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring payment to your session, or for sessions not paid for by insurance carriers. Credit cards may also be debited in the event that you fail to give adequate notice by phone or email to cancel a scheduled appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I authorize Folktown Counseling LLC

(full name)

to charge my credit card account (indicated below) for fees accrued with missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of $125 per 53 minute session + an additional 4% for the fee that I am charged by my credit card processing company.

Billing Address: City:

State: ZIP:

Phone#: Email:

Account Type: Drop Down

Cardholder Name:

Account Number:

Expiration Date: CVV:

SIGNATURE DATE

I authorize Folktown Counseling to charge the credit card indicated in this authorization form according to the terms outlined above. This authorization is for the services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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INTAKE FORM (To be filled in by patient)

PERSONAL INFO

Name: Age: Date of Birth:

Phone: Email:

Education: Gender: Vocation:

Relationship Status How did you hear about this office?

Mailing Address:

Are there any concerns receiving correspondence from this office to the contact info you provided? Yes No

Emergency Contact (name & number):
In an emergency do I have permission to contact this person, identifying myself as your counselor? Yes No
If no please indicate your concerns:

INSURANCE INFO

Insurance Company & Phone Number:

Insurance Id / Group Number: / Employer:

Policy holder? If not state name, address & phone of holder:

MEDICAL & PSYCHOLOGICAL HISTORY

Please state, if you are comfortable doing so, any current medical conditions you are experiencing:

Please list current or past medications taken for medical, emotional or psychological issues:

Share briefly your interest in exploring counseling:

List current or former counselors, psychiatrists or other professionals you have counseled with:

EMAIL CORRESPONDENCE: If you wish to communicate via electronic mail (email) please initial below. Be aware that I do not have encrypted email software and cannot guarantee that information transmitted by email will not be intercepted or read by other parties. By initialing below you agree not to hold Robert E. Deeble / Folktown Counseling LLC responsible for any breach of confidentiality that may occur by information contained in emails.

INITIAL :