Cindy Gregory, Certified Counselor
Mosaic Counseling Services, LLC
Office location : 112 W. Railroad, Suite 201 : Cle Elum, WA 98922 : 509.674.5144
Mailing address : PO Box 671 : Roslyn, WA 98941-0671

Name _____ Home Phone _____ Cell Phone_____

Physical Address _____ Date of Birth _____

Mailing Address, if different _____ OK to leave phone messages? Y N

City _____ State _____ Zip Code _____ e-mail _____

In case of emergency, who should be contacted? Name _____

Address _____ Phone numbers _____

Relationship to you _____

****

How were you referred to Mosaic Counseling? _____

In your own words, what brings you in for counseling services at this time? _____

_____

Have you seen a counselor in the past? Y N If so, who and when _____

_____

Was counseling helpful for you? Y N Have you been psychiatrically hospitalized? Y N

Have you ever felt suicidal? Y N Have you attempted suicide? Y N Is there a family history of suicide? _____

Primary Care Physician _____ Phone _____

Current prescribed medications _____

_____

Current over the counter medications, supplements, &/or vitamins _____

_____

Other health care providers _____

_____

Cultural/Ethnic

How would you describe your cultural/ethnic background? _____

What cultural/ethnic influences are important to you at this time? _____

Spiritual/Religious

Do you identify with any spiritual or religious beliefs? Y N

If so, would you like to include those beliefs in our conversations? Y N

Legal

Are you involved in any active cases (traffic, civil, criminal) at this time? Y N

If yes, please describe and indicate the court, hearing/trial dates, and charges: _____

_____

Do you have an attorney or probation/parole officer? Y N If so, who? _____

Do you have a history of any of the following: Traffic violations Y N DWI, DUI, MIP Y N

Criminal involvement Y N Civil involvement Y N

Military

Military experience? Y N Combat experience? Y N Branch of service _____

Date of induction and discharge _____

Abuse

Did you experience child abuse? Y N

If yes, please check which type(s): _____ Sexual _____ Physical ____ Verbal ____ Mental/Emotional

Other childhood issues: _____ Neglect ____ Inadequate nutrition ____ Head injury

Comments regarding childhood development: _____

_____

Social Relationships

How do you get along with people? Please check all that apply.

___ Affectionate ___ Aggressive ___ Avoidant ___ Follower

___ Fight/Argue often ___ Friendly ___ Leader ___ Outgoing

___ Shy/Withdrawn ___ Submissive ___ Other (specify): _____

Marital Status (more than one answer may apply)

	Single		
	Legally Married	Length of time	
	Divorced / In Progress	Length of time	
	Separated	Length of time	
	Unmarried, living together	Length of time	
	Widowed	Length of time	
	Annulment	Length of time	

Total number of marriages _____

Assessment of current relationship (if applicable) ___ Good ___Fair ___ Poor

Number of children ____

Chemical Use History

Substance	Method/Amount	Frequency	First Use	Last Use
Alcohol				
Marijuana				
Meth-Amphetamine				
Heroin / Opiates				
Caffeine / Nicotine				
Other				

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Disclosure of Information

Washington State Law requires that all counselors provide their prospective clients with certain information. The purpose of this requirement is to assist you in making an informed decision prior to, during and after the counseling process. Clients are not liable for any fees or charges for services rendered prior to receipt of this Disclosure Statement.

Professional Qualifications and Experience:
- Washington State Certified Counselor # CL60128147
- Bachelor of Arts, General Psychology, Central Washington University
- More than twenty years experience in the mental health field
- Dialectical Behavior Therapy
- Lifespan Integration

Therapeutic Orientation:
As a counselor, I believe that within you lies all you need to accomplish your goals. Over the years, I've accumulated skills that may be helpful to you on your journey of change. I will work with you to identify what concerns keep you from moving toward your goals. We will collaborate to determine the most appropriate methods of treatment. My commitment to you is to provide a safe, confidential, and mutually respectful environment; an environment that fosters change. Additionally, we will discuss whom you may wish to include in your plan of treatment.

Fee Information:
Please read, discuss as needed, and sign, the Fee for Service Agreement that is with your intake paperwork packet.

The following are required by Washington State Law:
- "... the certification of an individual under this chapter does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment." RCW 18.19.060.
- As a Certified Counselor, I am required to have a supervisory/consultation agreement with an approved supervisor/consultant. This is in place with Marti Bradley, Clinical Social Worker. WAC 246-810-025.
- As a Certified Counselor, I am not credentialed to diagnose mental disorders or to conduct psychotherapy as defined in WAC 246-810-010.

I must adhere to the ethical and professional standards of the Washington State Department of Health. If you feel that I have acted in an unprofessional or unethical manner, please bring this to my attention so we can clarify and solve the problem. If this does not resolve the issue, you may contact the State of Washington Health Systems Quality Assurance at: HQSA Complaint Intake, PO Box 47857, Olympia, WA 98504-7857, 1.800.525.0127 or 360.236.4700, e-mail: HSQAComplaintIntake@doh.wa.gov

Please sign below to attest you have read and understand the above information, and understand all WACs and RCWs cited here have been made available to read and/or have copies made for you.

Client Signature _____ Today's date _____

Cindy Gregory _____ Today's date _____

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CLIENT CONSENT FOR TREATMENT

I hereby attest that I have voluntarily entered into treatment at Mosaic Counseling Services, LLC. Further, I consent to have treatment provided by Cynthia (Cindy) Gregory, a Washington State Certified Counselor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that either party may discontinue the counseling at any time. Open communication between the client and counselor regarding a decision to discontinue services will help facilitate an appropriate plan for discharge.

_____	_____	_____
Client Name, Printed	Client Signature	Date

Confidentiality

Confidentiality of the information my clients share with me is very important. Client files are available only with their written permission. If the client is a minor child, the responsible parent or guardian's signature is required.

Duty to warn

The Revised Code of Washington (RCW) requires me to report suspected or known abuse and / or neglect of children or vulnerable adults.
If you are involved in any litigation and the court is informed of the service I provide, you may be waiving your right to keep your records confidential.
If you, the client, threaten to harm either yourself or someone else, and I believe the threat to be serious, I am obligated under the RCW to take whatever action deemed necessary to protect people from harm.

Cancellation and No Show Policy

Clients who are inconsistent in keeping their therapy appointments rarely receive benefit from their therapy. Appointments are scheduled for your therapy, and if you are unable to keep an appointment or will be late, it is your responsibility to contact this office. Clients will be charged full fee for not showing for an appointment or canceling with less than 24 hour notice.
Unless notified of late arrival, sessions will be canceled at 20 minutes past the scheduled start time and noted as a no show. Frequent short notice cancellations or no shows may result in closing services until you are ready to make a commitment to yourself, me, and counseling.

I have read and understand the above statements and certify that the information provided is true and correct. I understand I may request copies of all forms I have signed included in this intake package at any time.

_____	_____	_____
Client Name, Printed	Client Signature	Date

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FEE FOR SERVICE AGREEMENT

Effective August 1, 2016

Please understand that payment for your services is considered part of your treatment.

Please read and sign that you agree to this Fee for Service Agreement.

Initial contact via phone or in person, 15 - 20 min.:	No Fee
Initial Intake Interview (expect up to 90 minutes):	$140
Counseling appointments:	$90/hr.
Each additional 15 minutes:	$25/15 min.

_____ I agree to pay with cash or check for my session, due prior to each session. If I pay with a check, I understand the cost of any returned checks will be my responsibility.

_____ I understand Mosaic Counseling Services, LLC, does not bill insurance. I will receive a receipt for each session that I may choose to submit to my insurance.

I have read the above information and agree to assume responsibility of the Fee for Service Agreement and to pay my Certified Counselor, Cindy Gregory, of Mosaic Counseling Services, LLC, as indicated by my signature below.

_____	_____	_____
Client Name (Printed)	Client Signature	Date

* * * * * * * * * * * * * *

Note, with date and initials, any changes or arrangements here: _____
_____