NEW CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Erin Mullins MA. LMHCA, ACHt, LMT, CSP, RYT. Information collected about new clients is confidential and will be treated accordingly.

My practice is located at 14307 23rd PL. NE Seattle, WA 98125

206-388-6907

erin@erincmullins.com, www.erincmullins.com

Please feel free to park for free in front of the building and come to the front door.

CLIENT DETAILS

Name: ______________________Gender: Pronouns:

Street Address: ____

City: ______________________State: ______________________Zip Code: ________

E-Mail: ______________________Phone: ______________________

Date of Birth: ____/____/_____

EMERGENCY CONTACT

Emergency Contact Name: ______________________

Relationship: ______________________

E-Mail: ______________________Phone: ______________________

RELATIONSHIP STATUS

Marital/Partnered Status:

Length of Current Relationship(s): ______________________

Assessment of Current Relationship(s): ☐ Poor ☐ Fair ☐ Good ☐ Great

EMPLOYMENT

Are you currently employed? ☐ Yes ☐ No

Employer's Name: ______________________Occupation: ______________________

Street Address: ____

City: ______________________State: ______________________Zip Code: _________

Phone: ______________________

MILITARY HISTORY

Military Experience? ☐ Yes ☐ No Combat Experience? ☐ Yes ☐ No

Branch: ______________________Length of Service: ______________________

Type of Discharge: ______________________Rank: ______________________

HOUSEHOLD AND FAMILY

List your current immediate family:

Name: ______________________Relationship: ______________________Age: _____

-Living with you? ☐ Yes ☐ No

Name: ______________________Relationship: ______________________Age: _____

-Living with you? ☐ Yes ☐ No

Name: ______________________Relationship: ______________________Age: _____

-Living with you? ☐ Yes ☐ No

Name: ______________________Relationship: ______________________Age: _____

-Living with you? ☐ Yes ☐ No

Name: ______________________Relationship: ______________________Age: _____

-Living with you? ☐ Yes ☐ No

MEDICAL INFORMATION

Primary Care Physician and other significant providers:

_______________________Phone: _______________________

Street Address: ____

City: _______________________State: _______________________Zip Code: _________

List any current medical problems: ____

List any current medications: ____

List any current allergies: ____

Have you taken medication for a mental health concern? ☐ Yes ☐ No

Medication Name: _______________________Dates: _______________________

-Was it helpful? ☐ Yes ☐ No

Medication Name: _______________________Dates: _______________________

-Was it helpful? ☐ Yes ☐ No

Medication Name: _______________________Dates: _______________________

-Was it helpful? ☐ Yes ☐ No

LIFESTYLE

Please tell me about your sleep, movement/exercise and nutrition:

Have you experienced any significant changes/stressors/losses in the past year?

Please tell me about your favorite ways to release stress and your known coping skills.

SPIRITUALITY

As a transpersonal practitioner I can explore and support spiritual and transpersonal concerns.

Do you include spirituality in your life? If yes, are you interested in including it in counseling?

If you wish, please share about spiritual orientation and practice:

MEDICAL INSURANCE

Primary Insurance Company: ______________________

Policyholder's Name: ______________________Group #: ______________________

ID #: _______________Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _______________

PREVIOUS COUNSELING

Have you previously seen a counselor? ☐ Yes ☐ No

-If yes, who and where: ____

Approximate dates of counseling: ____

Reason for counseling: ____

Do you have a previous mental health diagnosis? ☐ Yes ☐ No

-If yes, describe: ____

What did you find most helpful in therapy? ______________________________________

What did you find least helpful in therapy? ______________________________________

Have you used psychiatric services before? ☐ Yes ☐ No

SUBSTANCE USE

Do you currently consume alcohol? ☐ Yes ☐ No

- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
- How many drinks? _____drink(s)

Do you currently smoke? ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____________________

Do you currently use any other drugs? ☐ Yes ☐ No

- What other drugs do you take? ____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Have you ever received treatment for alcohol or drug use? ☐ Yes ☐ No

- Where did you go? ____
- ☐ Inpatient ☐ Outpatient

Have you ever felt the need to cut down on your drinking/drug use? ☐ Yes ☐ No

Have you ever had other people criticize your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning? ☐ Yes ☐ No

CURRENT CONCERNS

What are the main reasons for which you are seeking counseling?

___

When did these first start?

___

What would you like to experience from counseling?

___

What is the most concerning issue for you right now?

___

Please tell me about your strengths & gifts?

___

Please tell me about your favorite ways to relieve stress. What are your coping skills?

FAMILY CONCERNS

Please check ANY of the following family concerns you are experiencing: Also note past

☐ - Abuse / neglect
☐ - Arguing
☐ - Alcohol use
☐ - Birth of a family member
☐ - Death of a family member
☐ - Divorce / separation
☐ - Drug use
☐ - Education problems
☐ - Financial problems
☐ - Inadequate health insurance
☐ - Inadequate housing / feeling unsafe
☐ - Infidelity
☐ - Feeling distant
☐ - Job change
☐ - Job dissatisfaction
☐ - Loss of fun
☐ - Lack of honesty
☐ - Lack of intimacy
☐ - Marriage issues
☐ - Physical fighting

List any other family concerns: ____

PERSONAL CONCERNS

Please select the severity of EACH of the following concerns:

- Alcohol use - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Anger - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Anti-social behavior - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Anxiety / paranoia - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Appetite/food related - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Binging / purging - ☐ None ☐ Mild ☐ Moderate ☐ Severe

- Crying - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Decreased sex drive - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Drug use - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Excessive worrying/rumination - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Fears/Phobias - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Headaches / migraines - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Hopelessness - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Hyperactivity - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Impulsivity - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Inability to focus - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Indecisiveness - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Low energy - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Low self-worth - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Nausea / indigestion- GI - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Nightmares - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Pain- ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Panic attacks - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Poor concentration - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Problems at home - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Racing thoughts - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Restlessness - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Sadness - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Self-love - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Self-harm - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Sleep deprivation - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Spiritual concerns - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Suicidal thoughts - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Trauma flashbacks - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Unresolved guilt - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Work issues - ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Workaholic (working too much) - ☐ None ☐ Mild ☐ Moderate ☐ Severe

List any other concerns: ____

SIGNATURE

Signature: _______________________Date: _______________________

Print Name: ______________________

GOOD FAITH ESTIMATE FOR MENTAL HEALTH SERVICES

No Surprises Act - for use by mental health providers no later than January 1, 2022

Instructions

Under Section 2799B-6 of the Public Health Service Act, mental health providers are required to provide a good faith estimate of expected charges for services to clients who are not enrolled in a plan, coverage, or federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling mental health services.

This form may be used by the mental health providers to inform uninsured or self-pay clients of the expected charges they may be billed for receiving certain services. A Good Faith Estimate must be provided **within 3 business days**. Information regarding services must be furnished **within 1 business day** of scheduling a service to be provided in 3 business days, and **within 3 business days** of scheduling a service to be provided in at least 10 business days.

Fill in the form with the appropriate information. The use of this form allows you to be in compliance with the Good Faith Estimate requirements.

Disclaimer: This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care. The estimate is based on information known at the time the estimate was created. This estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this estimate, you have the right to dispute the bill. You may contact the provider or facility listed on this form to let them know the billed charges are higher than the estimate. You can ask them to update the bill to match the estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises. Keep a copy of this Good Faith Estimate in a safe place or take a picture of it. You may need it if you are billed a higher amount.

Teletherapy invitation from Erin Mullins, MA, LMHCA, ACHt, CST, LMT, RYT

Please make sure to verify cost with your insurance company and they cannot guarantee the

information given to us. You will be liable for any cost not covered by the insurance company.
To access Erin Mullins's online "waiting room", please click on the link sent via therapy appointment software, where you will be asked to sign in using your name. Once you are
signed in, you will wait in a virtual "waiting room" until Erin Mullins opens the session at the
time of your appointment. As a reminder, please be sure to have your webcam turned on.
To assure your teletherapy session is not interrupted, we ask that you check your link to verify you can
login **24 hours prior** to your appointment.

_
Client or Parent/Legal Guardian Signature Date

____

________________________________ ________________________

Client'sName Relationship to Client

CREDIT CARD AUTHORIZATION

NO SHOW/LATE CANCELLATION FEES, INSURANCE COPAYS & DEDUCTIBLES, THERAPY FEES
In order to provide you and other patients of, *Erin Mullins MA, LMHCA, ACHt, CSP, LMT, RYT,* the best possible care, a minimum
of 48 hours notice is required to cancel or reschedule your appointments.
I, ____, understand the importance of notifying
my *therapist* at least 48 hours prior to my scheduled appointment that I am not able to keep my
appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid
being charged the session fee.
I, ____, give *Erin Mullins,* the

authorization to charge my credit card for each missed therapy session where 48 hours notice is not
given and for each missed therapy session where I fail to call and show for the appointment. This
credit card will also be used for all fees that have not been paid within 60 days (unless other
arrangements for payment have been agreed upon in writing between me and my therapist). I will be
provided a receipt for all payments upon request. This card may also be used for payment of services
upon my request (co-payment, deductibles, and fees).
I understand that I may revoke this agreement at any time by providing a request in writing. I am also
aware that when psychotherapy services rendered by *Erin Mullins,* have ended, this form shall
be shredded once I am terminated from treatment.
I am requesting that this card be used for payment of services (co-pay & fees):
_____Yes _____No
Name on card:
____
Card Number -- _______
Expiration Date: ___________/ ____________
Code: ____________Street Address: ____________________________Zip Code:
____
Email address for receipt:
____
Patient Name (printed):
____
Patient (or Parent/Guardian)/Card Holder Signature:
____Date:
____

PERMISSION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Name of Client: ____
Date of Birth: ____/____/_____
I hereby give consent to ________________________________(*name of therapist or*

practice) to exchange pertinent and relevant information with the individual/agency identified below.
Name: ____
Agency: ____
Street: ____
City/State/Zip: ____
Phone: ________________________________Fax: _________________________
Email: ____
Information obtained may include (*check all that apply*):
_____Clinical impressions and records
_____Academic records (cumulative records, report cards, standardized test scores, etc.)
_____Health records
_____Special education records (504 plan/IEP/PPT/team minutes, evaluations)
_____Psychiatric evaluations
_____Psychological evaluations
_____Social work evaluations
_____Educational evaluations
_____Speech and language evaluations
_____Other evaluations (vocational, occupational, etc.): ______________________________
_____Other: ____
Client or Parent/Guardian Signature: ____
Print Name: ____
Relationship to Client: ____
Date: ____________________

HIPAA Compliance Privacy Notice

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully.*
Name of Therapist/Practice: ____
Address: ____
Phone: _________________________Email: _____________________________________

Your Rights

You have the right to:

• Get a copy of your paper or electronic medical record.
• Correct your paper or electronic medical record.
• Request confidential communication.
• Ask us to limit the information we share.
• Get a list of those with whom we have shared your information.
• Get a copy of this Privacy Notice.

• Choose someone to act on your behalf.
• File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way we use and share information, as we:
• Tell family and friends about your condition.
• Share information in a disaster relief situation.
• Share information for marketing, sales, or fundraising purposes.

Our Uses and Disclosures

We may use and share your information as we:
• Treat you.
• Run our organization.
• Bill for your services.
• Help with public health and safety issues.
• Perform research.
• Comply with the law.
• Respond to organ and tissue donation requests.
• Work with a medical examiner or funeral director.
• Address workers' compensation, law enforcement, and other government requests.
• Respond to lawsuits and legal actions.

ELECTRONIC COMMUNICATION POLICY

To maintain clarity regarding our use of electronic communication during your treatment, I have prepared the following policy. Some electronic communication may put your privacy at risk and can be inconsistent with the standards of my profession.
Therefore, this policy has been prepared to ensure the security and confidentiality of your treatment and to make sure it is consistent with my profession's ethics and laws. If you have any questions about this policy, please discuss them with me.

Email Communications and Text Messaging

I use email communication and text messaging only with your permission and only for administrative purposes, unless we have made another agreement. Email exchanges and text messages with my office should be limited to topics like scheduling and changing appointments and billing matters. Please do not email or text me about clinical matters because these are not secure ways to contact me.
If you need to discuss a clinical matter with me, please call me so we can discuss it on the phone or wait until your next therapy session so we can discuss it in person.
Because text messaging is a not secure and is an impersonal mode of communication, I limit texting with clients to quick check ins about appointments and scheduling. Please do not text able our counseling work together

Social Media

I do not communicate with, or contact, any of my clients through social media platforms except through my professional pages. If I discover that I have accidentally established an online relationship with you, I will remove that connection. These types of casual social contacts can create significant

security risks for you.
I participate on various social networks, socially and/or professionally. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have the potential to compromise our professional relationship. I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions, we can discuss them during your therapy sessions**.**

CONSENT TO USE TOUCH IN THERAPY

With your consent, and according to my clinical judgment, I may use touch in our therapeutic work together to benefit your healing. I will draw from techniques in which I have received training, including *Sensorimotor psychotherapy, craniosacral therapy, structural integration, visceral manipulation, intraoral/nasal, pregnancy and post-partum support, end of life support, scar work, somato-emotional release, massage therapy, nerve work, yoga, reiki, polarity therapy, subtle energy, sourcepoint, morphogenic field work.* ______________
I believe the use of touch is a powerful tool for clients to get grounded and help them move through body-based trauma reactions. As infants, we experience feelings of being loved and nurtured through touch. Throughout our lives, our non-verbal touch experiences determine how we feel about ourselves and how we connect to others.
The interventions used in our sessions may include:

- Touching your hand or arm to reduce anxiety
- Positioning your feet, hands, and shoulders to create awareness of your body in relation to the earth
- Holding your physical tension so that you can relax
- Correcting your breath and posture to improve oxygen flow
- Interacting together with an object during role play to process past experiences

At each session, I will make sure you understand the nature and purpose of using touch in therapy and evaluate the appropriateness of touch in your situation. I will also check your comfort level regarding the location of touch, the amount of pressure, and the length of contact before and during each session.
The touch I provide in therapy is never sexual. Sexual touch of clients by therapists is unethical and illegal. I will never use touch in a manner that is shaming or derogatory, or to deliberately stimulate clients sexually.
While touch interventions are expected to enhance our therapeutic work together, they may have unintended side effects. They may trigger emotions, memories, or physical reactions that may be upsetting. I encourage you to share and process uncomfortable feelings and sensations with me as they arise, and you can revoke your consent of touch at any time.
Your needs and wishes take priority over any therapeutic touch intervention. You may request not to be touched at any time during our therapy sessions, even if you previously provided consent. You might also change your mind about the frequency and type of touch that feels comfortable from session to session.

I have read the above informed consent, understand, and agree to it. I will also make my concerns and considerations known to my therapist as they arise.
Client signature: _______________________________Date: _______________
Printed name: ______________________________________