



Disclosure Statement and Treatment Agreement

The State of Washington requires providers of psychological and counseling services to disclose specific information to their clients. This disclosure provides that information and must, by law, be acknowledged through the parent's signature. If you have any questions about the information contained in this statement, or about any other aspect of your child's counseling, please ask me at any time. Please read the following carefully. I will need to have a signed copy for my files and one for you to keep.

I am a Licensed Mental Health Counselor in the State of Washington. My State Certification number is License #LH00011132. I am required to tell you that this certification, by the State of Washington's Department of Licensing, does not imply set practice standards or guarantee the effectiveness of any treatment. You have the right to terminate or refuse therapy at any time. You have the right to ask any questions about my professional background and training, my approach to therapy, and/or policies. I am not a medical doctor, and I cannot make recommendations regarding medication. I can, however, refer you to a medical physician or psychiatrist if you have questions in this regard.

In 1969, I received my Bachelor of Arts Degree, and then in 1970, I received my Teaching Credential from San Jose State University, San Jose, CA. I taught until 1988, when I earned my Master's in Student Personnel Services with a focus on counseling children from Virginia Tech.

I have worked in a school setting since 1970 and with Lake Washington School District as an Elementary Counselor from 1991 until 2012. I have co-facilitated Wally's Club Seattle since 1997 and Casey's Clubhouse Kirkland since 2019. I retired from Lake Washington School District in 2011.

I continue my work with children, teens, parents, and individual adults.

Confidentiality

What individual children say within these sessions will be held confidential. Under State law, information concerning your child's progression may only be released to your other providers with your written consent. The only exceptions are the following: 1) If I am informed that you or your child intends to commit a crime or harmful act to yourself or another person; 2) If I have reasonable cause to believe that a child has suffered abuse or neglect; 3) If I am served a court order that requires me to release my records. It is my policy to discuss these instances of required disclosure with you.

For professional growth, monitoring, and support, I consult another professional. To gain more insight, I may discuss your child's treatment. If this is not acceptable to you, please inform me. In some cases, it might be useful to discuss your situation with a professional who has worked with your child or family (1.e. teacher, physician, previous counselor, etc.). Should this occur, I would discuss the benefits of such an exchange of information and, together, determine whether it is a suitable contact. In such cases, I will seek your written permission for this exchange of information.

Emergencies

Messages can be left on my voicemail at (425) 503-3925 or my email at leslie@lesliefieldscounseling.com. I will make every attempt to get in touch with you promptly.



Service and Fees for Individuals

\$160.00 set up fee (this includes reading files, contacting other professionals or other persons involved (with written permission), setting up paperwork, and working with any other organization involved)

\$160.00 Office Visit (50 minutes)

\$160/hour for additional paperwork, reports, phone calls, collateral contacts, and emails.

Sliding Scale is available in some situations.

You are to bill your insurance company.

Payment is due at every session unless other arrangements are made.

You must cancel within 24 hours, or full payment for the session is due.

By signing below, you acknowledge that you have read and agree to the above, and that you have received a copy of Washington State’s HIPAA information.

Signature of Parent/Guardian

Date signed

Printed name of Parent/Guardian

Phone number

Signature of Therapist

Date signed



Policy for Parents

The first four or five sessions with a child are generally evaluative.

If I am seeing your child in individual sessions, I appreciate you telling me at the beginning of the session whether there have been any unusual happenings since our last session.

I abide by and respect the ethical code of confidentiality in my work. The information and nature of the sessions will not be disclosed to any person or agency without your prior consent to do so. **There are two exceptions, which are mandated by Washington law:** I must report any life-threatening situations or any suspected physical or sexual abuse. In such cases, I will take necessary steps to protect the safety and well-being of those concerned.

When working with an individual child, I respect his/her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic services. It is my policy to include children in the room when you wish to talk with me about your child, except for the initial intake. If you would like to see me alone, please make a separate appointment.

Termination of the therapeutic relationship

A final "goodbye" session is essential to the counseling process. As part of your contract with me, you agree to a final session regardless of the reasons for termination.



Client intake: Minor

Please provide the following information by filling out this form and bringing it to your first session. The information you provide here is protected as confidential information.

Client Last Name

Client First Name

Middle Initial

____/____/____
Birthdate Age

Gender ID: Male Female Non-Binary Transgender
 Genderqueer Agender Prefer not to say

Pronouns

Home Address

City ST ZIP

Client Email Address

Client Phone

Cell Home Work

OK to leave message

OK to email

Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred By

____/____/____
Date

Parent / Legal Guardian

____/____/____
DOB

Email Address

Phone

Parent / Legal Guardian

____/____/____
DOB

Email Address

Phone

Are there any conflicts regarding the custody of the client? (if YES, please elaborate below)

NO YES



Family Information

List immediate family members (provide name, age, relationship to client, and where currently living). Also indicate under relationship, adoptive and step relationships.

Full Name	Age	Relationship To Client	Where Living
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Client's Strengths

What are your strengths? What are the best things about you?

Family Strengths

What are your family's strengths?

Developmental History

Were there any concerns or complications during pregnancy or childbirth?



Medical History

<hr/>		<hr/>
Client's Primary Care Physician (PCP)	Clinic Name (if applicable)	Date of last physical
<hr/>		<hr/>
Primary Care Physician / Clinic Address		City ST ZIP
<hr/>		<hr/>
PCP Email Address	PCP Phone	<input type="checkbox"/> OK to contact

- Do you have any current or ongoing medical issues? NO YES
- Have you had any surgeries or been hospitalized for medical reasons? NO YES
- Have you ever had a seizure or seizure disorder? NO YES
- Are you currently taking prescription or over-the-counter medications? NO YES
- Have you had any recent weight loss or gain? NO YES
- Have you ever had any sleep problems or nightmares? NO YES
- Have you ever had a serious head injury or been unconscious? NO YES
- Are there any family members dealing with major medical issues? NO YES

(if YES to any of the above, please elaborate below)



Social Interactions

Please check if any of the following are a concern:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Self-harm/Cutting | <input type="checkbox"/> Relationships with family |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Withdrawal/depressed mood |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Attention-seeking behaviors |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Difficulty managing conflict |
| <input type="checkbox"/> Running away | <input type="checkbox"/> Cruelty to others | <input type="checkbox"/> Inappropriate sexual behavior |
| <input type="checkbox"/> Eating habits | <input type="checkbox"/> Excessive worrying | <input type="checkbox"/> Defiant/Problems with authority |
| <input type="checkbox"/> Sleeping habits | <input type="checkbox"/> Fighting or bullying | <input type="checkbox"/> Relationships with friends/peers |
| <input type="checkbox"/> Immature behavior | <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Generally inappropriate behavior for age |

Please elaborate on any of the items checked above:

Do you make friends easily? YES NO

How many people do you count as friends in real life? 0 1 2 3. 4 or more

Do you participate in sports or extracurricular activities? YES NO



Mental Health

Have you had any previous counseling? YES NO

If yes, where and when? _____

Was it a generally positive experience? YES NO

Are you currently taking medication? YES NO

If yes, what and when? _____

Does anyone in your family have a history of mental health issues/conditions? YES NO

If yes, please elaborate:

Culture/Religion

What ethnicity(s) do you and your family identify with? _____

What religion or culture do you and/or your family align with (if any)? _____

Are there any concerns or difficulties that you are experiencing related to ethnicity, religious orientation, or culture?



Credit Card Authorization Form

_____/_____/_____
Client Name Client Birthdate

Parent/Guardian Name (if different from client) Parent/Guardian Name (if different from client)

Credit Card Information:

If you would like to pay by credit card, I will bill your card weekly or monthly. A cancellation of your appointment needs to be made within 24 hours of appointment time (depending on the nature of the cancellation); otherwise, you will be billed for the session.

Your appointment time is reserved just for you, thus when you commit to a time for the session it is not open or available for other clients. Please be aware of the cancellation policy.

Each billing will carry a \$5.00 service charge.

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

_____/_____/_____
Name as it appears on the card Card Number EXP CVV ZIP

Billing Address City ST ZIP

Cardholder Signature



Informed consent for tele-mental health

“Tele-mental health” is the provision of mental health services when the therapist/consultant and the patient/client are in separate locations, and the services are provided over electronic media. These services rely on several electronic, often internet-based, technology tools, which can include videoconferencing software, email, text messaging, telephone calls, virtual environments, and specialized mobile health apps.

Your therapist/consultant will be providing tele-mental health services via phone calls and/or videoconferencing, using the VSee platform. VSee is a cloud-based, HIPAA compliant and securely encrypted telemedicine platform that allows patients/clients to begin a session by clicking on a URL shared by the therapist/consultant via email.

You will need

1. Access to internet services and the technological tools required to engage with the Doxy.me platform
2. An email address to which your therapist/consultant can send your Doxy.me appointment time and the URL needed to access the “waiting room.”

Benefits and Risks

Benefits can include:

1. Receiving services at times when or in places where services may be otherwise unavailable
2. Receiving services in a fashion that may be more convenient and, at times, required by incapacity or vulnerability to illness
3. Receiving services when you are unable to travel to the service provider’s office

Risks can include:

1. Access to internet connection and cloud services that could cease working or become too unstable to use
2. Malicious actors (hackers) may have the ability to access your PHI as it is transmitted in the process of the tele-mental health service delivery
3. Computer or smartphone hardware can have sudden failures or run out of power mid-session or local services can be interrupted at significant moments and your provider may be unable to reach you to reconnect
4. Lack of in-person contact or presence in the distance between you and your provider may pose a difficulty which may be challenging to impossible to remedy online. These challenges can be processed with your provider as it is deemed important by either one or both of us.

Your Own Environment and Confidentiality

You will be responsible for creating a safe and confidential space during your video sessions. It’s important you consider spaces that are free of other people or of the possibility of being overheard or observed in any other way. Please inquire with your provider if you need assistance with managing your privacy during your video sessions.

