Karen M. Buckley, MSW, LICSW, ACSW, OSWC

Karen M. Buckley, LLC **Face Sheet**

Legal Name:_____

Preferred Name: _____

Maiden name or any other name used. _____

__Married ___Separated ___Divorced ___Widowed ____Partner ___Other
Age:___ Date of Birth: _____

Phone Number: _____
Is it ok to leave a message at this number Yes___No___

Emergency Contact: Name
Relationship to you: Phone Number
Is it ok to leave a message at this number Yes___No___

What is the main thing that brings you here today?
_____

Current living situation: _____
Are you satisfied with this situation? Yes No
What is your main support system? _____
Have you had any major losses in the past year? _____
If yes please explain. _____

List the main stressors in your life today: _____
_____

HEALTH/ MEDICAL HISTORY:
Do you have a medical Provider? Yes No
If yes, list provider _____
Do you take any medications?_____
If yes please list. _____
Have you been on any medications for medical conditions in the past? _____
If yes, please explain._____
Have you ever had psychiatric or mental health counseling? _____
If yes please include Reason: _____
Diagnosis: _____
Medication(s): _____
Do you use tobacco products or Marijuana?
If yes amt. Per day _____ Per Week _____
How frequently do you drink alcohol? _____
What do you usually drink? _____
Do you use any other drugs including marijuana: **TODAY or PAST**
List Drugs & years of use: _____

EMOTIONAL HEALTH: Please check box below:

- ❑ 1. Do you persistently feel sad or empty?
- ❑ 2. Have you lost interest or pleasure in ordinary activities including sex?
- ❑ 3. Have you had a decrease in energy and/or feel fatigued?
- ❑ 4. Have you had sleep disturbances (sleeping too much or experiencing insomnia)?
- ❑ 5. Have you experienced changes in your appetite (lack of appetite or over eating)?
- ❑ 6. Do you have difficulty concentrating, remembering or making decisions?
- ❑ 7. Do you feel guilty, worthless, hopeless?
- ❑ 8. Do you have frequent thoughts of death or suicide?
- ❑ 9. Have you made suicide attempts in the past?
- ❑ 10. Are you frequently irritable?
- ❑ 11. Do you cry frequently and easily?
- ❑ 12. Do you have chronic pains that do not respond to treatment?
- ❑ 13. Do you experience severe insomnia?
- ❑ 14. Do you feel restless?
- ❑ 15. Do you experience surges of energy?
- ❑ 16. Do you experience rapid mood swings?
- ❑ 17. Do you take excessive spending sprees or engage in high-risk behaviors?

Legal History:

1. Do you have any current or pending legal charges? _____
   If yes, please explain. _____
   _____
2. Have you had any alcohol related arrests? _____
3. Have you had any legal charges in the past? _____

_____

Signature ***Date***

_____

If Minor Signature of Paren/Guardian ***Date*** ***Karen M. Buckley, LLC***

Karen M. Buckley, MSW, LICSW, ACSW, OSWC

Disclosure of Information, Policies and Client Agreement

Karen M. Buckley, LICSW, ACSW, OSW-C
WA. State Licensing Number: 020704 LWOOOO5091
Office address: 2608 Pacific Ave. Suite C
Olympia, WA. 98501 (360) 556-0201

Washington State Law Requires the provision of the following information and written acknowledgement of its receipt. Please read it carefully. I welcome the opportunity to discuss any questions or concerns you may have regarding this agreement or my services.

Counselors practicing counseling for a fee must be registered, certified or licensed with the Department of Licensing for the protection of public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of treatment.

Your Rights as a Client in Counseling

As a client in counseling, you have certain rights that are important for you to know. There are also certain limitations to those rights, which you should be aware of. I have provided you with a copy of this detailed information. This includes the *Counseling or Hypnotherapy Clients* brochure printed by the State of WA. I have also offered you a complete listing of the Law Relating to Counselors 18.19 RCW.

Clients are to be informed of the purpose of the Counselor Credentialing Act. The purpose of the law regulating counselors is: (A) to provide protection for public health and safety; and (B) to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

As a client, you have the right to choose counselors who best suit your needs and purpose.

Your rights of Confidentiality Provided by RCW 18.19:

Your counselor cannot disclose any information you have told them during a counseling session except as authorized in RCW 18.19.180 or with your written permission.

6. If I believe that you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other party.

7. If you reveal that you have committed or are contemplating the commission of a crime, I may report that to the appropriate authorities.

8. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child. I am required by law to report this.

4. If you are currently in litigation, or become involved in litigation during treatment or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that process. Although I will request your consent to release information, subpoena or court order to turn over my records and testify can legally obligate me. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation so that I can exercise due caution to protect your privacy.

1. If you are using INSURANCE to bill for your services. If you submit claims to your insurance company, they will likely require some information regarding your treatment with me.

2. If you have been referred to me by an Employee Assistance Program (EAP) I may be required to disclose information to them.

3. If you, the client waives the privilege by bringing charges against me, the counselor.

4. As required under chapter 26.44 RCW

In some cases, it will be useful to the therapy for me to discuss your case with others such as your physician, your former therapist, your case manager etc. In such cases, I will seek your written permission for this exchange of information.

If someone else has directly referred you to me, I may as good business practice, acknowledge to them that you have contacted me and thank them for the referral. I will not discuss your detailed situation with them unless I have your permission.

My telephone number is listed above. I check my calls daily. If you have an emergency and are unable to reach me directly, call 911 or your local Crisis Clinic for immediate help.

You are free to terminate therapy at any time. It is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic benefit to you and the counseling process. Notice of your termination will result in my scheduling other clients in your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice of rescheduling, notice of termination will be assumed and your time slot will be given to the next available client.

Appointment and Fees:

Appointments last for 50 minutes unless we have arranged in advance to meet for longer. Longer sessions will incur an extra charge based upon the time. If you miss a session without canceling, (24-hour notice is required), I will bill you full for that time.

Insurance or other third-party payers will not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate.

My standard fees and rate are discussed with you prior to our sessions. I do offer a sliding scale rate that is available to you. I also have listings of payment dependent on your insurance. Receipts are available to you to document payment and rates. Payment must be received at the beginning of each session. Checks may be made out to me directly. I accept cash and checks. I do not accept gifts or bartering in exchange for counseling. A 35.00 fee will be charged for returned checks. A finance charge may be added on outstanding balances.

If I am doing work related to your treatment that is outside the bounds of our scheduled counseling, I will bill you on an hourly basis for all the time I spend on your case.

If you miss a session without giving 24 hour notice, you will be billed for that time. The charge is $135.00 for a no-show or late cancelations. Insurances do not cover this charge so you will need to pay for this charge.

_____

Initial Date

Billing and Payments:

You are 100% responsible for all services rendered. Insurances typically only cover a portion of your bill. You may also be subject to Co-Pays and Deductible. It is your responsibility to contact your insurance plan to understand what they will cover. In any event you are responsible for all incurred services and are expected to pay your bill.

If you are paying privately, the charge is **$135 a session.** _____

Initial Date

My Training and Approach to Therapy:

Definition of Counseling:

Counseling means using therapeutic techniques to help another person deal with mental, emotional and behavioral problems or to develop human awareness and potential. A registered, certified or licensed counselor is a professional who is paid for providing counseling services.

Education/Training:

I graduated Cum Laude from the University of New Hampshire in Durham, New Hampshire. I earned my Bachelor of Science at this time. I graduated from the school of Family Studies with a focus on Marriage, Family & Child Therapy. I also earned a minor in Women's Studies at this time. I earned my Masters in Social Work from the University of California Los Angeles. Living, studying and working in Los Angeles gave me a wealth of experience in cultural, ethnic and diversity issues. I have furthered my

professional standing by earning my State License and National Accreditation. I am a Licensed Independent Clinical Social Worker in the state of WA. This is the most prestigious level in the field. I have also earned my ACSW. This is a National Accreditation from the National Association of Social Workers. I attended Emory University in Atlanta, Georgia for advance education and internships on diversity and minority. This training focused on poverty, homeless and third-world social issues.

My work has always focused on empowering minorities. I have a special dedication for issues focusing on minorities, women & children. My resume is available to document this history in detail. I abide by the NASW code of Ethics and Standards. This is the highest level of professional standing. I counsel individual, couples and families. I provide a non-judgmental therapeutic approach to counseling. This atmosphere of nurturing and acceptance assists clients in learning skills to enhance their coping and improve their quality of life. Therapeutically I rely on multiple approaches from my advance training. This includes but is not limited to Cognitive Therapy, Behavioral Therapy, Systems Theory, Bowenian Theories, Family Systems Theory, Eco Mapping, Structural, Strategic and psychoanalytic therapies. Robert Ellis, Satire, Milan and Bowen Theories are also used. I also utilize Genograms as an Assessment Tool.

Quality of Services:

If you feel I have behaved in an unprofessional or unethical manner, Please advise me so that the problem will be clarified and resolved. If you feel that this does not resolve the issue, you may contact the following:
Department of Health, Health Professions Quality Assurance Division, PO Box 47869 Olympia, WA. 98504-7869

Client Consent to Treatment

I have read and understand the information provided. I was given the opportunity to ask questions. I understand and agree to the description of confidentiality and its exceptions. I consent to counseling with Karen M. Buckley, LICSW, ACSW, OSW-C. I understand I have the right to terminate counseling at any time I desire. I also understand that Karen M. Buckley, LICSW, ACSW, OSW-C requests notice of my termination. My signature below indicates that I consent to treatment and agree to all the policies explained above. I have also been offered a copy of this agreement. I understand that I am responsible for payment of all services.

_____

Client Signature Date

_____

Parent or Guardian Signature if client is a minor ***Date***