Chuck Britt, MA LMFT
360-336-3882
chuck@selftimeout.org
FAX 866-492-5137
924 South 11th Street, Mount Vernon, WA 98274

ENROLLMENT PACKET

WELCOME TO OUR SERVICES

ALL PERSONAL AND CREDIT CARD INFORMATION IS STRICTLY CONFIDENTIAL.

??? DISCOUNTED OR INSURANCE ???
PLEASE REVIEW THE "???DISCOUNTED OR INSURANCE??? DECISION GUIDE"
THEN CHECK YOUR PREFERENCE BELOW:

CHECK	DISCOUNTED RATES (NO INSURANCE BILLING PROVIDED)		CHECK	INSURANCE RATES (YOUR PRIMARY INSURANCE WILL BE BILLED)	
	INTAKE SESSION: $110.00	REGULAR SESSION: $75.00		INTAKE SESSION: $140.00	REGULAR SESSION: $100.00
				Primary Insurance Company:_____	
				I DO NOT BILL SECONDARY INSURANCE.	
				If you have two health insurance policies please call them to determine which insurance card to give me.	
				Note: If I am a "Contracted Provider" with your insurance company, I agree to accept their "Contract Allowable Fee" limitations.	
				Please provide a legible copy of both sides of your Primary insurance card along with these forms.	

NO SHOW AND LATE CANCELLATION POLICY

When you and I schedule a therapy session we are both making a commitment of our time.

- No-Shows and Late Cancellations (24 hours prior to scheduled appointment time) for first or subsequent sessions will be charged as a no-show.
- Cancelling at the time of the session will be charged against your credit card as a No-Show. (Including the first session.)
- NO SHOW or LATE CANCELLATION FEE: $60.00

PROVIDE YOUR CREDIT CARD INFORMATION (Exactly as it appears on your credit card bill)

Your credit card information and your authorizing signature must be on file prior to the first session.

CHECK YOUR CARD TYPE:	DISCOVER ☐ MasterCard ☐ VISA ☐ AMERICAN EXPRESS ☐ PayPal ☐	CARD HOLDER NAME AS IT IS ON THE CARD:	
CARD NUMBER:		EXPIRATION: MONTH: YEAR:	CVC CODE:
ACCOUNT BILLING ADDRESS: STREET:		CITY:	
STATE:	ZIP:		
I authorize Chuck Britt to charge the above credit card account for balances not covered by insurance.	SIGNATURE:		

- **No charge will be made to your credit card unless there is an actual session, no-show or late cancellation and an actual balance.**
- **YOU are responsible to pay for all session fees, copay, deductible, no-show and late cancellation charges.**
- **WHATEVER YOU OWE THAT YOU OR YOUR INSURANCE DOES NOT PAY WILL BE CHARGED AGAINST YOUR CREDIT CARD.**

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PROVIDE THE FOLLOWING INFORMATION TO MEET STATE INFORMATION AND INSURANCE REQUIREMENTS:

CLIENT INFORMATION

Name_____ Date Of Birth_____-_____-_____ Age_____ Gender M or F

Address_____ City_____ State_____ Zip_____

Home_____-_____-_____ Work_____-_____-_____ Mobile_____-_____-_____

SSN _____-_____-_____ EMAIL ADDRESS: _____

PARENT or GUARDIAN (If CLIENT is under 11 years of age.)

Name_____ Date Of Birth_____-_____-_____ Age_____ Gender M or F

Address_____ City_____ State_____ Zip_____

Home_____-_____-_____ Work_____-_____-_____ Mobile_____-_____-_____

SSN _____-_____-_____ EMAIL ADDRESS: _____

PROVIDE SIGNATURES COMMITTING TO PAY FEES FOR SCHEDULING AND RECEIVING SERVICES.

I understand that by scheduling any session with Chuck Britt, MA, LMFT,

and signing below that I am committed to promptly pay the fees detailed above.

Client or Guardian:_____**Date**_____-_____-_____

Client or Guardian:_____**Date**_____-_____-_____

Chuck Britt, MA. LMFT Charles M. Britt MA LMFT **Date 01 - 16 - 2015**

MAIL / FAX / OR EMAIL THIS 3 PAGE FORM
(AND IF USING YOUR INSURANCE SEND A CLEAR IMAGE OF BOTH SIDES OF YOUR INSURANCE CARD)
TO:

MAIL	FAX	EMAIL
Chuck Britt, MA, LMFT **924 South 11th Street** **Mount Vernon, WA 98274**	**FAX a .pdf file to:** **866-492-5137**	**EMAIL a .pdf file to** **chuck@selftimeout.org**

AFTER I GET YOUR APPLICATION
IF WE HAVE NOT ALREADY SCHEDULED A SESSION
I WILL CALL YOU TO SET UP YOUR INTAKE.

SKAGIT FAMILY STUDY CENTER

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DISCLOSURE STATEMENT

We have agreed to do important work together. I have designed this agreement to establish a safe structure for us and also to conform to Washington State Regulations. This structure, along with established professional ethics, protects our work and helps to make our relationship a safe place for growth and change. Please read the following carefully. If, for any reason, you have difficulty understanding any part of it please ask for assistance.

CLIENT RIGHTS:

- You have the right and the responsibility to control your own therapy.
- You have the right to choose a counselor that best suits your needs.
- You have the right to privacy, and information shared during the therapy process will remain confidential unless a signed release is obtained. (See exceptions below.)
- You have the right to ask questions at any time. I will do my best to be responsive.

Therapists practicing counseling for a fee must be registered or certified in accordance with the Counselor Credentialing Act with the Department of Health for the protection of the public health and safety. This empowers you with a complaint process against counselors who would commit acts of unprofessional conduct. Licensing of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you believe I have violated my responsibilities as your therapist, you can contact your local law enforcement agency or the State of Washington Department of Health at (360) 664-9098.

CONFIDENTIALITY:

Under the law, I will disclose confidential information in the following situations:

- When there is reason to suspect the occurrence of child abuse or neglect.
- When there is a clear threat to do serious bodily harm to self or others.
- To a court under court order.
- In the event that you bring charges against me.
- To the office management website, Office Ally, for the purpose of medical record keeping and medical insurance billing. Office Ally has signed a confidentiality statement, which is on file in my office and conforms to HIPPA requirements.
- When necessary to insure best practice I will seek consultation from other qualified professionals who are also bound by and respect your right to confidentiality.

COUNSELING GOALS:

The goal is **Voluntary** change. You can choose to change the way you think, and/or behave. It is possible that you may "get worse before you get better." Some experience this as they work at changing.

TREATMENT PROVIDED:

I am trained and licensed to provide individual, group and family therapy. I have a Masters Degree in Counseling Psychology, and over 28 years experience in the field. I do not discriminate on the basis of race, sex, age, religion, sexual orientation or physical challenges. I approach the therapy process from a family systems theoretical framework using a variety of interventions including but not limited to Gestalt, Reality Orientation, Play Therapy, Active Listening, Transactional Analysis, Strategic Interventions and I teach Therapeutic Parenting skills. I operate from a philosophical belief that the therapy process is most effective when the whole family participates. Duration of treatment will be negotiated as the therapy progresses. Good therapy is non-judgmental. I can invite you to look at the consequences of your choices. I have no right to judge anyone.

URGENT OR EMERGENCY SITUATIONS:

EMERGENCY…….. 911
CARE CRISIS RESPONSE SERVICES (24 HOUR)…….. 1-800-584-3578
CHILD PROTECTIVE SERVICES……. M-F 8:00AM TO 5:00PM 1-360-416-720
After hours 1-800-794-9402

FOR HELP (NOT AN EMERGENCY) WITH A SELF TIME OUT CALL CHUCK AT:

360-336-3882. Chuck will pick up if he can or return urgent calls as soon as he gets the message. Also go to our website at http://www.selftimeout.org for help with a Five Step Self Time Out.

CLIENT SIGNATURE AND AGREEMENT:

I have received and read this sheet and understand it's content and intent. I understand the limits of confidentiality. I understand that I may not get the results I want and that I can stop treatment at any time.

Chuck Britt, MA, LMFT: Charles M. Britt MA LMFT Date: 03-017-2014

Client:___ _____ Date:___-___-___ Client:___ _____ Date:___-___-___

Client:___ _____ Date:___-___-___ Client:___ _____ Date:___-___-___