Connie Bonner-Britt, MA LMHC
360-542-6895
connie@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.

Please complete this form providing all required information and bring it to your first session.

1. PROVIDE THE FOLLOWING CLIENT INFORMATION

Name_____ Date Of Birth_____-_____-_____ Age_____

Address_____ City_____ State_____ Zip_____

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

SSN _____-_____-_____ EMAIL ADDRESS: _____

PARENT or GUARDIAN INFORMATION (If CLIENT is under 13 years of age.)

Name_____ Date Of Birth_____-_____-_____ Age_____

Address_____ City_____ State_____ Zip_____

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

SSN _____-_____-_____ EMAIL ADDRESS: _____

2. PROFESSIONAL TESTIMONY AND REPORTS

CONNIE BONNER-BRITT, MA, LMHC no longer accepts applications in cases with clients involved in divorce, custody disputes, mediations or other legal proceedings. We no longer want to provide reports, documents or testimony for GALs or Courts. If you find yourself involved in such disputes or anticipate being in such a dispute we advise you to seek support from a Licensed Marriage and Family Therapist willing to participate. If an established case devolves into such disputes we will advise clients to seek support from other therapists interested in such work.

3. PROVIDE YOUR CREDIT CARD INFORMATION

(Exactly as it appears on your credit card bill)

This is required for all clients except Molina Insurance clients.

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:**
☐☐☐☐☐☐	**ZIP:**	
I authorize Connie Bonner-Britt to charge the above credit card account for balances not covered by insurance.	SIGNATURE:	

- **Having your credit card information is the only security that I will be paid.**
- **I do not want to use your credit card to get paid. Please pay at the time of service. YOU are responsible to pay for all session fees, copay, deductible, no-show and late cancellation charges at the time of service.**
- **No charge will be made to your credit card unless there is an actual session, no-show or late cancellation and an actual balance that is not being paid.**

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4. PAYMENT CHOICES

There are two Options to pay for your Therapy.
Please check your preference on the left and fill in that form.

CHECK	Option 1: DISCOUNTED RATES YOU AGREE TO PAY BY CASH, CHECK OR CREDIT CARD BEFORE EACH SESSION.	INTAKE SESSION: $120.00	REGULAR SESSION: $85.00
Please feel free to call Connie at: 360-542-6895 to request a reduced fee.		Connie and I agreed on the fees below:	

CHECK	Option #2: INSURANCE RATES (YOUR "PRIMARY" INSURANCE WILL BE BILLED)	INTAKE SESSION: $150.00	REGULAR SESSION: $110.00

STEP	STEPS TO COMPLETE BEFORE WE SCHEDULE YOUR FIRST SESSION.	DETAILS	CK
1.	What insurance company are you using? Call your insurance to verify that they will accept my credentials and pay the insurance portion of your bill.	Name Of Your Primary Insurance Company: _____	
2.	Verify with your insurance that they will accept Electronic Billing	Connie only does Electronic Billing.	
3.	Call your insurance company and tell them you need to know your Co-Pay per session before we schedule our first session.	Copay per session: $ _____	
4.	Call your insurance company and tell them you need to know your current Deductible balance before we schedule our first session.	Current Deductible Balance: $ _____	
5.	Connie does not bill 'Secondary' insurance.	If you have two policies check to see which is 'Primary' and use only that policy for your therapy.	
7.	Please provide a legible copy of both sides of your Primary insurance card along with these forms.	Or bring your card to the first session and I will make a copy for the file.	

5. PAYMENT 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 as a No-Show. (Including the first session.)
- NO SHOW or LATE CANCELLATION FEE: $70.00
- **Whatever you owe that your insurance does not pay is your responsibility at every session.**
- **I need you to keep your account with me current. Pay for each session before each session.**
- **You can pay with cash, by check, scheduled checks from your bank, and you can pay online at: www.selftimeout.com**

6. PROVIDE SIGNATURES COMMITTING TO PAY FEES FOR SERVICES.

I understand that by scheduling any session with Connie Bonner-Britt, MA, LMHC, and signing below I am declaring that the above information is complete and accurate and that I will pay any charges based on the Policy detailed above.

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

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

Connie Bonner-Britt, MA. LMHC _____ **Date**_____-_____-_____

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7. 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, Connie 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. Humans can choose to change the way we talk to ourselves, and then notice that we behave differently. It is possible that you may "feel worse before you feel better."

TREATMENT PROVIDED:

I am trained and licensed to provide individual, group and family therapy. I have a Masters Degree in Human Development, and over 30 years experience in the field. I do not discriminate on the basis of race, sex, age, religion, sexual orientation or physical challenges. I am a Minority Mental Health Specialist and Children's Mental Health Specialist. 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 A**fter hours **1-800-794-9402**

FOR HELP (NOT AN EMERGENCY) WITH A SELF TIME OUT CALL CONNIE AT: 360-542-6895
She will pick up if she can or return urgent calls as soon as she gets the message.
Also you can choose to 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.

Connie Bonner-Britt, MA, LMHC:___ _____ Date:___-___-___

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