Frank M. Bruno, MA, LMFT

frank@franktherapy.com| P: 425-625-9102 | www.franktherapy.com

Dear New Client,

Thank you for choosing me as your therapist. This packet includes the information you will need to begin counseling services.

New Client Form provides me your contact and billing information, and your reasons for seeking therapy. Also included in the *Intake Form* are my *Professional Disclosure Statement,* and *Client's Rights Statement.*

My ***Disclosure Statement*** describes: (a) how I conduct therapy; (b) my education and training; (c) billing and insurance policies; (d) fees for therapy services; (e) appointment scheduling guidelines; (f) your client rights and responsibilities; (g) my responsibilities as your therapist and as a mandated reporter; (h) confidentiality in therapy; and (i) how therapy is initiated and terminated.

Clients Rights Statement, and *Notice of Privacy Practices.* Please read, sign, initial and date all the forms where indicated. If you are scheduled for couples therapy, both you and your partner should individually complete the *Intake Form* and each sign, initial and date at the bottom of each page where indicated.

Please feel free to contact me with any questions. I look forward to meeting you.

Sincerely,

Frank Bruno, MA, LMFT

NEW CLIENT INFORMATION

Name _____ DOB ___/___/____ Age _____

Preferred Phone _____ _ □ Cell □ Home □ Work Other: _____

Email _____ Preferred Communication:
□ Cell □ Home □ Work □ Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip ____

May I send mail to this address? (Circle one) Yes No

Email _____May I use email to confirm appointments?
Yes No

Employer _____ Type of Work _____

Relationship Status (required by insurance companies)

Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact:
_____Relationship_____Phone_____

Fees for Service: I accept check and credit card payments on a fee for service basis payable at the end of every appointment. I will provide you a Professional Services receipt that you can use to obtain reimbursement from your insurance company at the end of every appointment. Clients typically receive imbursement at out of network rates. My rate is $125.00 per 1-hour session.

Financial Responsibility: I understand that I will be responsible for any outstanding financial debt associated with therapy services.

Client _____ Date _____

Therapist _____ Date _____

What prompted you to seek therapy?

_____

_____

_____

_____

Who is impacted by the issue?

_____

_____

_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____

_____

_____

Have you had any prior counseling or psychiatric treatment? ____ No ___Yes If yes:

When? _____ Where? _____

Reason for and length of counseling_____

Check one: Therapy was ____ helpful ___ not helpful. Please explain:

_____

_____

_____

_____

_____

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:

_____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify): _____
____Eating disorder	____Obsessive thoughts	

Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse? __Yes __No

Have you ever felt like you should cut down on alcohol or another drug use? __Yes __No

Has a friend or relative ever discussed concerns about your drug use? __Yes __ No

Is there a history of problem with alcohol or drug use in your family? __Yes __ No

Have you received help for drug or alcohol dependency? ____ No ___Yes If yes:

1. When? _____ Where? _____

   Check one: Treatment was ____ helpful ___ not helpful. Please explain:

   _____

   _____

   _____

MEDICATION

Current Prescribed	Dosage	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DISCLOSURE STATEMENT

Frank M. Bruno, M.A., LMFT
310 3rd Ave NE Suite 121A Issaquah WA. 98027
425-625-9102
frank@franktherapy.com

Washington State law requires mental health professionals to provide new clients a disclosure statement that specifies the therapist's background, experience, theoretical orientation, and approach to therapeutic services. This statement is provided to help you be informed about your rights and my clinical practice as a therapist.

State Licensure

Mental health professionals in Washington must be licensed by the state to protect public health and safety. I am licensed by Washington as a marriage and family counselor, LMFT. My license number is LF61067014. This license indicates that a practitioner has met basic educational, competency, and supervision standards.

Professional, Educational & Personal Background

My educational background includes:

- BA from the University of Southern California (USC)
- MBA from Pepperdine University
- MA in counselling and psychology from Antioch University

My professional experience spans over 30 years in business working as a high-tech executive. I have been married for 30 years and have raised two children. I decided to change careers and devote myself to the well-being and mental health of individuals, couples, and children. I am professionally committed and required to pursue knowledge of new developments in my field and to maintain my competency through ongoing education, and training,

Therapeutic Approach

My practice spans across working with individuals, couples, children, and families. I describe my practice as integrated meaning I do not practice one therapeutic approach. I work closely with people to understand what problems they face, what goals they want to accomplish from therapy, and then customize a plan specifically for them.

Depending on your unique needs, I may recommend Cognitive Behavioral Therapy (CBT), Systemic Family Therapy, Emotionally Focused Therapy (EFT), Gottman Marital Therapy Techniques, Solution-Based Therapy, or Psychodynamic approaches and Existential Therapy.

I seek to understand human problems in terms of the complex set of challenges people face both in terms of interpersonal and intrapsychic problems. I consider social and cultural systems, including religious and spiritual traditions, and the broader society in which people live as being part of what shapes and impacts people.

I welcome people from diverse ethnic backgrounds and members of the LGBT community.

I work with individuals and couples based on a plan that outlines a specific number of sessions typically from 10 to 20. The length of therapy will vary, however, depending on the child, family, couple or individual. Sometimes therapy can be very brief, and other times I work with individuals and coupes for much longer periods.

It should be acknowledged that counseling sometimes involves discussing difficult topics about a person's life, and it can bring up difficult feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. But research also shows that people who engaging in counseling benefit more than people who do not. Counseling can lead to better relationships, and significant reductions in feelings of emotional distress.

Practice Standards and Fees

Therapy is an important investment you make in yourself, and your important relationships. My ability to provide support for people is dependent on running a professional stable practice.

My fee for service is $125.00 for a 60-min. session for adults and children, couples and families. Unless otherwise arranged, full payment is due at the end of each session. My fees go up 10% every year on January 1st. I will remind you of this increase in advance. Unless there is a prior arrangement, full payment is required at the end of each session. The fee for returned checks is $50.

Since keeping appointments is essential to effective therapy, I emphasize the importance of attending all scheduled sessions and being on time. If for some reason, you cannot keep an appointment I require a 48-hour advanced notice or you will be charged the regular fee for the session. Changes for Monday appointments should be called in by Friday and changes for Saturday should be called in by Thursdays.

The fee for credit card charges is 3%. In addition, if you seek compensation from your health insurance, you will need to take responsibility for obtaining reimbursement yourself. I will provide you a Professional Services receipt at the end of every session that you can use to submit to your insurance company for reimbursement. I expect all clients to be financially responsible for all charges regardless of financial arrangements.

I am dedicated to providing effective therapy and mental health to all people who seek my support. I am a member of the AAMFT (American Association of Family Therapists) and I ascribe to all of their ethical and professional standards:
http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx

Professional Restrictions

I refrain from entering into a relationship outside of a professional one with any of my clients. This means I do not engage in social or business relationships with any clients that would potentially compromise the efficacy and the outcome of therapy. Therefore, I will not acknowledge the existence of a relationship with my clients outside of the therapy session. I do this to protect the confidentiality of our therapeutic relationship and the professional ethics that apply to it.

Client Rights

You have the right to choose a therapist who best suits your needs and goals. If you work with me, you have a right to raise questions about my therapeutic approach, and to request a referral if you believe you might make better progress with another therapist. If you believe I have engaged in unethical or unprofessional behavior you have the right to report your concerns to the department of health by contacting: U.S. Secretary of Health and Human Services. 1300 Quince St. SE PO Box 47869 Olympia Washington 98504-7869 or Phone: (360) 236-4910. You have the right to confidentially under the conditions specified in my Notice of Privacy Practices.

If I see you together with your partner or with other family members, confidentially extends to all those involved in therapy and I will not release to third parties' any information without first obtaining signed releases from everyone involved.

However, I will not necessarily be bound by confidentially in joint sessions with information I have obtained in individual sessions and discussions. This means I reserve the right to discuss in joint sessions information that you have shared with me in individual sessions if I believe it will help facilitate the achievement of the goals set forth in therapy.

Acknowledgement of Disclosures

I (we) understand the information and agree to the terms set forth in the above disclosure statement.

_____ _____ _____
Client (s) Signature Hourly fee Date

I acknowledge that the person who has signed above understands the information and agrees to the terms set forth in the above DISCLOSER STATEMENT.

_____ _____
Frank M. Bruno, MA, LMFT Date

CLIENT'S RIGHTS STATEMENT

Frank M. Bruno, M. A., LMFT
310 3rd Ave NE Suite 121A
425-625-9102
frank@franktherapy.com

The content of therapy sessions is confidential and cannot be revealed without your written permission. I make every effort possible to maintain strict confidentially and maintain the full privacy of everyone I work with in my practice. However, as a licensed professional I am under legal restrictions you need to be informed about.

This notice describes your rights regarding how you may gain access to, and control of your protected healthcare information, and how I may use and disclose it. I am required by law to abide by the terms of this Notice of Privacy Practices.

PLEASE REVIEW THIS INFORMATION CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA) mandates the protection and confidential handling of protected healthcare information. This notice informs you of your rights regarding your healthcare information under HIPAA. Your health information includes any information that I record or receive about your past, present, and future healthcare. HIPAA regulations require that I maintain this privacy and provide you a copy of this Notice.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by me in one or more of the following respects:

- To other health care providers (i.e., your physician) in order to coordinate your care.
- To third party payors (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payments, etc.).
- Voice-mail or other contact to you related to appointment reminders or other services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have a right to revoke. Under the privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information.
- Request confidential communication of your protected health information.
- Inspect and obtain copies of your protected health information.

- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by me of your protected health information.
- You may, without risk of retaliation, file a complaint as any violation by me of your privacy rights to the: United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

I have the following duties under the Privacy Rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth my legal duties and privacy practices with respect to such information.
- To abide by the terms of this Privacy Notice that is currently in effect.
- To advise you of my right to change the terms of the Privacy Notice and to make the new notice provisions effective for all protected health information maintained by me, and that if I do so, I will provide you with a copy of the revised Privacy Notice.

Please note that I am not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information.
- Amend your protected health information if it is accurate and complete.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

To further communication, and to fulfill my legal responsibilities, I want you to understand how I protect and use your identification, payment and health information. The law, through HIPAA, more clearly defines your rights, and I want to make sure that you understand your rights and my policies concerning this information.

Record Keeping Practice

Standard practice requires me to keep a protected record of your treatment. This includes relevant data about dates of service, payments for service, insurance billing, and relevant treatment information. This record of treatment is your Protected Health Care Information or "PHI." I may use or disclose your PHI for treatment, payment, and healthcare operation purposes. You have access to this information upon reasonable request.

Child Abuse or Neglect

If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

Adult Abuse

If I have reasonable cause to believe that abandonment, sexual or physical abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must report the abuse to the Washington Department of Social and Health Services.

Threat to Health or Safety

In the instance when you or someone else is in imminent danger of harm I may disclose your healthcare information for the purposes of safety.

Compulsory Processes

I may be required to disclose your personal healthcare information if a court of competent jurisdiction issues an appropriate order. I will comply with this order if (a) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, (b) no protective order has been obtained, and (c) I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

Uses and Disclosure of Healthcare Information with Your Written Authorization

I will make other uses and disclosures of your protected healthcare information only when your appropriate authorization is obtained. An "authorization" is written permission that permits specific disclosures. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with healthcare services for which I must submit subsequent claims for payment.

CONTACT INFORMATION

If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is: Frank M. Bruno, LMFT, 310 3rd Ave. Ste 121A, Issaquah WA. 98027
(425) 625-9102. EMAIL: frank@franktherapy.com

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me. I will not retaliate against you for filing such a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

Signature below is only acknowledgement that you have received this Notice of Privacy.

_____ _____

Date Client

_____ _____

Date Therapist

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks. For example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

- Efficacy. Most research shows that teletherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

Fees

The same fee rates will apply for teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

Records

The teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____

Client Signature Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to conduct in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in our designated safer waiting area until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. Hand sanitizer is provided in the lobby.
- You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.

- You will wear a mask in all areas of the office (I will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent agreement that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Date

_____ _____

Frank M. Bruno, LMFT Date