

Name _____

Date _____

Goals for Therapy

Goals are intentions you commit to during the time you are in therapy in order to make the changes you seek and to grow as a human being.

1. The aspects of my life that are not working for me and that I have entered therapy to change are (be brief and succinct):

2. In order to make those changes I will do the following:

3. What my therapist can do to support this process of change is:

4. I am most likely to undermine my success in therapy by:

5. Instead of undermining my success in therapy I will (this is the commitment part):

6. I will know I have accomplished my goals in therapy when I am:

Signature _____

Date of completion _____

Kate R. Casey, LMHC, RYT
1611 116th Avenue NE Suite 117
Bellevue, Wa 98004
425.643.0420

Contact and Health Information

Name _____ Date _____

Age _____ Gender Preference _____

Date of Birth _____

Email Address _____ (Print clearly)

Complete Address:

Phone Numbers: (Specify a confidential voice mail for leaving messages)

Cell _____

Home _____

Business _____

Married _____ Partnered _____

Divorced _____ Single _____

Widow _____ Other _____

Name of Insurance Company _____

Name and relationship of the insured _____

Insurance Policy Number _____

Who to Contact in Case of an Emergency _____

Pertinent Medical History:

Medications that you are currently taking_____

Lifestyle Habits: Frequency and amount

Cigarettes/Vaping_____

Marijuana_____

Alcohol_____

Drugs_____

Exercise_____

Hobbies_____

Previous Therapy:

Therapist's Name(s)_____

Reason for Therapy_____

Length of time in therapy_____

Identified Stressors in the past Year:

Kate R. Casey, M.C., LMHC, RYT 500hr
1611 116th Avenue NE
Suite 117
Bellevue, Washington 98004
425-351-0009
License Number LH00003890

CLIENT DISCLOSURE INFORMATION **AND CONSENT**

As a counselor providing assistance to an individual in the adjustment of emotional and behavioral problems or to achieve sensitivity and awareness of self and others to develop human potential, I am required by the Department of Licensing in the State of Washington to inform you of the following:

1. The type of counseling I provide is based on a "wellness model" focusing on your inherent strengths and abilities.
2. I utilize the following methods and techniques within a developmental framework: didactics, bibliotherapy, Gestalt, Bio-energetics, Psychodrama, cognitive behavior therapy, Transactional Analysis, dream interpretation, trance work, Family Systems Therapy, Corrective Parenting, mindfulness, meditation, and yoga.
3. Some of the methods and techniques may include physical contact and is not, under any circumstances, coercive, sexual or mandatory.
4. My educational training includes an undergraduate degree in psychology, a master's degree in counseling as well as a specialty in addictions and recovery, and I am a registered yoga teacher. I continue to enhance and update my clinical skills and education by attending workshops and trainings and continuing education classes.
5. The cost per session is _____ and length of treatment is determined by you, the client. I am willing to state my recommendations if requested. My sessions are typically 50 minutes and I work on flex time for the beginning 10 minutes and ending 10 minutes.
6. Appointment cancellation must be made within 24 hours in advance to avoid paying the full fee. If it is possible to reschedule for the same week there is no penalty. If you or I am not able to reschedule the same week then you will be financially responsible for the cancelled or missed session.
7. I frequently consult with my colleagues regarding clients and I attend ongoing consultation groups. Confidentiality is honored and consent is given by you, the client, in the event(s) I decide it is necessary to consult with other professionals.
8. Payment in full is expected at each session and no other arrangement will be acceptable unless it stated in a written contract and signed by both you, the client and me. Check with your insurance to see if they will pay a portion of the fee or will apply the fee towards your out-of-pocket deductible.
9. Counselors practicing counseling for a fee must be licensed with the Department of Health for the protection and health of the public.

10. There are situations in which I am required by law to reveal information without your permission.

These situations are:

- a. If you threaten clear and imminent danger to another person or to yourself, I am required by law to inform the intended victim and appropriate professional workers or public authorities.
 - b. If a court of law issues a legal subpoena, I am required by law to provide information specifically required.
 - c. If you are in treatment by order of a court of law, the results may be revealed to the court.
 - d. If you inform me of current incidences of child abuse, I am required by law to inform the Child Protective Services.
 - e. If you make statements that an elderly or disabled person has been abused or neglected, I am required by law to report that information to the appropriate authorities.
11. Therapy may involve periods of mental and emotional distress as you explore painful memories, feelings and events and challenge patterns of behavior and beliefs. You have been Informed and are aware of this possibility.
12. Therapy may transform behavior, self-image, and ways of interacting with others. This, in turn, may lead to changes in your relationships that could be stressful and it is important that you are aware of this possibility.

I have read and understand the information above and agree to work with Kate Casey within the guidelines as stated above. I have also received a copy of the Department of Licensing brochure, as well as a signed copy of this Client Disclosure Information and Consent form.

Client signature

Date:

Client name (printed)

Phone:

Address: