Sandalwood
Counseling LLC

Dr. Shannon Lilja DBH, LPC LMHC CDP CADC-II

NEW CLIENT INFORMATION

Client's name: _____ Birthdate: ____/____/____

Address: _____ City/ST/Zip:_____

Contact Phone: _____ Okay to leave message? [ ] Yes [ ] No

Alt phone: _____ Okay to leave message? [ ] Yes [ ] No

HIPPA and 42 CFR Part 2 are regulations that protect your privacy and enhance confidentiality. You may send emails or texts to me but privacy and confidentiality is not guaranteed (in large part because each are electronic data and visible across cyberspace). I will only respond to inquiries related to scheduling or other administrative topics AND I will delete the email or text once the communication episode is completed. If you do send an email that I feel is of clinical depth or significance, I will print it off and add it to your chart notes, to be included to your clinical record.

To protect your rights, I ask that you provide explicit permission to communicate electronically. Emails and texting are considered 'data' and are not considered confidential; therefore an explicit consent is required.
By initialing below, you are providing permission to communicate electronically…

Is it okay to send/receive short texts about appts or care, etc…? [ ] Yes [ ] No
Phone number to text: _____ Your initials _____

Is it okay to send/receive short emails about appts or care, etc…? [ ] Yes [ ] No
Email address: _____ Your initials _____

^ ^

Relationship status: [ ] Married [ ] Separated [ ] Recently or Soon-To-Be Divorced
[ ] Dating/In relationship [ ] Single/Not in Relationship

Living with: [ ] Self [ ] Roommate [ ] Partner/Spouse [ ] Children [ ] Parents
Employed? [ ] Type of Work _____ Student? [ ] Other: _____

Will this be self-pay or insurance-covered? _____

Do you have any medical conditions or issues? _____
Please list any medications you are presently taking: _____
_____
How did you hear about Sandalwood Counseling/Shannon Lilja? _____

Thank you for completing this form.
If you have any questions about this form, please ask ☺

Client Signature: _____ Date: _____

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FEE AND PAYMENT POLICIES

Fee for the intake appointment (50-60 minute)	$150.00
Fee for a 50-55 minute individual appointment	$120.00
Fee for a 50-55 minute couples appointment	$140.00

Payment is due prior to the rendering of services. Sessions will end promptly at the scheduled end-time; extending session time to accommodate client will occur only at the therapist's discretion.

Telephone calls with you or to other persons on your behalf that are greater than 15 minutes in length, will be charged at $120.00 per hour, billed on the quarter hour. Insurance will not pay for telephonic services.

By signing this form, it is acknowledged that Dr Shannon Lilja will not be asked to complete paperwork for or participate in SSDI/SSI claims or benefits, child custody involvement, court cases, employment fit-for-work cases, etc. Therapy-animal documentation (not companion) and/or FMLA paperwork will be considered. The charge for this service and documentation is $175.00 per hour (ie telephone calls, documents, etc), billed on the quarter-hour.

Before Sandalwood Counseling LLC will submit any insurance claims on your behalf, it is your responsibility to inquire about your coverage, deductible obligations, co-payments, number of sessions covered, etc, and to communicate this information to Sandalwood Counseling. Dr Shannon Lilja/Sandalwood Counseling is not paneled with OHP, Apple Health or Medicaid/Medicare; insurance claims must be first submitted by YOU to these insurances before secondary/supplemental insurances can be submitted by Sandalwood Counseling.

A release of information between Sandalwood Counseling and your insurance company in order for an insurance claim to be processed is required. Sandalwood Counseling will submit claims on your behalf for EAP services. Your authorization number of certification number is required to do so, as is a release-of-information to process the claim.

Note: if any claim amount is denied or not covered (due to deductibles, non-coverage, etc), you are responsible for full payment, which is due at notification from Sandalwood.

Filing out-of-network insurance claims are your responsibility. An invoice for claim submission will be provided to you at your request. You are responsible for full payment of services to Sandalwood Counseling LLC, regardless of insurance coverage. Outstanding balances may be turned over to a collection agency for remittance.

Sandalwood Counseling utilizes Square Card Reader technology for electronic payments (ie credit cards). **By signing below, you acknowledge that Square is not HIPPA compliant and therefore is not secure from complete confidentiality. Further, you authorize Sandalwood to swipe the card provided by you, for session payment via Square Card Reader and agree to charge your account an additional amount to cover the 2.75% Square processing fee.** With your signature, you grant permission for Sandalwood to exchange pertinent information with Square in order to process payment. Further, if your card is not read properly, or if payment is not transacted in completion, you are responsible for full payment of services to Sandalwood Counseling LLC by, or at the time of, the next scheduled therapy session.

In the case you write a check or provide an alternative payment method: by signing below, you acknowledge checks or other means of payment will require use of banking services and that you grant permission for Sandalwood to utilize or exchange necessary information in order to process payment.

CANCELLATION POLICY

Counseling is by appointment only. In the event you are unable to keep you appointment, it is your responsibility to notify me 24-hours before your session time to avoid the $80.00 no show or late-cancellation fee **(insurance does not cover this charge)**. Frequent cancellations could result in the loss of services.

I have read, and understand and agree to, these payment and cancellation policies…

Client Name: _____ SSN _____

Client Signature: _____ Date: _____

Sandalwood
Counseling LLC

PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

Dr. Shannon Lilja, D.BH, LPC, LMHC, CADC-II, CDP (WA)

Philosophy and Approach to Counseling

My therapeutic style in working with clients is warm, a little humorous, collaborative, and straightforward. Practicing from cognitive behavioral, solution- and emotion-focused theoretical models, I believe exploring your relationship between heart and mind can strengthen core functioning and encourage the change you seek, often leading to a more fulfilled, empowered, and authentic self. My role as therapist is to assist in facilitation toward self-discovery and personal growth, to unveil the strength and possibility within you.

While I may offer suggestions for growth or change, the responsibility to grow and change is yours. Please be aware therapy can have both benefits and risks. You may experience uncomfortable feelings such as sadness, guilt, fear, frustration, loneliness, or helplessness. Learning new ways of thinking, behaving, and relating to others may be difficult. While there is no guarantee of what you will experience, research indicates that therapy has many benefits for most clients, often leading to better relationships, solutions to specific problems, and a reduction in feelings of distress.

You may end our counseling relationship at any time. Should either of us feel a referral is appropriate, I may assist with recommendations; the responsibility to pursue referrals or recommendations is yours. While counseling sessions feel personal, our relationship is professional and limited to our sessions. If we cross paths outside of our sessions, I will not acknowledge you unless contact is initiated by you. Designed for your welfare and privacy, this allows our efforts to be directed toward the counseling process.

Education, Training, and Experience, Licensure, and Certification

I am a licensed mental health counselor in both Oregon (C2687) and Washington State (LH60129047) and abide by the Code of Ethics of both Washington & Oregon Board of Licensed Counselors and Therapists. I am also credentialed as a drug and alcohol counselor/professional in both Oregon (CADC-II) and Washington (CDP).

I hold a Doctorate of Behavior Health. Major coursework included integrated medical and behavioral interventions, psychopharmocology, medical terminology and population health management, research, and ethics. I also hold a Masters of Arts Degree in Counseling Psychology. Major coursework included Human Growth & Development, Personality and Counseling Theory, Advanced Marital Therapy, Social and Cultural Foundations, Psychopathology, Human Sexuality, Group Theory, Research, Traumatology, Career Development, and Ethics.

I am trained in several evidence-based treatment modalities including Moral Reconation Therapy (MRT), Seeking Safety, Living in Balance, Matrix, Thinking for Change, Staying Quit. I am regularly enrolled in continued education and training (including ethics) related to the subjects relevant to my profession.

Payment for Treatment Services:

Fees per session: $120 - $200 SEE FEE AGREEMENT FORM ENCLOSED WITH YOUR PACKET

Payment is due at the beginning of each session. If payment is not made, the session may be rescheduled.

Cancellation Policy

Counseling is by appointment only. In the event you are unable to keep your appointment, it is your responsibility to notify me 24-hours in advance to avoid the **$80.00** no-show, or late cancellation fee.
Insurance does NOT cover this fee; you are responsible for payment.

Alcohol and Drug Policy

Please refrain from using either, at least 12-hours prior to your counseling appointment. If I perceive that you are under the influence, I may terminate at my discretion and charge the full fee for that session.

Emergencies

If you feel you need to speak with me prior to our next appointment, please call/text my office at 503.260.5118. I will return your call as soon as I am able (I do not return calls on weekends). If you feel your situation is urgent or an emergency and cannot wait, call the Clark County Crisis (360.696.9560), dial 9-1-1, or go to the nearest hospital emergency room.

Confidentiality and Duty To Warn

Confidentiality belongs to you. You may direct me to release information to others, in writing. Release of information without your consent may only take place under certain circumstances: I have an ethical and legal obligation to prevent you from physically harming yourself or others. If I believe danger in imminent to self or others, I will use reasonable and conscientious effort to both protect you and/or warn a potential victim of your violence. As required by State law, I must report suspected abuse or neglect of a child, dependent adult, or developmentally disabled person if I have reasonable cause to believe that such an incident has occurred. I will attempt to inform you of my report, but cannot guarantee doing so. Further, I must respond to a court-ordered subpoena. Medical emergencies may also result in sharing your identity and/or confidential information. Your confidentiality also will not be guaranteed if your account is placed to collections.

Client Bill of Rights

The following client rights have been established by both the Oregon and Washington State Board of Licensed Professional Counselors and Therapists. Consumers of counseling or therapy services offered by licensees have the right:

1. To expect that a licensee has met the minimum qualifications of training and experience required by state law;
2. To examine public records maintained by the Boards and to have the Boards confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving as defined by rule and law, including the following exceptions:
    a. Reporting suspected child abuse, elderly abuse, or otherwise vulnerable adult. b. Reporting imminent danger to client or others. c. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies. d. Information that would facilitate treatment of a medical emergency. e . Sexual exploitation, abuse, illegal, or unethical and unprofessional conduct by a mental health professional. f. If you are a minor, access to your records by parents. g. Providing information concerning licensee case consultation or supervision, and h. Defending claims brought by the client against licensee

    7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

    You may contact the Board at the following address and phone number:

    Oregon Board of Professional Counselors and Therapists.
    3218 Pringle Road SE, Suite 250. Salem, OR 97302. 503.378.5499

Consent Agreement

I have read and understand this consent form and have had an opportunity to have my questions answered. At my request, I was given a copy of this document. I agree to the above limits of confidentiality and understand their meaning and ramifications. My signature affirms my informed and voluntary consent to enter into a therapeutic relationship with Sandalwood Counseling LLC.

Client Name: _____ **Last four/SSN#** _____

Client Signature: _____ **Date:** _____ **(SC:** _____**)**

Sandalwood
Counseling LLC

Dr. Shannon Lilja DBH LPC LMHC CDP CADC-II

752 Officers Row, Vancouver WA 98661 OR: 503.260.5118 Fax: 971.275.1081

Consent for the Release of Information / Request for the Release of Information

This authorization must be written, dated, and signed by the client or by a person authorized by law.

Client Name: _____ **Birthdate:** _____ **Last 4: SS #** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

PURPOSE OF RELEASE

Initial: [ ] To allow Shannon Lilja/Sandalwood Counseling to release information to, and obtain information from my Insurance Carrier to collect Insurance Coverage Information, Benefit (EOB), and Payment Processing.

_____	_____	_____	_____
Insurance Carrier	Address	Phone	Fax
_____	_____	_____	
Member ID #	Group #	Plan Name/Info	
_____	_____		_____
Policy/Insured's Name	Insured's Address		Insured's Birthdate

Insured's Employer: _____

Please **Initial** each of the following to acknowledge that you understand and accept all terms of this financial agreement:

[ ] I authorize my insurance company to be billed and I authorize the release of any information necessary to process claims. This may include patient and/or insured's information, including DOB, insurance policy number, address, phone, etc., patient biopsychosocial/psychological information including assessment and diagnosis of mental health or substance use disorders,** progress notes, treatment goals, attendance and/or discharge information.

[ ] I agree to pay my co-payment, co-insurance, any fee for services not covered by my insurance company, including deductibles. Your signature authorizes use of credit card processing, Square, banking institutions, etc., in order to process payment.

[ ] I agree to provide copies of my insurance card and authorize Sandalwood Counseling to file a copy in my clinical chart.

This consent shall remain in effect until all claims submitted and service performed, are paid and/or satisfied… *unless designated otherwise here*: _____ Reason (describe: _____

I understand information may be shared via phone, fax, electronic/written, or in person. The information shared will be the minimum level necessary to accomplish the purpose of this release. I understand I am not required to sign this release, and that the ability to access services will generally not be affected as a result of not signing. I realize refusal to sign may impact the coordination of services or treatment, and if related to insurance may impede coverage.

** I understand that my Records may be protected under state and federal confidentiality regulations (42CFR, Pt 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50, 100(4)(b), and WAC 388-865-0436) and, if so, cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that Sandalwood Counseling cannot guarantee that the recipient of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

_____	_____	_____
Client Name	**Client Signature**	**Date**

Sandalwood
Counseling LLC

Dr. Shannon Lilja DBH LPC LMHC CDP CADC-II

752 Officers Row, Vancouver WA 98661 Cell: 503.260.5118 Fax: 971.275.1081

Consent for Video Therapy / Online Counseling / Telehealth

This authorization must be written, dated, and signed by the client and/or by an authorized person

Client Name: _____ **Birthdate:** _____ **Last 4: SS #** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

PURPOSE OF RELEASE

Initial: [ ] To authorize the use of HIPPA-compliant online video software/platform (VSee or Doxy.me, as examples) between Shannon Lilja/Sandalwood Counseling and I, in order to communicate for psychotherapy/counseling services.

Please **Initial** each of the following to acknowledge that you understand and accept all terms of this financial agreement:

[ ] I understand the software platforms used (Vsee or Doxy.me) are HIPPA compliant. I also understand that despite the platforms used are HIPPA compliant, that there is still risk – there is no absolute guarantee of privacy.

[ ] I acknowledge that per Dr Shannon Lilja/Sandalwood Counseling's recommendation, I checked with my insurance carrier to confirm that online therapy is covered in my Plan – and that services are covered by my Plan. If for any reason, the insurance claim/EOB is denied and not covered, I agree that I am responsible for the charge (see Fee Agreement) and that I will pay in full at my earliest convenience.

[ ] I agree to pay for services, per the Fee Agreement.
Payment accepted is cash, check, credit card and due prior to the session.
If payment is check, please remit to: Sandalwood Counseling. PO Box 1866. Vancouver WA 98668
If payment is made by credit card, I understand that Ivy Pay or Square are used for transactions and that a charge of between 3% - 4% is added to the session fee. I further agree that providing my credit card information is required prior to the session and that the information may be kept on file to pay for future therapeutic sessions. I understand I will provide any address or card changes or updates and that I can speak with Dr Shannon Lilja about payment for clarification and alternative agreements.

_____ _____
Patient Name Name on C-Card

_____ _____
Billing Address of [pertaining to C-Card] City/State/Zip [pertaining to C-Card]

_____ _____
Card Number [ ] Visa [ ] M/C [ ] _____ Security Number on Back of Card

_____ _____
Client Signature **Date**