Sandalwood
Counseling LLC
Dr. Shannon Lilja DBH, LPC LMHC SUDP 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.

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, billing, or care, etc…?
[ ] Yes [ ] No
Phone number to text: ____ Your initials _____

Is it okay to send/receive short emails about appts billing, 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? [ ]ther: ______________

Will this be self-pay [ ] or insurance-covered [ ] insurance company: ___________________

Do you have any medical conditions or issues? ____
Please list any medications you are presently taking: ____________________________________
____
Emergency Contact & Contact Number: ____

If you have any questions about this form, please ask ☺

Client Signature: ____________________________________ Date: __________

Dr. Shannon Lilja DBH LPC LMHC SUDP CADC-II

FEE AND PAYMENT POLICIES

Fee for a 50-55 minute intake appointment (first session)	$175.00
Fee for a 45-minute therapy appointment (couples or individual)	$150.00

Payment is due prior to the rendering of services. Sessions will end at 45 minutes; 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 $150.00 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, therapy-animal accommodations, court cases, employment fit-for-work cases, etc. FMLA paperwork will be considered on a case-by-case basis. The charge for this service and/or 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.

A release of information between Sandalwood Counseling and your insurance company is required in order for an insurance claim to be processed. Sandalwood Counseling will submit claims on your behalf for commercial insurance or EAP services. Your authorization number of certification number is required for EAP services.

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. Outstanding balances may be turned over to a collection agency for remittance.

Sandalwood Counseling utilizes Square or IvyPay Card Reader technology for electronic payments (ie credit cards). **By signing below, you acknowledge these companies are not HIPPA compliant and therefore 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 current 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: _____________________ Client Signature: _____________________ Date: _________

PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

Dr. Shannon Lilja, D.BH, LPC, LMHC, CADC-II, SUDP

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.

Generally, you will be the one who decides when therapy will end, however I encourage you to make this decision in collaboration with me. Additionally, I have the right to terminate treatment at any time due to lack of payment, verbal/physical abuse from you, refusal to comply with the treatment plan, the termination of medication without a medical doctor's consent, or a development that occurs outside my scope of competence. If you report hallucinations/delusions, imminent or severe thoughts of suicide, or a mood disorder/diagnosis that is determined to be unmanageable ay our level of care, I reserve the right to determine another mental health professional or higher level of care is better suited for you. In the case of termination, I will attempt to assist with placement and support the transition to another provider for continued care. 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 (SUDP).

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 EMDR (Eye Movement Desensitization & Reprocessing), Flash Technique, Tapping, MRT (Moral Reconation Therapy), Seeking Safety, and others. I am regularly enrolled in continued education & training (including ethics) related to the subjects relevant to my profession.

Payment for Treatment Services:

SEE FEE AGREEMENT FORM ENCLOSED WITH YOUR PACKET

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 **$800.00** no-show/late cancel fee. **Insurance does NOT cover this fee.**

Alcohol and Drug Policy

Please refrain from using either (incl marijuana), 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.

TeleHealth/Online Therapy

You are responsible for the security on your computer, privacy, connection quality.

You will not record our sessions under any circumstance.

There are risks and consequences from telehealth (online therapy), including but not limited to: that despite reasonable efforts on my part the transmission of your information could be disrupted or distorted by technical failures; the transmission of your information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons.

The benefits of psychotherapy via telehealth (online therapy) may include, but are not limited to: the ability to express thoughts and emotions; diminished transportation and travel difficulties; unchallenged time constraints; and there may be a greater opportunity to prepare in advance for therapy sessions.

Emergencies

If you feel your situation is urgent or an emergency and cannot wait until our next appointment, call your local crisis line (Clark Cty 360.696.9560), dial 9-1-1, or go to the nearest hospital emergency room.
I may contact the proper authorities and/or your designated contact person if I feel you are in need of emergency services.
Please write your local crisis line number: ____

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.

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: ____

Client Signature: _____________________________________

Date: ______________

Shannon Lilja DBH LPC LMHC CDP CADC-II

Privacy Information

I adhere to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) as it pertains to treatment, payment/billing, and health care operations. All information, discussions, and documents are confidential and privileged information for all patients. Under federal law, disclosure of information regarding services provided and information about a patient requires written consent of release. I cannot reveal whether or not you are a past or current client nor can I disclose any of the information you discuss during our sessions without first obtaining your written consent to do so. There are exceptions:

If during your therapy, you are deemed to pose a threat of harm to yourself or to someone else, I am allowed to collaborate with the police or a hospital to take necessary measures to prevent harm.

If you share information that leads me to believe that a child under the age of 18 or a physically, emotionally, or psychologically compromised person (ie elderly or disabled person) is at risk for emotional, physical or sexual abuse, neglect, or exploitation, I am required by law to make a report to the appropriate authorities with or without your consent.

If you disclose misconduct by a previous therapist, I am required to make a report to the licensing board governing the license of the therapist. If a court judge orders me to release information or if I need to respond to a lawfully issued subpoena. If I need to cooperate with legal actions against a mental health professional by a licensing board.

My practice utilizes health information technology. Health IT involves the storage and exchange of health information in an electronic environment. I am committed to upholding privacy and security standards for the protection of electronic health information standardized by HIPAA.

The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic protected health information (e-PHI). This includes protecting client information from potential security threats, maintaining privacy disclosure statements, and using only authorized technical devices that have security systems.

I am required to keep records of all psychological services up to seven years. I keep all therapeutic records including appointment date and time of service, diagnostic information, general content and topic notes, treatment goals and progress, your medical, social, and treatment history, records I may receive from other providers or provide to others, and your billing information and records. Except in unusual circumstances that involve danger to yourself, you have the right to your records. Because these are professional records, misinterpretation is possible. It is recommended that if you do request records, that we review them together or that you have another mental health professional assist. You also have the right to request (in writing) your file be made available to another health care provider.

Please review my separate Professional Disclosure Statement, Fee Agreement, and Release-of-Information(s) for additional information.

I consent to the terms set above by Dr Shannon Lilja, DBH LPC LMHC SUDP CADC-II of Sandalwood Counseling, and agree to enter into treatment by way of either in-person or telehealth (online therapy).

______________________________ ______________________________
Client Name Client Signature

____
Date

Sandalwood Counseling LLC

Dr. Shannon Lilja DBH LPC LMHC SUDP 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: ______**

INSURANCE INFORMATION

___________________	___________________	____________________	_____________
Insurance Carrier	Address	Phone	Fax

____________________	__________________________	______________________________
Member ID #	Group #	Plan Name/Info

_______________________	__________________________________	_____________________
Primary 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:

[ ] 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.
I authorize my insurance company to be billed. 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 provide all insurance information needed (ID #, Group number, information in the insured, etc).

[ ] 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.

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

TELEHEALTH

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: ______**

<u>Initial</u>:

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

[ ] 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 check or credit card (including HSA) and due prior to the session.
If payment is made by credit card, please read/sign attached payment document.
If payment is check, please remit to: Sandalwood Counseling. PO Box 1866. Vancouver WA 98668
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.

____
Client Name

____ _____________
Client Signature **Date**

Dr. Shannon Lilja DBH LPC LMHC CDP CADC-II / Sandalwood Counseling LLC

Credit Card Recurring Payment Authorization Form

I, ______________________________________, authorize Dr. Shannon Lilja DBH LPC LMHC CDP, CDP, CADC-II of Sandalwood Counseling LLC to charge my credit card (indicated below) for scheduled therapy sessions.

- Scheduled psychotherapy session or co-pay amount $ 175.00 first session/intake
- Scheduled psychotherapy session or co-pay amount $ 150.00 Couples sessions
- Scheduled psychotherapy session or copay amount $ 150.00 Individual sessions
- Missed appointment or late cancellation charge $ 80.00
- Fees denied/not paid by my insurance company (within 120-days of date-of-service)
- Insufficient check amounts plus insufficient check fee ($35 per check returned)

I understand that either SQUARE or IVY PAY will be used for charging, which as of this date, is not HIPPA complaint.
I acknowledge that because of this, my complete confidentiality is not guaranteed. Charges will be labeled as "Medical Billing/SC" on my credit card statement - not my provider's name (due to confidentiality). If I have questions about charges, I agree to contact Dr. Shannon Lilja of Sandalwood Counseling. I further agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions initiate a charge-back, I agree to pay any and all fees (session and penalty) incurred by Dr. Shannon Lilja of Sandalwood Counseling.

I authorize these charges to my card beginning this date: ______/_______/_______ (initial: _______)
This authorization will remain valid until all charges and fees have been paid.

Account Type: [ ] Visa [ ] MasterCard [ ] Amex [ ] Other: _______________

Cardholder Name ____

Account/Card Number ____

Expiration Date _____________ CVV: ___________ Billing City/State/Zip:_______________

WOULD YOU LIKE AN EMAIL OR TEXT RECEIPT SENT? Yes No
If yes, please write your text number / email: ____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect all charges are satisfied or until I cancel it in writing, whichever is later. I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Client Name: ____

Client Signature ____ Date _________________

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 with Another Person

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: ______**

____
Person's Name

____
Person's Street Address

_______________________ _______
City and State Zip

__________________ __________________
Phone Number Fax Number (if applicable)

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

[ ] To allow Shannon Lilja/Sandalwood Counseling to release information to, and obtain information from the above person.

- [ ] Attendance/Appointment Information
- [ ] Insurance and/or Billing Information
- [ ] Diagnosis and/or Treatment Plan Information, including pertinent session content information
- [ ] Information to collaborate care (ie between medical or behavioral health providers)
- [ ] Information about drug or alcohol use **
- [ ] Discharge Information
- [ ] Other: ____

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**