Eileen Dey Wurst, M.A., LMHC

Integrative Individuals & Couples Therapy
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New Client Information Packet

Date:

Name(s):

A complete intake will be done at first session. In preparation, I ask you to review this packet and also complete prior to our first session. Thank you.

What are the issues you would like to work on in today's session?

Please also indicate how long these issues been occurring:

Have you ever received Reiki or guided imagery in a session before?
If yes, how long ago?
What was your experience like?

EMOTIONAL HISTORY
Please list any traumatic events or life changes (job, relationship, etc.) you would like me to know about. How do you feel today? Have you had counseling before? If so, when and for how long? Currently on any prescription medications/supplements related to emotional health?

PHYSICAL HISTORY
Are there any accidents, injuries, and/or diseases that have occurred in the last 1-3 years that you feel I should know about? Is anything physical bothering you today?

(Please use the back of this form if you require more room for your answers)

Disclosure Statement, Guidelines and Fees

Counseling Approach:
My role is to provide assistance, insight, and sometimes challenges through that process of change. In order for our sessions to be effective that is my task to create a safe, non-judgmental environment in which one can begin to explore the thoughts, feelings, experiences and attitudes that have influenced their behaviors and decisions thus far. With this in mind, together we then can begin to set new goals and work towards creating a more meaningful and authentic experience of one's life.

Credentials and Experience:
I have over 20 years experience as a social worker and counselor with prior experience in geriatrics, domestic violence, special needs, career counseling and addictions. As I am also a practicing Reiki therapist, I include energywork, sound healing and various meditation and visualization exercises into our session.
I received my Masters degree in Counseling, Education and Leadership from Montclair State University in NJ in 1997. I received my Licensed Mental Health Certification in 2010. For your benefit and my professional growth, I engage in regular consultation with colleagues. If I discuss your case, I will do so in such a way to insure your confidentiality.

The Counseling/Consultation Process
People come to counseling because they want something to be different in their lives. They may want to change their personal or family situation, solve a particular problem, or simply bring a healthier balance to their lives. The counseling process can be fun and exciting. It can also, at times, be very challenging, difficult and even painful. However, the goal will always be to bring about some positive change.
At our initial meeting, we will assess your current needs and concerns, and decide if we can work together to address them. We will evaluate the results of our work together, and determine the need for additional sessions, termination, or outside referral for further counseling or assistance. Throughout our work together, I will make every reasonable effort to professionally facilitate the resolution of your needs and concerns. Ultimately, you must decide to use what you gain from the counseling process.

Your Rights and Responsibilities
You have the right to ask me to explain my reasons for making certain recommendations or for using certain procedures. You also have the right to refuse to follow these recommendations, and/or to terminate the counseling process at any time and for any reason. I have the right and ethical responsibility to terminate counseling and offer a referral to another counselor if you choose not to follow my recommendations. *Either of us may request a final session to discuss the reasons for termination, and to decide on an appropriate referral if desired*. Please inform me if you are seeing another counselor or mental health professional during the course of our work together, so that we may provide consistent treatment for you. You have the right to confidentiality in the counseling relationship as described in the next section. Our work can only be effective with commitment and continuity. If you must cancel a scheduled appointment, please inform me no sooner than 24 hours before the appointment.

You will be responsible for payment for any missed or cancelled appointments, except in the case of personal emergency. Please be on time for your scheduled sessions, as other clients may have appointments with me immediately following yours. Note that if you are late, the session will still end on time, and you will still be responsible for full payment.

As a Licensed Mental Health Counselor, I adhere to the Code of Ethics and Standards of Practice approved by the Washington Board of Examiners in Counseling and the American Counseling Association. These ethics and standards are intended to protect the welfare of both my clients and the community I serve. A primary provision of these is my responsibility to protect your right to privacy: *I must keep all details of our counseling relationship, including anything you tell me, in strict confidence, unless I have your expressed permission to inform or consult*

with someone else. I may consult with colleagues for supervision with the understanding that I will not disclose your name or other identifiable personal information. This code of confidentiality has only a few exceptions:
1. I must disclose information to a third party if I learn of any potential abuse or neglect of a child or elderly person, or if I learn that you pose a threat of danger to yourself or any other person.
2. If I receive information confirming you have a disease known to be communicable and fatal, I must disclose this to a third party who by her/his relationship with you is at high risk of contracting the disease.
Before making the disclosure, I must first determine that you have not already informed the third party, and that you have no intention to do so.
3. In short, I have a "duty to protect" you and others from harm.
4. I will not disclose any information without first consulting my colleagues or other professionals regarding the validity of these exceptions. Should you request that I reveal information about our counseling relationship to others, I will ask you to first sign a release of information form specifying exactly what you wish revealed and to whom.

Fees
Regular Psychotherapy Session (60 minutes) $120.00 ***Fees are payable at the beginning of each session by check, cash or credit. Make checks payable to Eileen D. Wurst. Please have your check prepared in advance so that session time can be best utilized.***

Your Financial Responsibility

I will submit the service charges listed above to your insurance company, if I am an in-network provider for that insurance company. For those whose insurance companies with whom I am not an in-network provider, you will be responsible for submitting your own claims to insurance. Overall, you are ultimately responsible for your bill. Please refer to the Fee Schedule above for a list of specific charges. You are responsible for contacting your insurance company regarding your policy's coverage of these services and necessary referrals.
I understand I must give at least 24 hours notice prior to canceling my appointment or I will be charged for the scheduled appointment.
I understand that the responsibility for any portion of any charge not paid or denied by my insurance will transfer the patient's balance. You will be billed for any required co-pays.
If you have any questions about this form or my fees, please call 206-947-7687

Client signature: Date

Patient / Insurance Information (Please bring copies of your insurance card to first session)

Patient Name:				
DOB:	SSN:			
Address:	City:	ST:	Zip:	
Home Phone:				
Alternate Phone:				
E-Mail Address:				
Emergency Contact:				
Guarantor/ Primary Insurance Carrier:				
Name of Insured:				
DOB:				
SSN:				
Relationship to Patient:				
Address:	City:	ST:	Zip:	
Home Phone:				
Employer:				
Work #:				
Insurance Co:				
Ins. Co. Address:	City:	ST:	Zip:	
Ins. Co. Phone:				
Group #:	Policy #:	Spouse:		

I authorize my insurance benefits to be paid directly to the counselor, Eileen Dey Wurst, M.A., LMHC. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Signed: _____ Date: _____
(Guarantor of Primary Insurance Carrier)

Authorization for Mutual Exchange (for exchange of relevant doctor/prior counselor notes)

I hereby authorize the mutual exchange of information regarding the above named client between Eileen Dey Wurst, and the following person(s)/entities, for the sole purpose(s) stated below, and limited to the following time period(s):
Provider Name(s)/phone number(s):

EXP. DATE:
I understand that Eileen Dey Wurst will not send any information in print or electronically, or speak with anyone in person or via phone, regarding your Personal Health Information, except to those people and entities stated above.

Client signature: Date