

**David W. Anderson M.S.**  
**Licensed Mental Health Counselor**  
Discovery Counseling Associates  
Cornerstone Counseling Association  
4202 Meridian, Suite 203  
Bellingham, WA 98226  
Phone: (360) 676-9535 ext. 4  
FAX: (360) 733-4339  
danderson@discoverycounsel.com

### **Professional and Educational Background**

Dave holds a Master of Science degree in Psychology from Western Washington University, and also completed extensive Counseling Psychology coursework from City University. Dave is a Licensed Mental Health Counselor and is currently in private practice at Discovery Counseling Associates in Bellingham, Washington.

Dave has worked in the mental health field since 1984. His counseling experience with individuals and couples include Iverson Center in Seattle, Washington, Abba Counseling Services in Surrey, British Columbia, and Cornerstone Christian Counseling Services in Surrey, British Columbia. While at Cornerstone Christian Counseling Services Dave developed a recovery group program and offered various seminars and workshops. He enjoys working with individuals, couples, and families, utilizing cognitive-behavioral therapy, longer-term psychodynamic therapy, and memory-repair techniques.

### **Areas of Specialization**

Relationship problems: including marriage, parent-adolescent, etc.  
Premarital preparation  
Anxiety: including phobias, PTSD, etc.  
Depression  
Grief and other adjustment issues  
Burnout and other stress-related problems  
Recovery from childhood and adulthood trauma, abuse, and neglect  
Codependency, ACOA, and ACODF  
Self image and self esteem issues  
Personality Disorders  
Dissociative Disorders  
Spiritual direction and life direction  
Peak sports performance mental states ("the zone")

### **Personal Information**

Dave has been married to his wife Debra for 34 years. They have three adult children and one granddaughter. In his leisure time Dave enjoys gardening and woodworking

**Terms of Service and Disclosure Statement of David Anderson, M.S., L.M.H.C.**  
4202 Meridian Street, Suite 203, Bellingham, WA. 98226

I am a Licensed Mental Health Counselor in the state of Washington (#LH00008016). The following information should help you to understand key aspects of our counseling relationship.

**OUR RELATIONSHIP**

Professional ethics require that our contact be limited to counseling sessions and to counseling-related phone calls or email. I therefore cannot accept social invitations or gifts.

**CONSULTATION AND PEER REVIEW**

Discovery Counseling Associates is a consultative group of experienced therapists. Good clinical practice requires occasional peer review and consultation within this group. Please be aware that your case may be clinically reviewed in a confidential manner in this setting.

**CONFIDENTIALITY AND PRIVACY**

I will keep confidential anything you disclose to me, with a few exceptions as required by law. Please read the attached **Notice of Privacy Practices** for more information about your privacy rights, and initial here to acknowledge that you received a copy of the **Notice**, or that you were offered the **Notice** form and declined your own copy:

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**FEES AND PAYMENT**

Rates for counseling services are \$150.00 for the **initial session** (75-80 minutes) and \$100.00 per 50-55 minute session thereafter. **The initial session**, individual/couples/family therapy, groups, and court attendance may be billed at different rates and in accordance with your insurance company. Please let me know if these fees present a financial hardship for you if you are paying out-of-pocket. In special cases I may discount my standard fee.

With insurance carriers, we will decide together whether you will pay the full fee, or the co-pay/co-insurance only, at the time of service. **You are responsible for determining the specifics of your insurance coverage**, as well as procuring relevant paperwork, such as physician referrals, as your insurer may require. All insurance companies require that your therapist diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis that I plan to render before submitting it to your insurance carrier.

**Please note that as the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time your insurance company notifies me of any unpaid portion.**

## CANCELLATIONS

In the event that you are unable to keep an appointment, you must notify me **24 hours in advance** (unless there is a reasonable emergency). If I do not receive such notice, **you will be responsible for paying the full fee for the missed session. Your insurance company will not pay for missed sessions.**

If you need to cancel or reschedule you may leave a message on my voice mail at (360) 676-9535 extension 4. Also, please remember to leave your home and work phone numbers with every message so that I can get back to you even when out of the office.

## EMERGENCIES

If there is an emergency between sessions, you may leave a message on my voice mail at (360) 676-9535 extension 4. Telephone conversations should be kept as brief as possible, as they are normally not an appropriate method of conducting therapy. There is no charge for phone conversations of 10 minutes or less. But if a phone conversation of more than 10 minutes is necessary, you may be charged at the usual hourly rate. I typically listen to my voice mail messages three or four times daily. In the case of life-threatening emergency, please call **911**, go to your hospital's **Emergency Room**, or call the **24-hour Crisis Line at 1-800-584-3578**.

## RELATIONSHIP TO DISCOVERY COUNSELING ASSOCIATES

Please be informed that Discovery Counseling Associates is an association of therapists linked by a common faith, shared office policies, and facilities. We provide collegial support for one another and form a clinical consultative group, but we do not provide supervision over one another's practices. We are independent, private practitioners, and therefore do not assume responsibility for the other members' clinical work. I operate a 501-C-3 nonprofit organization in good standing with the IRS, named Cornerstone Counseling Association.

## COMPLAINTS

If at any time or for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concern, you may report your complaint to the Health Professions Quality Assurance Division at (360) 236-4902.

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By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure. I also give David W. Anderson M.S., LMHC permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

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Client or Guardian Signature

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David W. Anderson M.S., LMHC

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Date

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Date

**FINANCIAL CONTRACT**  
**With David W. Anderson M.S., LMHC**

Counseling fees are \$150.00 ( ) for the initial 75-80 minute session, and \$100.00 ( ) per 50-55 minute sessions thereafter. The initial session, individual/couples/family therapy, groups, and court attendance may be billed at different rates and in accordance with your insurance company. This fee is usually collected in full at the beginning of each session. Cash or checks are acceptable for payment (sorry, we can't take credit cards). I can provide you with a receipt for fees paid. With insurance carriers we will decide together whether you will pay me the co-pay or co-insurance only, or the full fee at the time of service. **You are responsible for determining the specifics of your insurance**, as well as procuring relevant paperwork such as primary care physician referrals, as your insurer may require. Assistance in clarifying billing questions is available by calling a billing specialist at Fast Medical Solutions at (360) 738-7773.

**Please note that as the recipient of services, you are responsible for all charges not paid by your insurance company. Payments will be due at the time the insurance company notifies me of any unpaid portion. Delinquent accounts will be referred to an outside collection agency. A fee of \$25.00 is charged for returned checks.**

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit to your insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or behavioral health care manager. If you have any questions about the details of your plan, please refer to your benefits booklet or contact your insurer.

I, \_\_\_\_\_, understand and agree to pay David W. Anderson M.A., LMHC the amount of \$150.00 ( ) for the initial session (75-80 minutes) and \$100.00 ( ) for each individual/couple/family session (50-55 minutes). I understand that I am responsible for payment for sessions not cancelled 24 hours in advance. Payment for services, whether full payment or co-payment, are to be rendered at the time of service. I hereby authorize this clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from me, over and above my indebtedness, will be refunded to me when my bill is paid in full.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_

**DISCOVERY/CORNERSTONE COUNSELING INTAKE FORM**  
Confidential Client Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ OK to leave message? Yes No

Work or Cel # \_\_\_\_\_ OK to leave message? Yes No

Spouse Name \_\_\_\_\_

Marital Status: Married \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed \_\_\_\_ Single \_\_\_\_

Children's Names and Ages \_\_\_\_\_

\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to You \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work or Cel # \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Did Someone Refer You to Me? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Current Medical Problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications \_\_\_\_\_

\_\_\_\_\_

**Check Any Additional Conditions You Have Had:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Chronic Fatigue     | <input type="checkbox"/> Hypoglycemia        |
| <input type="checkbox"/> AIDS/HIV        | <input type="checkbox"/> Chronic Pain        | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Alcohol Abuse   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Drug Abuse          | <input type="checkbox"/> OCD                 |
| <input type="checkbox"/> Anger Problems  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Panic Attacks       |
| <input type="checkbox"/> Anxiety/Phobias | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Skin Problems       |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Head Trauma         | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Suicide Attempt     |
| <input type="checkbox"/> Autism          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> High Chronic Stress | Other: _____                                 |

Have you served in the military? Yes \_\_\_\_\_ No \_\_\_\_\_ Combat? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had previous psychiatric care or counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Psychiatrists or Counselors \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reasons for seeking care \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was previous psychiatric care or counseling helpful? Yes \_\_\_\_\_ No \_\_\_\_\_

Church or Religious Affiliation \_\_\_\_\_

**PRIMARY INSURANCE:**

**SECONDARY INSURANCE:**

No Insurance Coverage \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Client ID # \_\_\_\_\_

Client ID # \_\_\_\_\_

Group/Plan # \_\_\_\_\_

Group/Plan # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to You \_\_\_\_\_

Relationship to You \_\_\_\_\_

**PERSONAL GOALS FOR COUNSELING**

Please List the Primary Concerns You Want to Discuss in Therapy, And the Specific Goals You Wish to Accomplish:

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