Randy C. Williams, M.A., LMFT
Licensed Marriage and Family Therapist
Discovery Counseling Associates
4202 Meridian St., Suite 203
Bellingham, WA 98226
Phone: (360) 676-9535
FAX: (360) 733-4339
rwilliams@discoverycounsel.com

Professional and Educational Background

Randy Williams, a Licensed Marriage and Family Therapist, has worked in the mental health field since 1985. He began his counseling career in California before moving to the Northwest in 1988 where he started his private practice and became director for Bethesda Christian Counseling in 1990. Randy was a co-founder of Discovery Counseling Associates in 1990. He holds a Master's Degree in Marriage, Family and Child Counseling from Azusa Pacific University in Azusa, California. Randy is a Clinical Member of the American Association of Marriage and Family Therapists (AAMFT).

Randy enjoys working with couples as well as individuals, in both short- and long-term cognitive and behavioral therapy. He has led marriage enrichment weekends both in the US and in Canada. He also developed and co-taught a lay caregiving program in Whatcom and Skagit counties for a number of years. He has served with Red Cross as mental health services liaison, and also as a support officer for the Bellingham Fire Department. Randy also served with the Whatcom/Skagit Industrial Critical Incident Stress Management team. He also has worked in a variety of different therapeutic settings, including drug and alcohol treatment and youth diversion programs.

Areas of Specialization

Randy works with adolescents and adults in individual, couples and family therapy. He specializes in:

- Relationship Issues: marriage, parent-child, etc.
- Infidelity
- Emotional and physical abuse
- Depression, Adjustment, and Mood Disorders
- Anxiety, Panic Disorders, and Phobias
- Obsessive-Compulsive Disorder
- Cognitive Behavioral Therapy
- Christian Counseling

Personal Information

Randy is married to Claire, and has a son, Ryan, in college and a daughter, Kimberly, in high school. He enjoys camping, hiking, baseball, reading, gardening, making saw dust, golfing, and occasional fly fishing.

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TERMS OF SERVICE / DISCLOSURE STATEMENT (effective 12/01/2006)
This document is designed to ensure that you understand key aspects of our professional relationship.

LICENSURE:
I am a Washington State Licensed Marriage and Family Therapist (#LF00001090).

OUR RELATIONSHIP:
Although you may at times feel very close to your therapist, it is important for you to realize that I have a professional relationship rather than a personal one. Professional ethics require that contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask to be related to you in any way other than in the professional context of our counseling sessions. You will be best served when the relationship stays strictly professional and the sessions concentrate exclusively on your concerns.

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:
Your therapist will keep confidential anything you say to him or her, 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: _________ (Please initial here)

FEES AND PAYMENT:
Rates for individual counseling services are $150 for the **initial session**, and $100.00 per 50-minute hour for sessions thereafter. The initial session, couples and family therapy, groups, consultation, training services, and court attendance may be billed at different rates and in accordance with our contracts with your insurance company.

While this fee may be collected in full at the end of each session, Randy Williams has agreements with Regence, Premera, Group Health Cooperative, and some others to collect your co-pay/co-insurance at the time of service, and submit billing for the rest directly to your insurance company. They will pay Randy Williams, LMFT directly for covered services.

With other insurance carriers, you and I 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 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 by your insurance company. Payments will be due at the time the insurance notifies us of any unpaid portion. Payment may be made by cash, check, VISA, Mastercard, Diners Club, or debit card (with a VISA or Mastercard logo).

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 half the individual service rate for the missed session**. **Your insurance company will not pay for missed sessions.**

If you need to cancel or reschedule you can leave a message on Randy Williams' voice mail at **(360) 676-9535 extension 3.** 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, I can may be reached by phone at **(360) 676-9535 extension 3.** Telephone conversations should be kept as brief as possible, as it is normally not an appropriate method of conducting therapy. If a contact of more than 10 minutes is necessary, you may be charged at the usual hourly rate. If you are unable to reach me during regular business hours, I can be reached by leaving a message and choosing the **urgent send option**. I will then be paged. There is no charge for contacts less than 10 minutes; for calls over 10 minutes you may be charged at the usual hourly rate. In the case of life threatening emergency, please call **911**, go to the **Emergency Room**, or call the **24-hour Crisis Line: 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 do not provide supervision over one another's clinical practices. We are independent, private practitioners, and therefore do not assume responsibility for the other members' clinical work. I am legally incorporated in Washington State as Randy Williams Counseling, Inc.

COMPLAINTS:
If at any time or for any reason you are dissatisfied with the 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.

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 Discovery Counseling Associates permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.

______________________________	______________________________
Client's Signature	Randy Williams, LMFT
______________________________	______________________________
Date	Date

Financial Contract
with Randy Williams, M.A., LMFT

Charges are $150 for the initial session, and $100 per 50-55 minute hour thereafter. Other services include: couple and family therapy ($100), consultation & training services ($125). **Cash or personal checks are acceptable for payment. I can also take VISA, Mastercard, and Diners Club, as well as debit cards branded with a VISA or Mastercard logo.** I can provide you with a receipt for fees paid.

While this fee is usually collected in full at the beginning of each session, Randy Williams Counseling, Inc. has agreements with Premera, Regence and some other insurers to collect co-payments and co-insurance, if any, at the time of service and submit billings for the insurance company portion directly to them. **Co-payments are due at time of service, without exception.** If you do not know your co-payment, then we ask for 50% of the fee as co-payment. They will pay me directly for covered services. This billing procedure is a service to you provided through our arrangements with your insurer. With other 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 coverage, as well as procuring relevant paperwork, such as primary care physician referrals, as your insurer may require. Assistance in clarifying billing questions is available through my billing specialist, Jean Reimer at Accupro Medical Services (360-366-0494).

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 the insurance company notifies me of any unpaid portion. A carrying fee of $2 per month is charged on all balances owed that are more than 90 days past due. Delinquent accounts will be referred to an outside collection agency. A fee of $25 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 it to your insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or a 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 Randy Williams, M.A., LMFT the amount of $150 for the initial session, and $100 for individual sessions or $100 for a couple/family session.
I understand that I am responsible for payment for consultations 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 the 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 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 COUNSELING ASSOCIATES ADULT INTAKE FORM

PLEASE COMPLETELY FILL OUT ALL PAGES.

Date: ______________________ Form filled out by: ___Self ___Other: __________________
Client Name: ___________________________ Date of Birth: _____________ Age: ________
Gender: ___Female ___Male
Referred By: _______________________ Primary Care Doctor: ___________________________

Address: ___________________________________ City/State/Zip: ________________________
Home Phone #: ________________ Cell #: ________________ Work Phone #: _______________
OK to leave message? ___**YES** ___**NO**
Employer: ______________________ Employer Address: _________________________________

Emergency Contact: Name: ______________________ Relationship to you: _______________
Home Phone #: __________________Cell #: __________________ Work #: ________________

PRIMARY INSURANCE

___**No Insurance Coverage**
Insurance Co.: __________________________
Insurance Co. Address: __________________
____
Insurance Co. Phone #: __________________
Client ID#: ____________________________
Group/Plan #: __________________________
Policy Holder Name:_____________________
Date of Birth:_________ SS #:_____________
Relationship to you: _____________________

SECONDARY INSURANCE

Insurance Co.: __________________________
Insurance Co. Address: __________________
____
Insurance Co. Phone #: __________________
Client ID#: ____________________________
Group/Plan #: __________________________
Policy Holder Name:_____________________
Date of Birth:_________ SS #:_____________
Relationship to you: _____________________

Person Responsible for Account: ___ Self ___ Other (fill out below)
Name: ______________________________ Address: ___________________________________
Home Phone #: __________________ Work: ________________ Cell: _____________________
SS#: _______________________ DOB: ______________ Employer: _______________________

FOR OFFICE USE ONLY

Dates of Referral: _______________ to ______________Date First Consulted:_________________
Number of Sessions: _____________ Ded.: ____________Co-pay/Co-ins: ___________________

SUBSTANCE USE

Check Past and Current Substance Use:									
	Past Use	How Often	**Current Use**	How Often		**Past Use**	How Often	**Current Use**	How Often
Hard Liquor					Tranquilizers/Sleeping Pills				
Beer/Wine					Inhalants				
Marijuana					Cocaine				
Speed/Amphetamine					Nicotine				
Heroin/Painkillers					Coffee				
Hallucinogens/Ecstasy					Soft Drinks				
PCP					Other				

Consequences of Substance Abuse: (check all that apply):

___ Hangovers
___ Seizures
___ Blackouts
___ Overdose
___ Withdrawal Symptoms
___ Medical Conditions
___ Loss of Control Amount Used
___ Sleep Disturbance
___ Assaults
___ Suicidal Impulse
___ Relationship Conflicts
___ Binges
___ Interference with School
___ Job Loss
___ Arrests

Psychiatric History:

Prior **Out**patient Therapy? __ Yes __ No Provider Name: ___________________________ Was It Beneficial?: __ Yes __ No

Prior **In**patient Therapy? __ Yes __ No Facility Name: ____________________________Was It Beneficial?: __ Yes __ No

MEDICAL HISTORY

Describe Current Physical Health: __ Good __ Fair __ Poor

List All Medications Client Is Taking. Include Non-Prescription Drugs And Health Supplements.

Drug Name	Purpose	Dosage	# Per Day
1			
2			
3			
4			
5			

Prescribed By: ____

Do you have any allergies to medication? ___ Yes ___ No If yes, which ones? ____________________________

Check Any Of The Following You Have Had In The Past Three Months:

__ Vision Problems
__ Stomach Aches
__ Memory Loss
__ Dizziness
__ Shortness of Breath
__ Back Pain
__ Head Injury
__ Weakness in Arms or Legs
__ Constipation
__ Loss of Consciousness
__ Chest Pains/tightness
__ Hearing Loss
__ Convulsion/Seizures
__ Diarrhea
__ Chronic Pain
__ Fainting
__ Nausea or Vomiting
__ Unusual Bleeding
__ Menstrual Irregularities
__ Headaches

Check Any of the Conditions You Have Had and the Date of Onset:					
Condition	**Date**	**Condition**	**Date**	**Condition**	**Date**
ADD/ADHD		Cancer		Learning Disability	
AIDS/HIV		Diabetic		Low Blood Pressure	
Allergies		Epilepsy		High Blood Pressure	
Anemia		Head Trauma		Obesity	
Arthritis		Heart Disease		Migraines	
Asthma		Hyperactivity		Stomach Ulcers	
Autism		Hypoglycemia		Thyroid Problems	
Depression		Panic Attacks		Skin Problems	
Anxiety Attacks		Obsessive/Compulsive		Other:	

Is There a History of Any of the Following in Your Family:								
	PAR ENT	SIBL ING		PAR ENT	SIBL ING		PAR ENT	SIBL ING
Alcoholism			Birth Defects			Mental Retardation		
Alzheimer's Disease/Dementia			Cancer			Obsessive/Compulsive		
Panic Disorder			Depression			Anger Problems		
Anxiety Disorder			Diabetes			Schizophrenia		
ADD/ADHD			Drug Abuse			Seizure Disorder		
Behavior Problems			Heart Disease			Suicide/Homicide		
Bipolar Disorder			High Blood Pressure			Thyroid Problem		
Violent/Abusive Behavior			Aspergers					

<u>SOCIAL-ECONOMIC HISTORY:</u> (check all that apply for client)

Marital Status:
__ Single, Never Married
__ Engaged _____ Months
__ Married ______Years
__ Divorced _____Years
__ Separated _____Years
__ Divorce in Process
__ Live-in for____Years

Employment:
__ Employed and Satisfied
__ Employed but Dissatisfied
__ Unemployed
__ Coworker Conflicts
__ Supervisor Conflict
__ Unstable Work History
__ Retired

Financial Situation
__ No Financial Problems
__ Impulsive Spending
__ Current Legal Issues
__ Poverty or Below-Poverty Income
__ Large Debt

Military History:
__ Never in Military
__ Military Service – No Combat
__ Military Service – combat

Education:
__ Did Not Complete High School
__ Completed High School
__ GED
__ Years of College _______
__ College Degree: ________

Religious or Church Affiliation: ____

List Any Other Persons Living In Clients Home:		
Name	***Age***	***Relationship to Client***
List Children Not living in the Home:		
Name	***Age***	***Relationship to Client***

PERSONAL GOALS for COUNSELING:

Please List Issues To Discuss In Therapy Which Are Primary Concerns And Specific Goals You Wish To Accomplish:

____

____

____

____

____

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Notice of Privacy Practices Regarding Protected Health Information

effective April 14, 2003

To our clients: *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for us to "***use***" your PHI within our practice group, or "***disclose***" your PHI to an outside entity for the following purposes:

1 ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

2 ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

3 ***Health Care Operations*****:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your "***Psychotherapy Notes***"—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

1 **Child Abuse:** If your therapist has reasonable cause to believe that a child has suffered abuse or neglect, she/he is required by law to report it to the proper law enforcement authorities.

2 **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that abandonment, abuse, financial exploitation, sexual or physical assault, or neglect of a vulnerable adult has occurred, she/he must immediately report it to the appropriate authorities.

3 **Health Oversight:** If the State Department of Health subpoenas your therapist as part of its

investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

4 **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This privilege does not apply when you are being evaluated for a third party or for the court. You will be informed in advance if this is the case.)

5 **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

6 **Worker's Compensation:** If you file a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

<u>IV. Patient's Rights</u>

1 ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

2 ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

3 ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

4 ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

5 ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

<u>V. Therapist's Duties</u>

1 We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

2 We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

<u>VI. Complaints</u>

If you have a complaint about the way we have handled your privacy rights, you may contact:
Dave Anderson, Privacy Officer; 4202 Meridian St., Suite 203, Bellingham, WA 98226; 360-676-9535.

Pre-Authorized Credit Card Payment Form

As the person named below (or the person responsible for payment of this client's fees), I hereby give my permission to keep my signature on file and to charge my credit card account for the balances of charges not paid by the insurance company or myself after 45 days from date of billing.

I understand that this form is valid for two (2) years unless I cancel the authorization through written notice.

____
Client Name

____
Responsible Party Name on the Credit/Debit Card

____
Cardholder Billing Address

____
Type of Credit/Debit Card (VISA, MC, Diners Club)

____
Credit/Debit Card Number

____
V-Code (last 3 numbers on the back of card)

____
Credit/Debit Card Expiration Date

____
Cardholder Signature **Date**