



Please complete this form so that we may better serve your needs

DATE : _____

NAME: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ OTHER PHONE: _____

E-MAIL ADDRESS : _____

HOW MAY WE CONTACT YOU? _____

BIRTH DATE: _____

SOCIAL SECURITY NUMBER : _____

GENDER/SEX: F/M (circle one)

EMERGENCY CONTACT: _____

RELATIONSHIP STATUS: SINGLE MARRIED LONG TERM RELATIONSHIP
 DATING SEPARATED DIVORCED OTHER (please explain)

ARE YOU A PARENT? YES NO OTHER (please explain)

SLEEP QUALITY: _____ (using 1 as very bad and 10 as very good)

ACTIVITY/EXERCISE LEVEL: _____ (using 1 as low level and 10 as high level of activity)

LIST ACTIVITIES: _____

ALCOHOL USE: YES NO IF YES, HOW MUCH _____

TOBACCO USE: YES NO IF YES, HOW MUCH _____

OTHER SUBSTANCE USE (NOT PART OF A FORMAL MEDICAL TREATMENT PLAN): _____

ETHNIC BACKGROUND (OPTIONAL): AFRICAN AMERICAN HISPANIC/LATINO

ASIAN/ PACIFIC ISLANDER CAUCASIAN

OTHER, DESCRIBE: _____

OCCUPATION: _____

EMPLOYER: _____

LENGTH WITH CURRENT EMPLOYER: _____

AREA WHICH BEST DESCRIBES YOUR REASON FOR CONTACTING IN-SIGHT: (check all that apply)

PERSONAL RELATIONSHIP FAMILY HEALTH (YOURS ___ /OTHER'S ___)

LIFE TRANSITION EMPLOYMENT FINANCIAL

OTHER

PLEASE DESCRIBE: (feel free to use the back of this sheet if you need more writing space) _____

HAVE YOU WORKED WITH ANY TYPE OF PROFESSIONAL PROVIDER ON THIS ISSUE? YES NO

HAVE YOU WORKED WITH ANY TYPE OF PROFESSIONAL PROVIDER ON ANY OTHER ISSUE? IF YES, PLEASE DESCRIBE:

IF YOU ANSWERED YES TO EITHER OF THE 2 PREVIOUS QUESTIONS, PLEASE PROVIDE THE PROFESSIONAL'S NAME(S) AND DISCIPLINE.

PLEASE LIST ALL CURRENT MEDICATIONS: _____

HOW WERE YOU REFERRED TO IN-SIGHT?

HEALTH CARE PROVIDER SELF FRIEND COWORKER

FAMILY MEMBER OTHER, DESCRIBE _____

ADVERTISEMENT (PLEASE SPECIFY) _____



EXPLANATION OF SERVICES AND DISCLOSURE

Welcome to In-Sight: Solution Focused Therapy. In-Sight is an agency that provides EMDR, psychotherapy, and coaching to individuals, couples, families, and professionals. It is In-Sight's goal to assist and support those faced with complex issues, whether personal or professional.

In-Sight works together with our clients to understand what they want and need from their therapy and will offer realistic solutions that address these needs. In doing this, In-Sight will develop a treatment plan specifically designed for each client.

THERAPISTS

BRENA LEVER, LICSW, MSW:

Brena Lever is a Licensed Independent Clinical Social Worker (#LW00007098) and a Certified EMDR* Therapist. She received her Masters of Social Work, with a specialization in Occupational Social Work, from the University of Maryland at Baltimore. She has worked in many settings, including forensic, emergency medicine, Employee Assistance Programs and international adoption. In these positions, she has worked as both a clinician and a consultant. As a Certified EMDR practitioner, Brena combines this advanced therapy model with more traditional models, such as Cognitive-Behavioral Therapy (CBT), allowing her to design a treatment plan that best fits the individual needs of each client. Her treatment model emphasizes setting goals and developing strategies to attain them. Brena's additional training has included the following: Brainspotting, Lifespan Integration, Imaginal Nurturing, Crisis Intervention, Critical Incident Stress Debriefing and Management and Mediation and Conflict Resolution

Brena is proud to be working with EMDR HAP (Humanitarian Assistance Program), a nonprofit organization which can be described as the EMDR equivalent of Doctors Without Borders. She also does work for The Soldiers Project Northwest, which provides free psychological treatment to military service members.

* EMDR (Eye Movement Desensitization and Reprocessing) is a therapy model that allows a person to identify and process past traumatic events that are continuing to have a negative effect on the individual. These events can be as seemingly insignificant as a negative interaction with a parent during childhood, or as catastrophic as a life-threatening event.

CONFIDENTIALITY

All information discussed with In-Sight is strictly confidential in nature and shall be used solely by In-Sight professionals. This information will not be disclosed or released without written permission of the client, and will be done in a manner consistent with In-Sight information handling procedures. If an In-Sight professional believes there is a physical threat to a client or someone named by a client, state and federal law require disclosure of that information.

In compliance with Washington State law (RCW 18.225.105), information shall only be disclosed under the following circumstances:

- (1) With the written authorization of that person or, in the case of death or disability, the person's personal representative
- (2) As required under chapter 26.44 or 74.34 RCW or RCW 71.05.250; or [abuse/neglect, harm to self/others]

(3) To any individual if the person licensed under this chapter reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the individual or any other individual; however, there is no obligation on the part of the provider to so disclose.

(4) If the person waives the privilege by bringing charges against the person licensed under this chapter;

(5) In response to a subpoena from the Secretary of Health. The secretary may subpoena only records related to a complaint or report under RCW 18.130.050;

FEE AND PAYMENT

Individual sessions are \$150/session*.

Telephone conversations \$15/5 minutes

Couples sessions are \$180/session*.

*Sessions are 50 minutes in length.

Fees are due at the beginning of each session; exceptions to this will only be permitted following specific arrangements agreed upon between the client and provider.

In-Sight will put forth every effort to accommodate the various schedules of its clients. The client will be responsible for payment of a canceled session if the therapist is not notified within 24 hours prior the scheduled appointment.

Brena Lever accepts insurance as an "out of network provider" for insurance carriers. An invoice that contains any information required by your insurance company will be provided in order for you to receive any reimbursement that is due to you under your plan.

Payment will be accepted in cash, check or credit card (there will be a 2.75% service fee applied to credit card charges).

CLIENTS' RIGHTS

Each client has the right to refuse treatment, at any time. In addition, they have the right to choose a practitioner and treatment modality which best suits their needs.

Each client has a legal right to obtain list of, or copy, the acts of unprofessional conduct listed under RCW 18.130.180. This document can be requested from the following address:

Health Professions Quality Assurance
Customer Service Center
PO Box 47865
Olympia WA 98504

Email: hpqa.csc@doh.wa.gov

Phone : (360) 236 - 4700

Fax: (360) 236 - 4818

I HAVE READ AND UNDERSTAND THIS EXPLANATION OF SERVICES.

CLIENT _____ **DATE** _____

IN-SIGHT _____ **DATE** _____