



Maria-Jose Soerens, M.A., LMHCA

The River Beneath

200 First Ave West, Suite #400

Seattle, WA 98119

Intake Form

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email Address _____

*Home Phone _____ Work Phone _____

Sex (M/F) _____ DOB _____ Single Married Divorced Separated
Co-habiting

Is it acceptable to contact you at home? Y / N

If "no" then how can I contact you? _____

Are you currently under medical care? Y/N Describe:

Name of Personal Physician & Phone Number: _____

Are you currently taking prescribed medications? Y / N

If yes, then please explain/describe. _____

List any psychiatric/mental health medications you have taken. _____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention. _____

Please circle any of the following struggles that pertain to you:

Anxiety Depression Fears/Phobias Eating Disorders

Sexual Problems Suicidal Thoughts Separation/Divorce Relationships

Finances Drug/Alcohol Use Career Choices Anger

Self-Control Unhappiness Insomnia Religious Matters

Work/Stress Health Problems Cutting/Self-Mutilation Thought Patterns

From the struggles that you marked above, which one concerns you the most? Is there any other struggle not listed, that you would like me to know about?



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Explain:

Were you born in a country outside the US? Y / N

If yes, describe and for how many years: _____

Is there any other country that is a meaningful part of your story? Y / N

If yes, describe and for how many years: _____

How long have you lived in the US? _____

What is the main language spoken in your current home? _____

What is the language most meaningful to you during your childhood? _____

What language would you prefer to be used during our sessions? _____

In a scale from 1 to 10, 1 being unlikely and 10 being very likely, how confident are you that your struggles will be resolved with the help of therapy?

1 2 3 4 5 6 7 8 9 10



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Training and Degrees: I am a bilingual (native Spanish speaker) independent mental health counselor licensed in the State of Washington (MC60107190). I received my Bachelor of Arts in Psychology from Universidad Central de Chile in 2005 and a Master in Counseling Psychology from Northwest University in 2007. I have been in private practice since 2009. I have conducted psychosocial evaluations for immigration cases and provided treatment in English and Spanish for victims of domestic violence, sexual abuse, and torture. I have worked with immigrant and refugee populations since 2006, and have participated in research studies for this specific population. I have specific training on issues of domestic violence and I have served as a mental health counselor at Samaritan Center of Puget Sound and Seattle Therapy Alliance, a low-income clinic for women in Seattle. My work is supervised by a licensed mental health counselor, Dr. Nancy Murphy.

Counseling Orientation: I view the evaluation process as forming an alliance with you to explore the nature of the struggles related to your journey of immigration to the U.S. During the session I will ask you about your personal story, your present situation, and the symptoms associated with it. In some cases, talking about your personal experiences can prompt you to connect with past wounds. In such cases, I may advise you to seek counseling.

Billing and Insurance Information: The fee for psychological evaluations will be \$100.00 per 50-minute session. A base fee of \$550 covers two clinical hours and three hours of preparation of the report. If your case demands us to meet for a longer time, I will bill accordingly. In occasions, I may be asked to attend court hearings for your case, in which instance I will also bill for my time. Payments are to be made on the day when we meet in the form of check or cash. Credit card payments can be arranged but you will be responsible for the service fees (2.75% if present or 3.5% fee if paying remotely.) If more time is needed, the payment must be made before I send my report to your lawyer. Payment options are available on a case-by-case basis. If we have arranged a payment plan, you commit to follow up with that plan to avoid the use of a collection agency.

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate the evaluation at any time. Used clinical hours and scheduled clinical hours will not be refunded unless cancelled with a 48-hr notice.

Confidentiality: There is a legal privilege in this state protecting the confidentiality of the information that you share with me. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality. There are legal exceptions to confidentiality. The following situations are those in which the information you have shared with me may be shared with others.

- 1) The client gives written permission to share confidential information.
- 2) Anything that suggests a crime or harmful act.
- 3) If the client is a minor, and there is indication that she/he was the victim or subject of a crime.
- 4) The client brings charges against the counselor.
- 5) In response to a subpoena.
- 6) As required under chapter 26.44 RCW.

When it is possible, we will discuss any exceptions to confidentiality as they arise.



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Consultations: I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas as to how to best help you reach your goals. These consultations are obtained in such a way that confidentiality is maintained.

Scheduling Appointments: Appointments are generally made taking into consideration the timeline for your case. When you make an appointment, I reserve that time for you exclusively.

Cancellation/No shows: If you need to cancel your appointment, please let me know **at least 48 hrs** in advance. Missed sessions or cancellations within 48 hrs of a scheduled appointment will be charged to your credit card at the hourly fee. Charges for missed sessions cannot be billed to insurance.

State Information: Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (A) To provide protection for public health and safety; and (B) To empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure called "Counseling or Hypnotherapy Clients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact Nancy Murphy at (206) 363-9601 or the Department of Health at the following address and phone number: Department of Health, Counselor Programs P.O. Box 47869, Olympia, WA 98504-7869, 360.664.9098

Contacting Me by Phone: You may leave me a message at 360.930.9403 or email me at cote@theriverbeneath.com. I will check these messages on a regular basis. Please limit your phone conversation and email needs to appointment scheduling and emergencies.

Emergencies: If you are in an emergency and cannot reach me, please call one of the following numbers for help: General Emergencies 911
Crisis Clinic 800.244.5767 or 206.461.3222

I have read and understand the information presented in this form.

Client Signature

Date

Therapist

Date



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Responsibility for Balance

Please provide your credit card information in case we must charge you for late cancellations or outstanding balances:

Credit card number: _____

Name on card: _____

Expiration date _____

I authorize The River Beneath, Counseling & Advocacy to charge the remainder of my balance

Signature _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name	Client Date of Birth
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This is to authorize that the information specified below regarding the above person be disclosed between:

Maria-Jose Soerens, M.A., 200 First Ave W #400 Seattle, WA 98119	and	_____ Person or Facility _____ Street _____ City State Zip Phone: _____ Attention: _____
Phone: (206) 390-0940 Attention: _____		Phone: _____ Attention: _____

Specific Information to be Disclosed:

<input type="checkbox"/> Intake Evaluation	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical History	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Medications	<input type="checkbox"/> Medical Diagnosis	<input type="checkbox"/> Other: _____

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____
Client Parent Legal Guardian

Emergency Notification

In case of emergency, notify:

Name: _____

Address: _____

Work Phone: () _____

Home Phone: () _____

Relationship: _____

OR

Name: _____

Address: _____

Work Phone: () _____

Home Phone: () _____

Relationship: _____

Client Signature: _____