Dr. Brandy A Marks, DRS

Licensed Mental Health Counselor

COUNSELING STATEMENT, CONFIDENTIALITY and PRIVACY POLICIES

Welcome! We pray that your life will be forever changed by your experience here as God changes hearts when we have a willing attitude and by the power of His Word.

Credentials

My name is Brandy Marks. A single mother of 2 grown sons, I was a registered nurse for 22 years and a counselor since 1991. I earned a Master of Education in guidance and counseling (1993 at City U), and a Doctor of Religious Studies in Biblical Counseling (2009 at Trinity Theological Seminary). I was licensed in Washington, 2001. I accept some insurance: Aetna, American Behavioral, Amerigroup, Cigna, First Choice, Pacific Source, ProviderOneWA (FFS), United Behavioral, and others.

Policies

At your counseling experience, I want you to be aware of a few things that are essential if the counseling you receive is to be transforming. They are as follows:

. The counseling is from God‘s Word, and may use relevant secular models such as cognitive behavioral and relational, all of which includes the body, mind, emotions, and spirit.

. Biblical counsel, when done with genuineness, is always “heart focused”. There can never be real change or healing in one‘s life without a change of heart.

. Heart change is not about "head knowledge“, but learning to apply ones learning to life. God’s Word is essential to Biblical counseling. It changes lives. While helping you to understand and apply Gods word, ultimately, the process is aimed at helping you change whatever you desire to change.

. In a Spirit of Love, I do my best to help you or your child choose to change his or her heart, so you may have the healing and abundant life that Christ desires for us (John 10:10). If you or a family member is prepared with a willing spirit to examine your heart, and change whatever the Lord convicts you of in counseling, then the Fruit of His Spirit (Galatians 5:22) will reign in your life.

Confidentiality

“All must submit themselves to the governing authorities, for there is no authority except what God has established. (Romans 13:1)

By law, health care information pertaining to you may be released *only with your written consent* or the consent of a parent or guardian. If you want information released about your participation in counseling, then a signed “Release of Information” will be required. A release is legally valid for ninety (90) days from the date of your signature. Nonetheless, the law (RCW 18.19.180) provides exceptions to client confidentiality where information may be released without your consent:

- In the event of a medical emergency, information necessary for treatment may be released.
- In the event of a threat of harm to oneself or someone else, if a threat is perceived to be serious, the proper individuals are contacted. This may include a person against whom a threat is made.
- In the event of suspected child, dependent adult or elder abuse, then the proper authorities must be contacted. The abuse does not have to be personally witnessed by the counselor.

- If you register a complaint with the Washington State Department of Health, information will be released as requested [mainly for licensed counselors].
- If ordered by a judge or other judicial officers, information regarding your treatment must be disclosed.
- If an attorney in Washington State subpoenas your records, the records will be released unless you file a protection order within 14 days of the subpoena.
- In the event of a client's death or disability, information will be released as authorized by the client's personal representative or beneficiary.
- I am not required to treat as confidential any communication that reveals the contemplation or commission of a crime or harmful act.
- Evidence that a minor who is also a client is or was a victim of a crime may be released to the proper authorities.

Record Keeping:

I take brief notes in session and/or may also record the session at times for teaching purposes.

Insurance and Payment

When an appointment is scheduled, we ask that you *give at least 24 hours notice of cancellation or you will be charged for the full session*. Please sign below to indicate your agreement with our policy. Please sign your name indicating you have received a copy of this and the HIPPA notice.

Your Signature _____ Date _____

Print Name _____

Insurance information for billing:

o A copy of insurance card (made at first appointment) Insurance name:_____

o Your member ID (on ID card) _____ Social Security # _____

o Group name, (from your ID card) _____

o Group number (on member ID card) _____

o The primary member's full name _____ Date of Birth _____

o The client or patient's full name _____ Date of Birth _____

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o If you were treated for an accident and/or on-the-job injury the following is also needed:

o Insurance Carrier's Phone # on Card _____

o If an accident, give date, time, and details.

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Brandy A Coffee Marks, D.R.S., L.M.H.C.

CLIENT INTAKE NAME: _____ SPOUSE

Today's Date: _____ Male ☐ Female ☐

Date of Birth: _____ Age: _____

Physical Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home Phone _____ Work: _____ Cell/Alternate.: _____

E-mail:_____ Employer: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____

Relationship to you: _____

Daytime Phone: _____ Evening: _____ Cell/Alt: _____

REFERRED BY: _____

Where were you born? _____

What is your ethnic identity? _____

Religious preference:_____

Are you: now employed? ◯ Full ◯ PartTime; and/or a Student ◯ Full ◯ Part time

◯ a Homemaker ◯ Retired ◯ Other _____ How long? Yrs ___ Mos____

If not employed, how are you supported? ☐ Savings ☐ Family ☐ SS ☐ Other _____

Spouse's employer, if employed? _____

What type of work? _____

How long has s/he been at their present job? _____

What is the highest grade of school you completed?

_____

_____

If you are a student, where do you attend school?

_____

What is the condition/s of your health?

(check one) ◯ Excellent ◯ Good ◯ Fair ◯ Poor

List primary health issues or injuries_____ _____

Are you currently taking prescription medication? ◯ Yes ◯ No Name/dosage _____

_____

Have you ever been diagnosed with a learning disability or mental illness ? ◯ Yes ◯ No

What?_____

Do you have a history of substance abuse? ◯ Yes ◯ No What? _____

Have you had any counseling in the past? ◯ Yes ◯ No If yes, When: From _____ to _____

What was the outcome of counseling?

◯ Issue Resolved ◯ Issue partially resolved ◯ Issue unresolved ◯ Stop attending

Has anyone else in the family experienced similar problems? _____

SYMPTOMS YOU ARE EXPRESSING OR OTHERS HAVE OBSERVED

Your Behavior/s ***Check all that apply*** :

◯ Overeating	◯ Suicidal thoughts	◯ Defiant toward authority	◯ Compulsions
◯ Forgetful	◯ Vomiting	◯ Smoking	◯ Take too many risks
◯ Isolation	◯ Poor social skills	◯ Hair pulling	◯ Lack of motivation
◯ Drink too much	◯ Hitting	◯ Unfriendly toward co-workers, peers, etc.	
◯ Not obey the law	◯ Procrastination	◯ Sleep disturbance	◯ Crying
◯ Hurts self	◯ Poor concentration	◯ Phobic avoidance	◯ Temper tantrums
◯ Profanity	◯ Nervous tics		

Your Dominant Feeling/s: ***Check all that apply*** :

◯ Happy	◯ Peaceful	◯ Unhappy	◯ Annoyed	◯ Bored
◯ Distraught	◯ Conflicted	◯ Restless	◯ Depressed	◯ Regretful
◯ Lonely	◯ Anxious	◯ Contented	◯ Fearful	◯ Excited
◯ Panicky	◯ Helpless	◯ Energetic	◯ Relaxed	◯ Envious
◯ Tense	◯ Jealous	◯ Impatient	◯ Calm	◯ Guilty
◯ Loss of control	◯ Sad	◯ Lack of joy	◯ Unkind to others	

Your Dominant Physical Complaints ***Check all that apply*** :

◯ Headaches	◯ Stomach trouble	◯ Skin problems	◯ Dizziness	◯ Tics
◯ Dry mouth	◯ Stuttering	◯ Fatigue	◯ Burning skin	◯ Muscle spasms
◯ Bedwetting	◯ Toothache	◯ Unable to relax	◯ Fainting spells	◯ Blackouts
◯ Weight loss or gain	◯ Tingling sensation	◯ Allergies	◯ Numbness	◯ Flushes
◯ Bowel disturbances	◯ Indigestion	◯ Hearing problems	◯ Don't like being touched	

YOUR PURPOSE HERE:

Describe in your own words the reason you came to counseling:

What do you hope to achieve in counseling - your dreams and/or goals?

Do you believe in Jesus/God? ☐ Yes ☐ No Doubts you may have?

Alternate beliefs?

SAVE PRINT CLEAR EMAIL