Tahni Kalina, MSW, LICSW

402 E Yakima Ave, Ste 800 Yakima, WA 98901
Phone (509) 952-3319   FAX (509) 457-2756

PLEASE COMPLETE THE FOLLOWING:

CLIENT NAME______________________________________ SOC SEC#____________________

DATE OF BIRTH_______________ GENDER: _______________________

ADDRESS: ____

CITY________________________ ZIP CODE__________________

PHONE # ____________________ EMAIL ADDRESS ______________________________

OCCUPATION_________________________EMPLOYER__________________________________

IF APPLICABLE:
PARTNER/SPOUSE NAME____

PARTNER/SPOUSE DATE OF BIRTH_______________

PRIMARY DOCTOR ____

MEDICATIONS ____

HAVE YOU BEEN IN COUNSELING BEFORE ? _____NO _____YES

PRIMARY INSURANCE

INSURANCE NAME _____________________________________ ID #_______________________

GROUP # _______________ WHO IS THE PRIMARY SUBSCRIBER? _______________________

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE NAME_____________________________________ ID#_______________________

GROUP#_________________ WHO IS THE PRIMARY SUBSCRIBER? _______________________

____ ___________________
CLIENT SIGNATURE DATE

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Counselor Disclosure

I completed a Bachelor of Science Degree in Psychology at University of Oregon in 1992 and a Master of Social Work Degree at Eastern Washington University in 2000. I have worked in the counseling field since 1994 in a variety of treatment settings providing services to children, adolescents, adults, couples and families. I have been in private practice since 2009 providing individual,couples and family counseling, primarily to adolescents and adults.

My counseling style is strength based and focused on finding solutions to more effectively manage life's challenges. I utilize a variety of treatment models to best meet your needs, including cognitive-behavioral therapy, solution-focused therapy, trauma recovery and mindfulness based therapy. I have obtained specialized training in mindfulness, suicide prevention, trauma-focused cognitive behavioral therapy and functional family therapy.

I use a collaborative approach, when necessary, to work with you to identify support people and other community resources to achieve maximum results.

Counseling goals are generated by you and treatment may be short or long term depending upon your needs and on decisions you make as the counseling process develops. I may offer reading recommendations, assign homework and ask you to practice new skills in and out of the office setting.

STATEMENT REQUIRED BY STATE LAW

Counselors practicing counseling for a fee must be registered or licensed 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 imply the effectiveness of any treatment.

The purpose of the Counselor Credentialing Act is to: provide for public health and safety, and to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.
If you have a complaint about the way I have handled your privacy rights, you may contact me or the Department of Health, PO Box 47869, Olympia, WA98504 or 360-236-4902.

PAGE ONE – PLEASE SEE BACK SIDE

CONFIDENTIALTYAND PRIVACY: As your counselor, I will keep confidential anything you say to me, with a few exceptions as required by law. Any unencrypted communication sent via text or email cannot be guaranteed secure. Please weigh this risk in choosing how to communicate outside of sessions. It is my policy not to engage through social media sites with any current or former clients.

PLEASE READ THE ATTACHED NOTICE OF PRIVACY PRACTICES for more information about your privacy rights, and initial here to acknowledge that you have received a copy of this notice: ___________________or that you were offered the notice form and declined your own copy________. (initial here to decline a copy)

FEES AND PAYMENT: The fee is **$185 for an initial intake evaluation.** Ongoing sessions are **$125 for a 45 minute session or $185 for a 60 minute session**. If you have no insurance coverage, the full fee is due each visit.

If your **deductible** is met and you have coverage, I will collect your **co-pay** and bill your insurance company for the balance. Usually the insurance company will then pay me directly. Insurance companies require that I diagnose your mental health condition before they agree to pay for services. If you wish, I will inform you of the diagnosis I plan to submit to your insurance carrier. I accept cash, check, debit or credit card for payment.

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.

CANCELLATIONS: If you are unable to keep your appointment, please contact me **24 hours** in advance of your scheduled appointment in order to avoid **a late cancellation or no show fee of $50.00. If I can reschedule you within the next 7 days, no late fee will be charged.**

Your insurance company will not pay for missed sessions. If you need to cancel or reschedule you can leave a message on my voice mail 24 hours a day, 7 days a week at 509-952-3319. Please remember to leave a phone number where I can reach you with your message.

EMERGENCIES: If there is an emergency between sessions, please call my voice mail and leave a message. If you are unable to reach me, or I am unable to call you back in a timely fashion and you feel the need for emergency help, please contact Open Line at Comprehensive Mental Health (509) 575-4200. In the case of a life threatening emergency, please call **911 or go to the emergency room at the nearest hospital.**

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

Client's Signature ____Date_________________

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AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

CLIENT NAME: ________________________________ DOB__________SS#______________________

ADDRESS: ____

INFORMATION IS TO BE DISCLOSED TO AND/OR RECEIVED FROM:

NAME OF PERSON/AGENCY ____

ADDRESS__________________________________PHONE_________________FAX_________________________

FOR PURPOSES OF: _______ EVALUATION_______TREATMENT______OTHER

I AUTHORIZE TAHNI KALINA TO RELEASE MY:

____GENERAL MENTAL HEALTH RECORD

____INFORMATION RELATED TO CHEMICAL DEPENDENCY/SUBSTANCE ABUSE

____PSYCHOTHERAPY NOTES

____INFORMATION RELATED TO HIV/AIDS AND OR/SEXUALLY TRANSMITTED DISEASES

____OTHER____

I understand that I many revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 90 days after the last dated signature.

____
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child many include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

____
Signature of Parent/Guardian Date

____
Signature of Witness Date

90 day signature updates

____
Signature of Client/Parent/Guardian or Authorized Representative Date

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