Follman
Counseling Agency

ANGER MANAGEMENT INTAKE INFORMATION
FOLLMAN AGENCY, 910 S. ANACORTES STREET, BURLINGTON, WA 98233

PLEASE PRINT

Name			**Date**
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Phone	**Email address**	**Age**	**Date of birth (m/d/y)**
Employer:	**Employer's Phone Number:**		**Occupation:**
Name of person with whom you live			**Relationship**
Name of person to call in an emergency	**Phone**		**Relationship**
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Name of person completing this form (if not client)			
Name of referring or responsible physician/clinician			
Street Address			**Suite/Apt #**
City	**State**		**Zip Code**
Phone			

Do you have a Primary Care Provider and/or Mental Health Provider: **Yes** ☐ or **No** ☐

If yes whom_____

Would you like the Follman Agency to communicate with your Primary Care Provider and/or Mental Health Provider? **Yes** ☐ or **No** ☐ (If yes, please fill out a release of information for the provider.)

LEGAL			
Current Legal Charge:			
Court:			Case #
BAC:	Offense:		Date of Offense:
Probation Officer:			Contact:
Outstanding Warrants: ☐Yes ☐No If yes, what and when:			
Past Convictions: ☐Yes ☐No			
Charge	**Date of Charge**	**Court**	**Final Outcome**
Name of Attorney:		**Attorney's Contact:**	
Attorney's Address:			

BILLING INFORMATION		
Program Costs:	Payment Plan:	Insurance Company:
Insurance Company Address:	Phone #:	Member #:
Deductible:	Portion Used:	Co-Pay or Percentage Paid:

***Please attach a copy of insurance card here:**

Anger Management Program

Level I: Client will attend (1) one session a week for (12) twelve weeks, Schedule (1) Intake, and an exit interview.

Level II Client will attend (1) one session a week for (18) eighteen weeks, Schedule (1) Intake, and an exit interview.

Level III Client will attend (1) one session a week for (26) Twenty-six weeks, Schedule (1) Intake, (1) individual appointments (halfway through the program), and an exit interview.

GROUP:

- Group Sessions -Tuesdays 5:00pm-6:00pm

- Intake, Individual and Exit Interview by appointment only

GROUP COUNSELOR: Jim Follman, Ph.D., LMHC, NCAC 1

START DATE: _____

Client Name: _____ **Date:** _____

FINANACIAL POLICY WILL GO HERE.

ANGER MANAGEMENT PROGRAM
GROUP THERAPY WEEKLY ATTENDACE ONLY
12 WEEK PROGRAM – LEVEL 1

WEEKLY – 12 WEEKS:

INTAKE - $350.00 DOWN PAYMENT REQUIRED	**$**	**95.00**
12 WEEKLY GROUP SESSIONS (12 HOURS) X $50.00	**$**	**600.00**
EXIT INTERVIEW	**$**	**95.00**

PROGRAM CHARGES:

$350.00 Down Payment Due at Intake	**$220.00/2 Months**	**Program Cost: $790.00**

ANGER MANAGEMENT PROGRAM
GROUP THERAPY WEEKLY ATTENDACE ONLY
18 WEEK PROGRAM – LEVEL 2

WEEKLY – 18 WEEKS:

INTAKE - $350.00 DOWN PAYMENT REQUIRED	**$**	**95.00**
18 WEEKLY GROUP SESSIONS (18 HOURS) X $50.00	**$**	**900.00**
EXIT INTERVIEW	**$**	**95.00**

PROGRAM CHARGES:

$350.00 Down Payment Due at Intake	**$185.00/ 4 Months**	**Program Cost: $1,090.00**

ANGER MANAGEMENT PROGRAM
GROUP THERAPY WEEKLY ATTENDACE ONLY
26 WEEK PROGRAM – LEVEL 3

WEEKLY – 26 WEEKS:

INTAKE - $350.00 DOWN PAYMENT REQUIRED	**$**	**95.00**
26 WEEKLY GROUP SESSIONS (26 HOURS) X $50.00	**$**	**1,300.00**
1 INDIVIDUAL SESSION	**$**	**95.00**
EXIT INTERVIEW	**$**	**95.00**

PROGRAM CHARGES:

$350.00 Down Payment Due at Intake	**$205.00/ 6 Months**	**Program Cost: $1,585.00**

ANGER MANAGEMENT PROGRAM RULES

1. You must call and cancel appointments you cannot keep within 24 hours, if possible. Missed appointments are billed at $40.00, which is not covered by insurance.

2. All Persons enrolled in groups or other treatment programs at this agency are expected to be coherent when presenting for treatment.

3. Do not come to group or counseling if you have an infectious disease.

4. No alcohol, other drugs or weapons, including knives, are allowed in any facility of this agency.

5. You must meet your financial obligations according to the arrangements you set up. Any account past due 30 days will result in suspended service. **Payments are due before/ on the 20th of each month.**

6. The Follman Agency is not responsible for lost or stolen articles.

7. Abusive language or behavior that threatens human dignity or physically harms another client or staff member is grounds for dismissal from treatment.

8. You must respect the confidentiality of other clients. Who you see here and what you hear must not be taken outside of this agency.

9. You must wear appropriate attire to any agency function. Shoes and shirts are mandatory. If you arrive dressed indecently, you will be asked to leave.

10. It is your responsibility and obligation to see that the above conditions are met.

11. Reoffending while attending treatment is in violation of probation and treatment program requirements.

Client Signature: _____

Date: _____

ANGER MANAGEMENT
NON-COMPLIANCE

You may be placed in immediate non-compliance for any of the following failures to comply:

1. No contact with the counselor for over two weeks. (Leaving a message may not be sufficient.)
2. Two consecutive unexcused absences or a pattern of absences/late arrivals. (Excused absences are arranged before, not after, the absence.)
3. A positive urinalysis for an illegal drug.
4. An arrest or citation for any gross misdemeanor or felony (includes violations of court orders and DUIs.)
5. Inattentive or disruptive behavior, which in the opinion of the counselor reflects an unwillingness to benefit from the program.
6. Non-compliance with chemical dependency treatment, if also in such treatment.
7. Non-compliance with any condition of your specific treatment plan.
8. Financial suspension that extends beyond three weeks without resolution.

If put in non-compliance you will normally be required to do the following in order to have the possibility to re-enter the program:

1. Immediately pay for all services rendered (payment plan becomes null and void.)
2. Submit to a re-evaluation requiring an individual appointment. There will be a charge of $95 for this appointment.
3. Complete any additional evaluations and start any recommended treatment (chemical dependency or a full psychological evaluation for example.)
4. Start the program over again **from the beginning** if the re-evaluation finds that treatment is indicated.

I, the undersigned, do understand, accept, and promise to abide by the terms of non-compliance of the Anger Management Program at the Follman Agency.

_____ _____

Client Signature Date

_____

Client Name (Printed)

_____ _____

Counselor Signature Date

FOLLMAN AGENCY
INTAKE ANGER MANAGEMENT

PHOTO

You have my permission to photograph me for the purpose of staff recognition only. I understand that this is confidential and for use within the FOLLMAN AGENCY only.

_____ _____
Client Signature Date

OPEN DOOR POLICY

The insurance provider for Follman Agency requires each counselor to leave his or her office door slightly open during individual sessions, unless otherwise permitted by the client. Please select one of the following:

☐ I prefer the door to be closed during individual sessions.

☐ I prefer the door to remain slightly open during my sessions.

_____ _____
Client Signature Date

APPOINTMENT REMINDER

Please check which you prefer:

☐ It is OK to call and leave an appointment reminder on my phone, if you cannot reach me in person.

☐ Please do **not** call and leave any messages on my phone.

_____ _____
Client Signature Date

ZOOM & EMAIL

You have my permission to email me for all treatment related purposes, including Zoom links for treatment or appointments. I understand that this is confidential and for use within the FOLLMAN AGENCY only.

_____ _____
Client Signature Date

Anger Management Treatment Contract

Name:_____ **Date:**_____

I agree to participant in my recommended treatment program. In addition to my attendance, I understand and agree to the following conditions. (Please initial each item which applies to you)

_____Completing all court ordered requirements mandated by law is my responsibility. I agree to contact The Follman Agency in the event I can not keep my commitment and make special arrangements to make up missed treatment.

_____I understand that The Follman Agency by law, must report to my probation officer following conditions:

- Compliance and progress in treatment
- Lack of significant progress in treatment
- Relapse including other drug use
- If needed, a revised treatment plan

_____I understand that The Follman Agency has the authority to alter or change a diagnosis or treatment recommendations made by any evaluating agency and that treatment itself is an ongoing evaluation process.

_____Submit to random urinalysis (UA) test to determine drug/alcohol use and/or breathalyzer test to determine if alcohol use has recently occurred, at my expense.

_____I understand that The Follman Agency holds the philosophy that meeting my financial obligations and responsibilities are a measure of my progress in treatment. Failure to keep financial obligations is not showing significant progress in treatment and could result in termination unless special arrangements are made with the financial department and upheld.

_____In the event of a medical emergency, and my doctor is not available , I may be given emergency medical treatment by qualified medical personnel or hospital when deemed immediately necessary or advisable by a physician to safeguard my health.

Physician's Name (IF NEEDED)_____

Office:_____Phone: _____

The concerned court require you to do at least a minimum prescribed treatment program. This program must be completed as required by law to allow us to sign Department of Licensing forms which require your counselor's signature. This includes progress reporting on all clients and adult probation and parole.

Client Signature:_____Date:_____

Counselor Signature:_____Date:_____

Parent or Guardian:_____Date:_____

CLIENT DISCLOSURE INFORMATION

The Following information is being released to you in compliance with the requirements of WAC 308-190-040:

The Follman Agency is certified to offer behavioral health treatment by the Washington State Health Department.

The type of treatment that you will receive at this facility is anger management treatment. It includes, but is not limited to, individual counseling, group counseling, family counseling, aftercare/discharge planning, and educational services.

All counseling staff of this agency is required to be registered with the Department of Health. A record of each counselor's registration certificate and their registration number are kept in their permanent file in our business office.

All counselors are also required to meet the minimum academic, training, and experience requirements of a qualified counselor as defined by WAC 388-60. In addition, qualified counselors are required to obtain continuing education to maintain their qualified counselor status. This agency is required to keep these records in each counselor's personnel file, which are inspected regularly by Department of Behavior Health Recovery.

You have the right to the counselor registration number and to inspect the academic, training, and experience records of any counselor that you receive treatment from. You may arrange to inspect the above information by writing and calling the office listed below.

Follman Agency
910 South Anacortes Street, Burlington, WA 98233
(360) 755-1125

I have signed consent to treatment and have been advised to the fee schedule.

I have read and understand the above information.

_____ _____
Client Signature Date

_____ _____
Authorized Program Representative Date

DISCLOSURE STATEMENT
JAMES H. FOLLMAN, PhD, LMHC, & CDP

Licensed Mental Health Counselor
Chemical Dependency Professional
State Certified Problem Gambling Counselor

Washington State law requires that mental health counselors provide new clients with a disclosure statement informing them of their rights and specific information regarding the counselor and therapy.

STATE CERTIFICATION

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. I have the following licenses:

Licensed Mental Health Counselor (#LH00008388)
Chemical Dependency Professional (#CP00001856)
State Certified Problem Gambling Counselor (11-01)

PROFESSIONAL BACKGROUND

EDUCATION

Doctorate Degree in Counseling Psychology, Walden University, Minneapolis, MN
Master of Education, Guidance and Counseling, City University, Bellevue, WA (1993)
Bachelor degrees from Western Washington University (1981) and Eastern Washington University (1989)

Professional Experience

1993 – Present: Follman Agency – Mental Health & Chemical Dependency

THERAPEUTIC APPROACH

Each person's therapy is individually determined according to his or her treatment goals. My clinical orientation emphasizes the importance of using an integrative approach that takes into account the whole person (bio/psycho/social) within the context of their culture and relationships. I utilize cognitive/behavioral strategies for implementing change and clinical hypnosis when appropriate.

The length of therapy varies according to the nature of your concerns. It usually takes a few sessions to clarify the focus of treatment and develop a treatment approach that will best fit with your needs and goals.

CLIENT'S RIGHTS

You have the right to choose a therapist who best suits your needs and goals. You are encouraged to express any questions or complaints about your therapy and you have the right to a referral to another therapist if that need should arise.

The purpose of the Counseling Credentialing Act and the laws regulating counselors is (1) to provide protection for public health and safety and (2) to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Client confidentiality is assured except under the circumstances covered by state and federal regulations (RCW 18.19.180). The main exceptions include consultations with other clinicians and disclosures that indicate you (1) are about to commit a crime, (2) are involved in child or dependent adult abuse, (3) are a danger to yourself or others, or (4) are unable to meet your own basic needs in taking care of yourself.

For more information or complaints, write to:

(continued)

Department of Health, Health Professions Quality Assurance
PO Box 47869
Olympia, WA 98504-7669
OR you may call:
(360) 236-4700

PRACTICE STANDARDS

My fee is $125.00 per individual session. A session is 50 minutes. Payment is expected at the time of the appointment unless you have insurance coverage. In that case, please plan to make your co-pay at time of the appointment. In either case, you agree to be financially responsible for all charges.
Keeping regular appointments is essential to effective therapy. If you need to cancel an appointment, please call within 24 hours prior to the appointment to avoid a cancellation charge ($40). For emergencies, call 911.

ACKNOWLEDGEMENT OF DISCLOSURE

Your signature below indicates that you have received this disclosure statement and that you have read, understood and agreed to the terms provided.

_____ _____
Client Signature Date

I am satisfied that said person understands and agree to the terms set forth in this disclosure statement.

_____ _____
Jim H. Follman Date

PATIENT DISCLOSURE INFORMATION

WAC 246-810-030 Requires counselors to inform patients of the counselor disclosure law

The purpose of the law regulating counselors is:
a. To provide protection for public health and safety; and
b. To empower the client/patient by providing a complaint process against counselors who commit acts of unprofessional conduct.
Patients/clients have the right to choose counselors who best suit their needs and purposes.
The extent of confidentiality provided by RCW 18.19.180(1) through (6). Note: Federal confidentiality regulations supersede every item in RCW 18.19, so following the federal regulations for informing the client/patient of the federal confidentiality regulations satisfies this requirement.
Patients are to be provided a list of copy of the act of unprofessional conduct in RCW 18.130.180 and the following address and telephone number:

Department of Health
Health professions Quality Assurance Division
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4903

UNPROFESSIONAL CONDUCT
Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.
Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
All advertising which is false, fraudulent, or misleading;
Incompetence, negligence, or malpractice, which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction. The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substance for oneself.
Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
Failure to cooperate with the disciplining authority by:
Not furnishing any papers or documents
Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority
Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder
Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority
Hiding or abetting an unlicensed person to practice when a license is required
Violations of rules established by any health agency
Practice beyond the scope of practice as defined by law or rule
Misrepresentation or fraud in any aspect of the conduct of the business or profession
Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk

Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health
Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service (continued)

Conviction of any gross misdemeanor or felony relating to the practice of the person's profession
The procuring, or aiding or abetting in procuring, a criminal abortion
The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority
The willful betrayal of a practitioner-patient privilege as recognized by law
Violation of chapter 19.68 RCW

Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding
Current misuse of alcohol, controlled substances or Legend drugs
Abuse of a client or patient or sexual contact with a client or patient
Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or series intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

Client Signature:_____ Date:_____

CONFIDENTIALITY OF ANGER MANAGEMENT TREATMENT PATIENT RECORDS

The confidentiality of anger management treatment participant's records maintained by this program is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a domestic violence treatment participant unless:

Please initial below

_____The patient consents in writing; OR

_____The disclosure is allowed by a court order; OR

_____The disclosure is made to medical personnel in a medical emergency; OR

_____The disclosure is made to qualified personnel for research, audit, or program evaluation; OR

_____The patient commits or threatens to commit a crime either at the program or against any person who works for the program; OR

_____The patient talks about hurting oneself, hurting someone else, child abuse, elderly abuse, or pet abuse.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

See 42 U.S.C. §§ 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal regulations.

_____	_____	_____
Client's Signature	Date	Counselor Signature

RECORD OF CONSENT TO RECEIVE SERVICES

I herby affirm that I have voluntarily consented to receive services at the **Follman Agency**, and hereby consent to participate in the Anger Management Program and treatment, which is provided.

Signed: _____ _____

Client Signature Date

_____ _____

Parent or Guardian Date

_____ _____

Witness to above Signatures Date

The Follman Agency Financial Policy

Thank you for choosing the Follman Agency as your treatment provider. We are committed to your treatment being successful. Please understand your bill is considered a part of compliance with your recommended treatment program.

All patients must complete our information and insurance form before attending group.

Payments are due on/before the 20th of each month. If payment is not received by the 20th, your treatment will be suspended and we request you to not attend group/session until payment is received. Your account will be charged a $10.00 fee for the Suspension Letter. Drug Screen charges will be due at time of service. We accept MasterCard, Visa, Discover and American Express. Accounts more than 90 days past due will be forwarded to SB&C for collections and your account will be charged $20.00 for the collection letter.

Regarding Insurance
The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and a copy of a recent insurance card. Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Regarding Insurance Plans where we are a participating provider. All deductibles are due prior to treatment. All copays are to be paid according to your payment plan. In the event your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients and Minor Patients.
Adult patients are responsible for full payment at time of service. **Minor Patients**: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at the time of service has been verified.

Missed Appointments/No Show
Unless canceled at least 24 hours in advance, our policy is to charge $40.00 for missed appointments. Please help us serve you better by keeping your scheduled appointments. Follman Agency reserves the right to not treat a patient after the patient has missed three scheduled appointments. For new patients who miss their evaluation or intake appointment without 24-hour cancelation notice will be required to prepay the missed appointment fee before scheduling any future appointment.

Interest
We reserve the right to charge interest in the amount of 5% as provided by state law.

Non-Compliance
In the event you leave treatment without paying and wish to re-start, you are subject to a $50.00 re-start fee. Please note that failure to pay will result in non-compliance of your treatment program.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date _____
Signature of Patient (Please Print Patient's Name Clearly Below This Line)

_____

X_____ Date _____
Signature of Parent/Guardian

FOLLMAN AGENCY FINANCIAL AGREEMENT

DATE: _____ **NAME:** _____ **DOB:** _____

I hereby agree to immediately advise the FOLLMAN AGENCY of any changes in:

1. Change of address/phone number
2. Insurance Coverage
3. Employment Status

I hereby agree to pay all fees for services currently or previously rendered by the Follman Agency. I understand the full monthly payment must be made on my account by the 20th of every month or my account will be subject to a $10.00 late payment fee. Also, I am aware that I will be suspended from treatment immediately if payment is not made. I will contact the Follman Agency to reestablish a payment schedule or services may be discontinued until payments are current. In the event of default of payment, I will be held liable for the unpaid balance, including any attorney or collection fees permitted by law. I understand accounts 90 days past due will be sent to collections (SB&C, LLC).

I understand my records are protected under the Federal and State Confidentiality Regulations and cannot be *disclosed without my written consent unless otherwise provided within the Regulations. I also understand I may* revoke this consent at any time except to the extent action has been taken in reliance on my account (i.e., probations, courts, etc.) and in any event this consent will expire when my account is paid in full.

RELEASE OF INFORMATION: I authorize the Follman Agency and/or the Insurance Company to release any information required to process claims.

RELEASE OF BENEFITS: I hereby authorize my Insurance Benefits to be paid directly to the Follman Agency.

TREATMENT PROGRAM: _____

PROGRAM CHARGES:

Down Payment	Monthly Payment	Program Cost
$350.00 Down Payment		

I agree to pay the Follman Agency in monthly installments of $ _____ per month until the fee of $_____ is paid in full. I agree to make a down payment of $_____, which shall be applied to the end of my payment schedule.

_____

Patient Signature Above Line (Please Print Clearly Below)