InSight
Solution Focused Therapy

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 CONSENT

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, LCSW, MSW:

Brena Lever is a Licensed Independent Clinical Social Worker (#LW00007098), Licensed Clinical Social Worker (#LCSW121696), 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.

FEE AND PAYMENT

Fees are due at the beginning of each session. Fees for virtual sessions are due prior to the start of each session. In-Sight accepts payments through Venmo and Zelle. We are open to other forms of payment and are happy to make these arrangements with our clients.

Cancellation: In-Sight has a 24 hours cancellation policy. The client will be responsible for payment of a canceled or missed session if the therapist is not notified within 24 hours prior to the scheduled appointment.

Insurance: Brena Lever is an "out of network provider" for medical plans. In-Sight will, upon request, provide the client with any necessary documentation, should they want to submit a claim through their health plan.

CONFIDENTIALITY

All information discussed with In-Sight is strictly confidential and shall be used solely by In-Sight professionals. This information will not be disclosed or released without written permission of the client. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her/themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years or an elderly person over the age of 65.
4. Suspected neglect of the parties named in item #3.
5. If a court of law issues a legitimate subpoena for information stated on the subpoena.
6. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
7. Other rare instances where disclosure is allowed or required by law.

TELEHEALTH

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth.
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 206-351-5894 to discuss a solution.
7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
8) Emergency Protocols: I agree to provide my current address at the beginning of each session and confirm my emergency contact.

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 a list of the acts of unprofessional conducted.

In **Washington State**, this document can be requested from the following address:

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

Email: hpqa.csc@doh.wa,gov
Phone: (360) 236-4700
Fax: (360) 236-4818

In **California**, you may contact the Board of Behavioral Services (BBS) online at: www.bbs.ca.gov, or by calling (916)-574-7830.

I have read and understand this Explanation of Services:

Client_____ **Date**_____

In-Sight_____ **Date**_____