



formerly Presbyterian Counseling Service

restoring hope . . . reconciling relationships . . . transforming lives

Welcome to Samaritan Center of Puget Sound

We are pleased that you have chosen Samaritan for assistance at this time in your life.

We hope that you will find this to be a positive and useful experience.

About Samaritan Center

Samaritan Center of Puget Sound is accredited by the Samaritan Institute and affiliated with the Presbytery of Seattle. Our therapists come from a variety of Christian faith perspectives and represent a wide range of ages and life experiences. They are interested in and respectful of the spiritual values, beliefs and cultural heritage of all persons.

In providing therapy, we seek to engage in a process that is attentive to the integration of mind, body and spirit. We believe that healing occurs on multiple levels – mind, body, spirit and soul – and are always willing to consider with our clients the physical and spiritual as well as psychological aspects of healing. We are curious about the part that spirituality plays in wrestling with life's dilemmas and transition points, and we bring our own heartfelt responses to the situations in which our clients find themselves. We endeavor to promote growth and well-being in our clients, engaging with them in a collaborative manner to make the changes that they desire in their lives.

Parking at the Ravenna Office:

Off-street parking is available in the lot adjacent to the Church, as well as along Ravenna Blvd.

Young Children:

Please do not leave young children unattended in the waiting room. We cannot be responsible for their safety.

Crisis Calls:

In the event of a personal crisis, clients may call Samaritan's on-call therapist at 206-527-2266. To leave a message for the on-call therapist during office hours (M-F 9am-6:30pm), clients should press 0 during the recorded message, or, if the call is made outside of office hours, press 6. If the call is not returned by the on-call therapist after a half hour, clients should call the Crisis Clinic at 206-461-3222.

Non-Crisis Calls:

To leave a non-crisis message, to cancel or change an appointment with your therapist, call 206-527-2266 and follow the voice prompt.

On the following pages you will find information that will ensure that your needs as an informed client are met. This includes the training, professional background of your therapist, his or her theoretical orientation and approach to therapy, the rights of clients in therapy, and information about confidentiality.

DISCLOSURE STATEMENT

ANNA H. ANDERSON

Training and Professional Background

Anna Anderson is a member of the American Association of Marriage and Family Therapy and Washington State Association of Marriage and Family Therapy. She is involved in continuing education to grow her therapeutic skills, and regularly attends professional trainings. Additionally, she is involved in a peer consultation group with other colleagues.

Anna has a Master of Science in Marriage and Family Therapy and Master in Education in School Counseling, both from Seattle Pacific University. She has 14 years of experience working with youth and families in a variety of settings including schools, YMCA, camps, Young Life, church, Youth Eastside Services, The Moyer Foundation. Anna works with clients of all ages from diverse backgrounds. She is licensed as a marriage and family therapist with the State of Washington State Department of Licensing M.S., M.ED., LMFT (License No. LF60484649).

Theoretical Orientation and Approach to Therapy

Anna's orientation for therapy comes from a "systems" perspective. She focuses on how individuals function in relationships to those around them, as well as asking about what is going on inside them. Within this context, she examines how individuals can be separate, while also remaining connected to others. When working with clients, she displays unconditional acceptance, energy, and insight.

Rights of Clients

It is appropriate for clients to raise questions about the therapist, the therapeutic approach, the progress of therapy, and the cost. As informed consumers, it is the client's responsibility to choose the therapist and therapeutic modality which best suits their needs. Clients have the right to request a change in therapeutic approach, referral to another therapist, or termination at any time. In addition, clients have the right to refuse treatment.

All therapists at Samaritan Center of Puget Sound are bound by the ethical codes of their professional organizations, by the laws of the State of Washington, as well as by agency policy regarding the special nature of the therapist-client relationship. This agency expects all therapists to continually be aware of the influential position they hold in the relationship with clients, using this influence in a constructive way. If a client thinks his/her therapist is not meeting this ethical responsibility, he/she is strongly encouraged to address this with the therapist and/or bring it to the attention of the agency's President/CEO. If you suspect that your therapist's conduct has been unprofessional (as defined by RCW 18.130.180), you may contact the Department of Health by phone at 360-236-4700 or mail : Health Systems Quality Assurance Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857.

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. To see your record, or get more information about it, contact your therapist.

Confidentiality

Counseling sessions are held in strict confidence. In general, it is the client or the guardian of a minor child (age 12 and under) guardian, not the therapist, who determines whether protected health information may be released outside Samaritan Center of Puget Sound. However, there are some exceptions to this rule:

1. Washington State Law requires that suspected abuse or neglect of a child (anyone under the age of 18) be reported.
2. Washington State Law requires that suspected abuse, abandonment, neglect, or financial exploitation of vulnerable adults be reported.
3. Washington State Law requires that others be informed if your therapist has reasonable cause to believe that you are gravely disabled or present an imminent likelihood of serious harm to yourself or others. If a threat against others is perceived to be serious, the proper individuals must be contacted; this may include the individual against whom the threat is made.
4. Washington State Law requires that behavior by healthcare professionals which is unprofessional or poses a clear and present danger to patients or clients be reported to the Washington Department of Health.
5. In the event of a medical emergency, emergency personnel may be given necessary information.
6. If you bring a complaint against your therapist with the State of Washington Department of Health, information will be released.
7. In the event of a court order, therapists may be required to disclose information in the presence of a judge.
8. In the event of your death or disability, the information may be released if your personal representative or the beneficiary of an insurance policy on your life signs a release authorizing disclosure.
9. In order to ensure the highest quality of care, your therapist may seek consultation and supervision from other therapists; in these circumstances, identifying information is protected and confidentiality rules bind the consultants.
10. Health information, excluding Psychotherapy Notes, may be disclosed without written authorization from you for the purposes of treatment, payment, and health care operations. Examples of these types of disclosures are listed in Section I of the Notice of Privacy Practices for Samaritan Center of Puget Sound.
11. If you provide written authorization to disclose information to an identified third party for a specified purpose, your therapist will disclose it. You may revoke this authorization in writing at any time. When you revoke an authorization it will only impact shared health information from that point on.

By my signature below, I acknowledge that I have received, read, and understand the Disclosure Statement.

Signature of Client or Personal Representative _____ Date _____

Signature of Client or Personal Representative _____ Date _____

Therapist Signature _____ Date _____
Anna H. Anderson, MS, MEd, LMFT

By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices for Samaritan Center of Puget Sound.

Signature of Client or Personal Representative _____ Date _____

Signature of Client or Personal Representative _____ Date _____

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

You will receive one copy of this form and one will be kept in your Samaritan record.

Name _____

Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure to have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

☐

Somewhat difficult

☐

Very difficult

☐

Extremely difficult

☐

— — — — —

GAD-7	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

☐

Somewhat difficult

☐

Very difficult

☐

Extremely difficult

☐

During the past 12 months...

Do you have concerns about your drug/alcohol use?	Yes	No
How many alcoholic drinks do you have daily/ Weekly?		
Did you spend time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	Yes	No
Did your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	Yes	No
Did you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	Yes	No
Is somebody close to you concerned about your alcohol consumption or drug use?	Yes	No

Over the past 2 months, please rate on a 0-7 scale to what extent these symptoms have being a problem for you. (0= not problem at all; 7= major problem).

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Diminished capacity for pleasure	<input type="checkbox"/> Manic/hypo-manic
<input type="checkbox"/> Low motivation	<input type="checkbox"/> Diminished sexual interest	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Anger: aggressive/abusive	<input type="checkbox"/> Eating and food problems	<input type="checkbox"/> Obsessive thinking
<input type="checkbox"/> Anger: irritability/temper/yelling	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Pessimism
<input type="checkbox"/> Anxiety: (symptoms of o.c.d.)	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Poor impulse control
<input type="checkbox"/> Anxiety: panic	<input type="checkbox"/> Gambling problems	<input type="checkbox"/> Procrastination/avoidance
<input type="checkbox"/> Anxiety: phobic	<input type="checkbox"/> Grief, loss	<input type="checkbox"/> Regret/remorse/shame
<input type="checkbox"/> Anxiety: worry	<input type="checkbox"/> Guilt thoughts/feelings	<input type="checkbox"/> Relationship/interpersonal problems
<input type="checkbox"/> Body image problems	<input type="checkbox"/> Impaired attention/concentration	<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Compulsive behavior	<input type="checkbox"/> Intrusive thoughts	
<input type="checkbox"/> Pain	<input type="checkbox"/> Self-esteem difficulties	
<input type="checkbox"/> Health problems (specify): _____		
<input type="checkbox"/> Other (specify): _____		

Comments: _____
