# Christine R Copeland PhD

140 N Stromberg Avenue
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## CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY

Name: ______________________________ (First / Middle Initial / Last) Name you go by: __________________ Sex: M F

Date of Birth: ______________________ Social Security Number: ______________________

Street Address: ______________________________________________

City: ______________________ State: __________ Zip Code: __________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home Phone: ( ) __________ Work: ( ) __________ ext: ______ Cell: ( ) __________

Email: ______________________ Employer: ______________________

Spouse's Name: ______________________________ Daytime Phone: __________

Emergency Contact: ______________________________ Daytime phone: __________

**In order to protect your privacy, please indicate the location that you would NOT want to be contacted:**

❑ Home ❑ Work ❑ Email ❑ Cell

Primary Care Physician: ______________________________ Clinic Phone: __________

Referred to this office by: ______________________________________________

Insurance Company: ______________________________ Phone Number: __________

ID Number: ______________________ Group Number: ______________________

Is the insurance policy under the patient's name: ❑ Yes ❑ No

If **NO**, full name of the policy holder: ______________________________

Address of the policy holder: ______________________________

Date of birth of the policy holder: __________ Relationship to Insured: __________

Your insurance may require we contact your primary care physician as a way of coordinating treatment. If this is the case, we are obligated to notify your physician about services being provided. If this is not required by your insurance, your signature below indicates your authorization to exchange information with your primary care physician.

**SIGNATURE:** ______________________ **TODAY'S DATE:** ______________________

NAME_____________________________________________ DATE__________________________

Here is a list of complaints that people sometimes have. Read each one carefully and select the one that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU IN THE PAST MONTH, INCLUDING TODAY. Do not skip any item.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

Nervousness or shakiness inside 0 1 2 3 4
Faintness of dizziness 0 1 2 3 4
The idea that someone else can control your thoughts 0 1 2 3 4
Trouble remembering things 0 1 2 3 4
Difficulty making decisions 0 1 2 3 4
Feeling easily annoyed or irritated 0 1 2 3 4
Pain in heart or chest 0 1 2 3 4
Feeling afraid in open spaces 0 1 2 3 4
Thoughts of ending your life 0 1 2 3 4
Feeling that most people cannot be trusted 0 1 2 3 4
Poor appetite 0 1 2 3 4
Suddenly scared for no reason 0 1 2 3 4
Temper outbursts you could not control 0 1 2 3 4
Feeling lonely even when you are with people 0 1 2 3 4
Feeling blocked in getting things done 0 1 2 3 4
Feeling lonely 0 1 2 3 4
Feeling blue 0 1 2 3 4
Feeling no interest in things 0 1 2 3 4
Feeling fearful 0 1 2 3 4
Your feelings being easily hurt 0 1 2 3 4
Feeling that people are unfriendly or dislike you 0 1 2 3 4
Feeling inferior to others 0 1 2 3 4
Nausea or upset stomach 0 1 2 3 4
Feeling that you are watched or talked about by others 0 1 2 3 4
Trouble falling asleep 0 1 2 3 4

Feelings of guilt 0 1 2 3 4
Feeling afraid to travel on buses 0 1 2 3 4
Trouble getting your breath 0 1 2 3 4
Having to avoid certain things, places, or activities because they frighten you 0 1 2 3 4
Your mind going blank 0 1 2 3 4
Numbness or tingling in parts of your body 0 1 2 3 4
The idea that you should be punished for your sins 0 1 2 3 4
Feeling hopeless about the future 0 1 2 3 4
Trouble concentrating 0 1 2 3 4
Feeling weak in parts of your body 0 1 2 3 4
Thoughts of death or dying 0 1 2 3 4
Having urges to beat, injure, or harm someone 0 1 2 3 4
Having urges to break or smash things 0 1 2 3 4
Feeling very self-conscious with others 0 1 2 3 4
Feeling uneasy in crowds 0 1 2 3 4
Never feeling close to another person 0 1 2 3 4
Spells of terror or panic 0 1 2 3 4
Getting into frequent arguments 0 1 2 3 4
Feeling nervous when you are left alone 0 1 2 3 4
Other not giving you proper credit for your achievements 0 1 2 3 4
Feeling so restless you couldn't sit still 0 1 2 3 4
Feeling of worthlessness 0 1 2 3 4
Feeling that people will take advantage of you if you let them 0 1 2 3 4
Having to check and double-check what you do 0 1 2 3 4
The idea that something is wrong with your mind 0 1 2 3 4

Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected by each by circling the appropriate number. Please circle one number for each item.

Not a problem = 0 Slight problem = 1 Moderate problem = 2 Serious problem = 3 Severe problem = 4

1. YOUR EXPERIENCES AT WORK OR SCHOOL

General Performance 0 1 2 3 4
General Satisfaction 0 1 2 3 4
Lateness 0 1 2 3 4
Absenteeism 0 1 2 3 4
Negative feelings about work 0 1 2 3 4
Relating to supervisors 0 1 2 3 4
Relating to coworkers 0 1 2 3 4
Other____________________________ 0 1 2 3 4

2. YOUR BEHAVIOR

Difficulty with daily routines 0 1 2 3 4
Physically abusing others 0 1 2 3 4
Using alcohol or drugs to cope 0 1 2 3 4
Lying 0 1 2 3 4
Stealing 0 1 2 3 4
Other________________________________ 0 1 2 3 4

| 3. YOUR FEELINGS AND MOODS | | 4. YOUR INNER THOUGHTS AND IDEAS | |
|---|---|---|---|
| Depression (sadness) | 0 1 2 3 4 | Having repeated unwanted thoughts | 0 1 2 3 4 |
| Euphoria (feeling “high”) | 0 1 2 3 4 | Worrying about your health | 0 1 2 3 4 |
| Sudden changes in mood | 0 1 2 3 4 | Believing you are better than others | 0 1 2 3 4 |
| Lack of energy | 0 1 2 3 4 | Seeing things without apparent cause | 0 1 2 3 4 |
| Not liking self | 0 1 2 3 4 | Hearing things without apparent cause | 0 1 2 3 4 |
| Not liking others | 0 1 2 3 4 | Feeling confused | 0 1 2 3 4 |
| Tearful more frequently | 0 1 2 3 4 | Memory | 0 1 2 3 4 |

INDICATE IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING HEALTH PROBLEMS:

| | | | |
|---|---|---|---|
| Abdominal pain | Eye problems | Skin problems | Backache |
| Gastrointestinal problems | Shortness of breath | change in bowel habits | Headaches |
| Ulcers | Change in menstrual pattern | Hearing problems | Nausea or vomiting |
| Change in urinary pattern | Hypertension | History of present seizure disorder | Chest pain |
| Loss of interest in sex | Cough | Unable to function sexually | colitis |
| Palpitations (racing heart) | Weight gain/loss (what period of time?___________________) | | |
| Problems with muscles, joints, bones | | | |

LIST ANY MEDICATIONS YOU ARE NOW USING, EVEN IF OCCASIONALLY, AND FOR WHAT PURPOSE YOU TAKE THEM:

| MEDICATION | DOSAGE | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have any physical handicaps? (describe) ___________________________________________________________

Do you have trouble seeing? ________________________________ Hearing? __________________________________

Have you had any of the following:

Head Injury ___________________ Diabetes ____________________ Learning Disabilities __________________

Cardiac Problems ______________________

Date of last physical exam (month) ______________________ (year) ____________________________

HAVE ANY OF YOUR RELATIVES HAD:

Alcoholism ______________________________________________________________________

Drug Dependency ______________________________________________________________________

Mental/Emotional Problems______________________________________________________________________

INDICATE THE AMOUNTS OF THE FOLLOWING SUBSTANCES YOU USE ON A DAILY BASIS:

Alcohol _______________________________________________________________

Drugs (not prescribed)____________________________________________________

Prior Treatment: Inpatient ______________ Outpatient ___________________

Have you had any previous psychological testing? _________ Yes _________ No

Name of therapist of agency that did this testing __________________________________________________________

What do you do in your free time?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES AND HEALTH CARE PROVIDER DISCLOSURE**

I, ______________________________________________ [patient name], or the parents or legal guardian of the patient, have reviewed the following documents:

[Initial documents received]

_________ Notice of Privacy Practices (attachment on email or in office)

_________ Health Care Provider's Disclosure Form (the following pages)

________________________________________________ ______________________

Signature of Patient (or Parent or Legal Guardian) Date

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## PLEASE **READ** AND SIGN BOTH STATEMENTS:

### TREATMENT AND PAYMENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary forms and billings to collect from my insurance carrier as a courtesy. Any amount paid to this office will be credited to my account, however I fully understand that I am personally responsible for payment. I understand that any applicable co-pay will be charged to me at the time of service unless prior arrangements have been made. If payment is made directly to me by my insurance, I agree to make equal and immediate payment to this office. I also understand that if I suspend or terminate my treatment, any fees for professional services might become due and payable immediately.

There is a $50.00 fee for missed appointments or late cancellations (less than 24 hours notice), that is NOT billable to insurance.

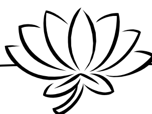
For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

In the event of difficulty with my insurance company, I authorize this office to initiate a complaint to the Insurance Commissioner on my behalf.

Patient Signature:____________________________ Date Signed:________________________



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## Disclosure Statement & Office Policies Agreement

*Welcome!* You have made an important decision to deal with a challenge or change in your life. Before you begin the work this will require, you have the right as a consumer to be informed about the nature and limitations of me as a particular practitioner and of the therapeutic relationship in general.

Therefore, it is essential that you take the time to read the following carefully. Feel free to ask me questions about anything that seems unclear. When you have read and understood each page, sign and date the bottom of the last page. Be sure to bring this agreement with you to our first meeting, along with the registration, insurance and biographical information forms.

I look forward to meeting with you.

### Education and Experience:

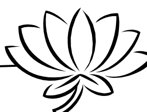
I received my doctorate in Developmental Psychology from the University of Hawaii in 1980, and began supervised practice in Kent, WA in 1982.

Additional training includes testing, family systems therapy, interactive guided imagery, and the Myers'-Briggs Type Indicator.

Prior to licensure, I taught courses in Developmental and Intro Psychology at the University of Hawaii, Parenting classes at Renton Voc tech, and in various schools and churches in the King County area, co-facilitated a group for the Domestic Abuse Women's Network, and volunteered at Kent Youth Services. In 1988 I was licensed as a psychologist in the State of Washington and was in private practice until January of 1997, when I relocated to England. Between 1997 and 2002, I developed curricula and conducted groups on developmental and cultural transition in New York, Maryland, and England. In 2002, after the death of my husband, I returned to Seattle, where I resumed private practice. In 2006, I remarried and moved my practice to Edmonds. I am a mother and grandmother.

If you wish, you may request a more complete resume.

Psychology licensure provides that psychologists have passed written and oral examinations administered by the Examining Board of Psychology for Washington State and attests that Psychologists are qualified to engage in the independent practice of psychology. The Washington licensure law provides complaint and discipline recourse procedures for clients. *Inquiries about a psychologist's professional qualifications and/ or treatment may be directed to the Examining Board of Psychology, Division of professional Licensing, P.O. Box 9649, Olympia, WA 98054.*



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## THERAPEUTIC APPROACH:

My therapeutic approach draws on various psychological orientations, including developmental and attachment theory, psycho-educational, cognitive-behavioral, and family systems therapy.

- The developmental aspect has to do with meeting the changes occurring across the life span, recognizing that as human beings we have a life-long need for healthy, nurturing attachments to significant others;
- the psycho-educational aspect with providing information to increase the repertoire of skills and strategies to meet a challenge;
- the cognitive-behavioral aspect with addressing outmoded or ineffective attitudes, beliefs and thoughts;
- the systems aspect with the fact that we are all part of networks of people, be they partners, extended family, fellow employees, or larger community;

The particular approach used will depend on the kind of challenge or change you face, where you are in the change process, and your particular personality style.

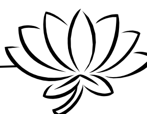
Be aware that the above treatment approaches are *not* clinically appropriate for some conditions or situations. I will work with you during the first few sessions to develop a treatment plan to best meet your needs, and then will continue to update this as we go. If at any time I find that your interests are better served by another professional, I will discuss this with you and make appropriate referrals.

Psychotherapy requires your very active involvement, honesty, and openness, and *all* of these approaches will require some effort on your part. You may be assigned tasks between sessions, and I will ask for your feedback and views on your therapy, and will expect you to respond openly and honestly.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, anger, and anxiety. Therapy can often involve talking about unpleasant aspects of a person's history and behavior. It can also lead to a significant reduction in feelings of distress, better relationships, and problem solving, *but there are no guarantees*.

**Clients' Rights:** You have the right to refuse treatment, to change therapists, to receive referral to another therapist, to ask questions concerning your evaluation and treatment, and the right to raise questions about the therapist, the treatment approach, and the progress made at any time.

**Emergencies:** If there is an emergency during our work together, or in the future after termination, where Dr. Rummer Copeland becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the registration form.



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**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.,) neither you nor your attorney, nor anyone else acting on your behalf will call on Dr. Rummer Copeland to testify in court or at any proceeding, nor will a disclosure of the psychotherapy records be requested. However, Dr. Rummer Copeland may be legally obligated, by subpoena or court order, to turn over your records and testify. A subpoena requires your consent to release information. A court order signed by a judge does not.

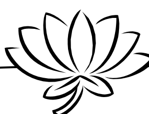
**Contacting Me:** While I am with clients, my calls are answered by the office manager. I work generally only on Thursday and Friday. On the days I am in the office, I usually return calls by the end of the next day, except on weekends and when out of town. If I do not return your call soon enough and you feel it is an emergency, you may call the Crisis Clinic at 425-258-4357, or go to the nearest hospital emergency room. My practice is not designed for emergency services. Please note that I may be away for extended periods of time. At such times, you can call the office, and a member of the staff will attempt to contact me.

**Fees:** My hourly fee is $225 for a diagnostic interview (50 to 60 mins) or testing and $190 for a full session (50 mins) for individuals and couples. In addition to clinical appointments, I charge this amount on a prorated basis for all other professional services you may require, such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings or consultations with other professionals which you have authorized, or preparation of records or treatment summaries.

Please keep one copy of this document for your information. Sign the other and return it to me.

- **I have read Dr. Rummer Copeland's Disclosure Statement and Office Policies Agreement and have had the opportunity to ask questions**.
- **I understand I may contact the State Department of Licensing if I have any concerns.**
- **I understand I am financially responsible for all charges whether or not paid by insurance.**
- **I hereby authorize Dr. Rummer Copeland to release all information necessary to secure the payment of benefits and authorize the use of this signature on all my insurance submissions whether manual or electronic.**
- **I understand that Dr. Rummer Copeland will write to my primary care provider after the initial appointment to assure coordinated care in your behalf.**
- **I agree to abide by the terms therein.**

**SIGNATURE:**____________________________ **TODAY'S DATE:** __________________________



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I am located in Port Townsend, WA at 140 N Stromberg Ave. It is a blue house on the corner of Stromberg and Island View, and the office is above the garage, which is on the right side of the driveway. Please park on the street.

The door to the office is to the right of the garage door. If it is unlocked, please come in and come up the stairs. It should be open 20 to 30 minutes prior to your appointed time, so that you can come up, get a cup of tea or coffee, and fill out any needed paperwork. If it is locked, you may need to wait in your car for a few minutes.