Print Form

EnergyMatters

The following contains information about my practice and answers some important and frequently asked questions. If you have additional questions that are not covered here, please feel free to ask me.

At the initial session, we will discuss the specific problems for which you seek help. I need this information to formulate an assessment and treatment plan. We may also discuss questions you have regarding my policies and procedures. Therapy is a process. It is not possible to predict how long a particular problem may take to resolve. We will discuss the best treatment modalities for your specific needs and goals.

Occasionally, individuals may experience an increase in emotional discomfort or stress while working toward treatment goals. Please inform me of any such changes that concern you. During treatment, I will make suggestions to help you. However, you are responsible for making decisions for yourself and/or your family. If you do not think that sessions are helping or proceeding as you wish, we can discuss alternatives. Remember, you always retain the right to request changes or refuse treatment. I encourage you to discuss any questions, doubts, or preferences regarding the treatment.

If I feel that you would benefit from other services, programs or a different type of therapist, I will discuss these options with you and assist you in making appropriate arrangements.

CONFIDENTIALITY

Counseling works best when people talk freely about issues that are important. Information shared during therapy is kept confidential. I abide by the laws and ethical principles that govern confidentiality. I will not disclose to anyone anything you tell without you or your guardian's written permission. Below are a few exceptions to these standards:

- Clients under 18 years of age and their parents should be aware that, with some exceptions, the law may allow parents to examine their child's treatment record. Privacy in psychotherapy is often crucial to success. It is my policy to require an agreement from the parents that they will not access their child's records. In these cases, I will give parents an account of the overall goals of the child's treatment, my estimation of the degree of progress being made, and notification of any concerns I have regarding imminent and serious danger. Any other information will be provided at my discretion. Whenever possible, I will discuss such release with the child in advance.

- The courts and state law stipulates that information cannot be kept confidential if a client is facing risk of harm. For instance, information cannot be kept private if someone discloses child abuse, abuse of an older adult, or plans to kill another person or themselves.

- If someone commits a crime against the therapist, the police may be called.

- Non-custodial parents generally have the right to learn about treatment their child(ren) is receiving, Finally, if I am called to court, the court can order that information shared in counseling be disclosed.

- Clinical information may be released to insurance carriers as required for payment or review of a claim.

- Release of your records is necessary when ordered by court subpoena. However, I will discuss this with you beforehand and request a written release should this be in your best interest.

FEES, APPOINTMENTS AND CANCELLATION POLICY

Successful therapy requires an acceptance of responsibility, a commitment to explore change, and a positive working alliance between the client and the therapist. Regular and on-time attendance to appointments is part of the responsibility. Appointments are reserved for you. If you are unable to attend a scheduled appointment, a 24-hour notice is recommended to avoid being charged. No-shows are charged at 50% of the hourly fee. Please be aware that insurance companies do not reimburse for missed sessions. Therefore, the responsibility for payment rests with you. Under special or extenuating circumstances payment will be waived for the late cancellation or missed appointments. Messages or cancellations can be left on my voice mail.

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The initial assessment and regular session fee varies by therapist. Initial assessment (first session only) ranges from $175-$250. Regular session ranges from $150-$240. Your copayment/co-insurance is $_____.

You are expected to pay your fee or insurance co-pay at the time of each visit. If you have an annual medical insurance deductible, this will need to be paid before your insurance will begin this reimbursement. If benefits are exhausted or coverage is denied, you are expected to pay any unpaid balances before continuation of treatment.

TELEPHONE CALLS AND EMERGENCIES

You may leave me a voice mail for me at any time, day. Information on my voice mail includes the phone numbers for the county crisis line or you can go to your local emergency room.

MISCELLANEOUS

If you chose to terminate therapy, you may sign a release of information to have your psychotherapy notes copied for another therapist. My charges are $1.00 per page for copying any notes or documents in your file.

I reserve the right to terminate your therapy with me. If in my opinion, I determine that you would be better served by working with another therapist or for any other reason, I will inform you that our therapeutic relationship has terminated.

INFORMED CONSENT FOR TREATMENT

- I have had the opportunity to review the above information and agree to enter treatment under these conditions.
- I give my consent to receive treatment for myself and/or grant permission for treatment to be provided for my dependent family member(s)
- I give permission for my therapist to use consultants to plan services for myself and/or my family.
- I give permission for my therapist to release information as needed to secure any applicable insurance benefits.

Client Signature: _____ Date _____

Parent/Legal Guardian: _____ Date _____

Parent/Legal Guardian: _____ Date _____

Therapist: _____ Date _____

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INTAKE EVALUATION

IDENTIFYING INFORMATION:

Client's Name: _____ Today's Date: _____

Partner's Name (if being seen as a couple): _____

Address: _____ City, State & Zip: _____

Telephone: _____(Cell) Telephone:_____(Work) Email: _____

May we leave a message? yes ○ no ○

Gender: ____ Age: _____ Date of Birth: _____ Marital Status: _____

Others living in the home: (Please include Name, Date of Birth & Relationship to Client)

_____

Other family outside the home: (Please include Name, Date of Birth & Relationship to Client)

_____

REFERRED BY: _____

EDUCATION: Yourself: _____ Partner: _____

OCCUPATION: Yourself: _____ Partner: _____

EMPLOYER: Yourself: _____ Partner: _____

SOCIAL SECURITY NUMBER: Yourself: _____ Partner: _____

EMERGENCY CONTACT: Name: _____ Telephone: _____

INSURANCE INFORMATION:

Name of Policy holder: _____ _____ Date of birth: ___/___/___

Address of Policy holder: _____ City, State & Zip: _____

Relationship to client: _____

Insurance Company: _____ Telephone: _____

Insurance Company Address: _____ City, State & Zip: _____

Employer of Policy Holder: _____

ID # of Insured: _____ Group #: _____

INSURANCE INFORMATION (Secondary):

Name of Policy holder: _____ _____ Date of birth: ___/___/___

Address of Policy holder: _____ City, State & Zip: _____

Relationship to client: _____

Insurance Company: _____ Telephone: _____

Insurance Company Address: _____ City, State & Zip: _____

Employer of Policy Holder: _____

ID # of Insured: _____ Group #: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to the party who accepts assigned or to myself. I authorize payment of medical benefits to the provider of services.

Client Signature: _____ Date: _____

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Client's Name: _____

PRESENTING PROBLEM (Please describe the problem(s) that brought you here today):

_____

_____

_____

_____

_____

_____

CHECK ANY SYMPTOMS THAT YOU ARE HAVING:

- ☐ Depression
- ☐ Extreme Sadness
- ☐ Trouble Concentrating
- ☐ Memory Problems
- ☐ Change in eating habits
- ☐ Feeling of extreme happiness
- ☐ Trouble performing your job
- ☐ Lack of enjoyment of usual activities
- ☐ Self-esteem problems
- ☐ Perfectionism
- ☐ Obsessions of Compulsions
- ☐ Feeling fearful
- ☐ Physical complaints of pain
- ☐ Problems with anger
- ☐ Thoughts of hurting yourself or others
- ☐ Hopeless
- ☐ Feeling tearful
- ☐ Change in sleeping habits
- ☐ Lack of energy
- ☐ Weight Changes
- ☐ Change in sexual interest or function
- ☐ Problems getting along with friends or family
- ☐ Feeling Stressed
- ☐ Easily Irritated
- ☐ Feeling Guilty
- ☐ Feeling Nervous
- ☐ Sudden feelings of panic
- ☐ Muscle Tension
- ☐ Acting Violently
- ☐ Thoughts of killing yourself or others

HAVE YOU BEEN IN COUNSELING BEFORE? (Please circle your answer) **Yes** ○ **No** ○

If you have been in counseling before, please describe below, starting with the most recent first.

A. When was the counseling? Date: _____

B. Whom did you see? Name: _____

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MEDICAL INFORMATION

Have you seen a doctor in the last year? (Please circle your answer) **Yes** **No**

If yes, what was it for? _____

_____

Who is your primary care doctor? Name: _____

Are you taking any prescriptions, or over-the-counter medications? (Please circle your answer) **Yes** **No**

If yes, what are you taking? _____

Do you have problems sleeping? (Please circle your answer)	**Yes**	**No**
Do you have problems eating? (Please circle your answer)	**Yes**	**No**
Do you get regular weekly exercise?	**Yes**	**No**
Have you witnessed violence?	**Yes**	**No**
Have you been affected by rape?	**Yes**	**No**
Have you been involved in an accident?	**Yes**	**No**
Are you experiencing abuse (physical, sexual or emotional)?	**Yes**	**No**
Have you experienced a loss, such as infertility, abortion, miscarriage?	**Yes**	**No**

PSYCHIATRIC HOSPITALIZATIONS (Please circle your answer) **Yes** **No**

Where: _____ Dates: _____

Reason: _____

HAVE YOU BEEN PRESCRIBED PSYCHIATRIC MEDICATIONS? (Please circle your answer) **Yes** **No**

Who prescribed your medications? _____

SUBSTANCE USE HISTORY (Please circle your answers)

Do you/have you used tobacco in any form?	**Currently**	**Past**	**No**
Do you/have you used alcohol?	**Currently**	**Past**	**No**
Do you/have you used caffeine in any form?	**Currently**	**Past**	**No**
Do you/have you used recreational drugs?	**Currently**	**Past**	**No**
Has there been any substance use or abuse in your family?	**Currently**	**Past**	**No**

PRIOR TREATMENT FOR SUBSTANCE ABUSE

Where: _____ Dates: _____

Reason: _____

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DEVELOPMENT HISTORY (Please circle your answers)

Were there any problems with your mother's pregnancy or your delivery?	**Yes** ○	**No** ○
As a child, did you have emotional or medical problems?	**Yes** ○	**No** ○
Have there been any mental health problems in your family?	**Yes** ○	**No** ○
Has there been any family crisis such as marital separation or divorce?	**Yes** ○	**No** ○

Briefly describe your relationship with your parent(s):

_____

_____

Briefly describe your relationship with your sibling(s):

_____

_____

Briefly describe your temperament:

_____

_____

_____

How do you handle conflict?

_____

_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past. present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company. reviewing services provided to you to determine medical necessity. or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services. I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to. quality assessment activities. employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes pm will be disclosed only with your authorization. I may use your PHI to remind you of appointments.

Required by Law. Under the law, I must make disclosures of your PID to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

- Abuse and Neglect reporting and investigation
- Judicial and Administrative Proceedings
- Deceased Persons
- Emergencies (including immediate risk to self or others)
- Family Involvement in Care
- Health Oversight
- National Security

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (sue as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to your therapist at one of the addresses below:

9860 SW Hall Blvd Ste B, Tigard OR 97223

1880 Willamette Falls Dr. #260, West Linn, OR 97068

8532 N Ivanhoe Ste 203, Portland OR 97203

3314 SW Kelly Street, Portland, OR 97239

3325 NE Wasco St, Portland OR 97232

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing at 9860 SW Hall Blvd Ste B, Tigard OR 97223 or 8532 N. Ivanhoe Ste 203, Portland OR 97203 or 3325 NE Wasco St, Portland OR 97232 or 1880 Willamette Falls Dr. #260, West Linn, OR 97068 or 3314 SW Kelly Street, Portland, OR 97239, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 Or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 20, 2018.

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Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Patient/Client Name: _____

Date of Birth: _____

Social Security #: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact my therapist at one of the addresses below:

9860 SW Hall Blvd Ste B, Tigard OR 97223
8532 N Ivanhoe Ste 203, Portland OR 97203
3325 NE Wasco St, Portland OR 97232
1880 Willamette Falls Dr. #260, West Linn, OR 97068
3314 SW Kelly Street, Portland, OR 97239

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, heath care surrogate, etc):

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date