INFORMED CONSENT

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 I suspect abuse, I may be required to report it.
- 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.
- There are times when I may seek peer consultation about your case. In that event, I will keep all of your identifying information confidential.

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. A cancellation of an appointment in less than 24 hours will be charged at 50% of the hourly fee. No shows are charged at 100% of our 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.

The initial assessment and regular session fee varies by therapist. Initial assessment (first session only) is $200. A regular session is $180. 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.

Fees will be charged in 15 minute increments for phone calls, written reports, reviewing chart notes and case consultations with other professionals, teachers, family members, etc. per our hourly rate.

In the event your therapist is subpoenaed, the court orders a release of records, or your therapist is requested to testify, he/she is required to respond. Your therapist will discuss with you available options, if any. Any time spent reviewing, compiling and distributing records, talking with attorneys, parents and other professionals involved in the case, written testimony, transportation to court, court attendance, in-person testimony or any action your therapist needs to take in this situation will be charged at our full hourly rate in 15 minutes increments.

TELEPHONE CALLS AND EMERGENCIES

You may leave a voice mail for me at any time, day or night. 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. **Fees for copied records:** $30 for 1-10 pages, .50 per page for 11-50, .25 per page for 51+, $6.50 for electronic records postage. **Workers' Compensation Records:** .10 for one page, .50 for each additional page, $6.50 for electronic records postage.

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, you need a higher level of care, there is non-compliance with treatment, threatening behavior, or for any other reason, I will inform you that our therapeutic relationship has terminated. I will provide you with appropriate referrals.

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 ____________

INTAKE EVALUATION

IDENTIFYING INFORMATION:

Child's Name: ______________________________ Today's Date: ______________

Custodial Parent(s): ______________________________

Address: ______________________________ City, State & Zip: ______________

Telephone: ______________ (Cell) ______________ (Mother) ______________(Father)

Email: ______________(Child) ______________ (Mother) ______________(Father)

Gender: _____ Pronouns: __________ Age: ___ Date of Birth: __________

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

____

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

____

REFERRED BY: ______________________________

SCHOOL: ______________________________ **Grade:** ______________

SOCIAL SECURITY NUMBER: ______________________

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: ______________

EnergyMatters

Child's Name: ________________________________

PLEASE DESCRIBE THE PROBLEM(S) THAT BROUGHT YOU HERE TODAY:

____

____

____

CHECK ANY SYMPTOMS THAT YOU ARE HAVING:

____ Depressed mood
____ Extreme sadness
____ Trouble concentrating
____ Change in sleeping habits
____ Bedwetting
____ Change in eating habits
____ Problems getting along with family
____ Lack of enjoyment of usual activities
____ Trouble doing school work
____ Feelings of stress
____ Perfectionism
____ Worries
____ Feeling fearful
____ Low self-esteem
____ Physical complaints of pain
____ Anger outbursts
____ Running away
____ Has cut or hurt themselves
____ Thoughts of killing themselves
____ Feelings of hopelessness
____ Tearful / crying spells
____ Memory problems
____ Lack of energy
____ Weight/Appetite changes
____ Problems getting along with friends
____ Feelings of extreme happiness
____ Truancy
____ Irritability
____ Isolation/withdrawal
____ Expressing feelings of guilt
____ Nervous
____ Sudden feelings of panic
____ Tense/Uptight
____ Acting violently
____ Harm animals
____ Fire setting
____ Thoughts of killing others

WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

____

____

Have you worked with the child's teacher or school counselor? **Yes** **No**

If YES please describe below:

Name of counselor: ______________________________

Date(s):______________________________

Explain what happened: ______________________________

MEDICAL INFORMATION

Has the child seen a doctor in the last year? **Yes** **No**

If yes, what was it for? ______________________________

Who is the child's primary care doctor?______________________________

Is the child taking any prescriptions, or over-the-counter medications? **Yes** **No**

If yes, what are they taking? ______________________________

Does the child have problems sleeping? **Yes** **No**

Does the child have problems eating? **Yes** **No**

Please describe any problem(s):______________________________

____

____

Does the child get regular weekly exercise? **Yes** **No**

Has the child witnessed any violence? **Yes** **No**

Has the child been affected by rape or molestation? **Yes** **No**

Has the child been involved in an accident? **Yes** **No**

Is the child experiencing abuse (physical, sexual or emotional)? **Yes** **No**

HAS THE CHILD BEEN PRESCRIBED PSYCHIATRIC MEDICATIONS? **Yes** **No**

If YES, please describe:

Medication	**Date Started**	**Frequency**	**Duration**

HAS THE CHILD HAD ANY PSYCHIATRIC HOSPITALIZATIONS? **Yes** **No**

Where: ______________________________ Dates: ______________

Reason: ____

SUBSTANCE USE HISTORY (if applicable)

Does the child use tobacco in any form?	**Currently**	**Past**	**No**
Does the child use alcohol?	**Currently**	**Past**	**No**
Does the child use caffeine in any form?	**Currently**	**Past**	**No**
Does the child use recreational drugs?	**Currently**	**Past**	**No**

HAS THERE BEEN ANY PRIOR TREATMENT FOR SUBSTANCE ABUSE? **Yes** **No**

Where: ______________________________ Dates: ______________

Reason: ____

DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or delivery of the child?	**Yes**	**No**
Were there any problems with eating, sleeping, or crying spells (colic, nightmares, etc).	**Yes**	**No**
Did the child demonstrate any difficulties or delays in walking, talking, toilet training?	**Yes**	**No**
Has there been any family crisis, such as marital separation or divorce?	**Yes**	**No**
Has there been any substance abuse in the family?	**Yes**	**No**

Briefly describe the child's relationship to parent(s):

____

____

Briefly describe the child's temperament:

____

____

SCHOOL HISTORY

When did the child start school? ______________________________

Where there any problems when the child started school?

____

____

What kind of grades is the child getting?

____

Describe any changes in the child's school performance?

____

____

How does the child get along with their teachers?

____

____

How does the child get along with their friends or peers in school?

____

____

What is the child's favorite subject(s) or school activities?

____

____

What subject(s) or activities does the child have problems with?

____

____

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

8532 N Ivanhoe Ste 203, Portland OR 97203

3325 NE Wasco St, Portland OR 97232

20390 Willamette Drive, West Linn, OR 97068

3314 SW Kelly Street, Portland, OR 97239

- **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 12month 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 20390 Willamette Drive, 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.

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
20390 Willamette Drive, 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