Discover Counseling
7320 SW Hunziker St., Suite 204 | Tigard, OR 97223
Phone: 971.222.8166 | **Fax**: 866.802.8062
Email: intern@discovercounseling.com

Statement of Understanding and Consent for Treatment

Psychotherapy is not like a medical doctor visit; it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

In couples therapy, if you and your partner decide to have some individual sessions, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner*. I will remind you of this policy before beginning such individual sessions.

I am generally available by appointment only, Tuesday and Thursday. You may call and leave a confidential message at any time and I will return your call as soon as possible. My policy for after-hours coverage is to leave a message and I will return your call the next business day. If you are in need of urgent or emergency services after hours, contact your local social services, crisis line (Washington County: 503-291-9111) or dial 911.

Please understand that information obtained from you is confidential under Oregon law. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.
2. When there is reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/neglect of a child, elderly person, disabled person, or any animal is occurring or has occurred.
4. Information necessary for billing purposes, justification for treatment, and resolution of a complaint.

Your ***INITIALS*** beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time.
_____ I understand and have reviewed statement of financial responsibilities.
_____ I have received a professional disclosure statement.
_____ I have received a copy of HIPAA's Notice of Privacy Practices.
_____ I understand that any records sent to or retrieved from other professionals will be marked and directed as "NO FURTHER DISCLOSURE" to protect your privacy.

Your signature indicates that you understand this "Statement of Understanding and Consent for Treatment" and agree to the above. I hereby give Discover Counseling, LLC consent to provide my treatment.

_____	_____	_____
Print Name	**Client Signature**	**Date**
_____	_____	
Clinician Signature	Date	

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Statement of Understanding and Consent for Electronic Communication

I utilize various methods of communication to maintain contact with clients. Please understand this office is portable and thus phone contact with me will be on a cellular phone through a secure router in this office. There are various methods of contact with me including phone and email. I utilize text messaging in very limited circumstances and only for scheduling or basic information purposes.

Please be aware that electronic communication via telephone or email may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy. The type of information transmitted via email should be used for scheduling or other incidental issues only. Contacts to discuss all other issues should be made preferably in person or via phone if arises.

As a general rule, I do not have contact with clients outside of the office that is unrelated to mental health treatment. This rule applies to various internet messaging sites, social networking sites, and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship. Please ***INITIAL*** below:

_____ I understand the risks associated with utilizing any electronic methods of communication and agree to do so at my own risk.

_____ I understand email contacts will be for scheduling and incidental purposes. All other forms of communication will be made preferably in person or via phone if emergency arises.

Print Name	**Client Signature**	**Date**
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HIPAA 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 it carefully. You have the right to get a copy of your paper or electronic medical record, correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of this privacy notice, choose someone to act for you, and file a complaint if you believe your privacy rights have been violated. You have some choices in the way that we use and share information as we tell family and friends about your condition, provide mental health care, and market our services. We may use and share your information as we treat you, run our organization, bill for your services, help with public health and safety issues, do research, comply with the law, address workers' compensation, law enforcement, and other government requests, and respond to lawsuits and legal actions. You can get a paper copy of your medical record. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.We can share health information about you for certain situations such as reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in response to a subpoena. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Client Signature: _____ **Date:** _____

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Statement of Financial Responsibility

Fees: As an intern, I provide services according to the Income-Based Fee Schedule for Intern Counselor, based on a 50-minute session. Phone calls, reports, and other services provided outside of regularly scheduled appointments are billed in 15-minute increments. Payment is due in full by cash, check, or credit card on the date of service. Each session paid by credit/debit card will be charged individually with an additional $1 fee per transaction on the date of service.

Cancellation Policy: Please call 24 hours in advance to change or cancel an appointment to allow that time for another person. You are able to leave a message 24 hours a day. If you do not show for an appointment and do not call to cancel within 24 hours of the session, you will be billed the full rate.

Payment Policy and Agreement: In the event that my account has not been paid within 90 days, I authorize Discover Counseling, LLC to charge the following account for services according to the financial policies and payment agreement above at which time account will be charged any unpaid balance.

Type of card:
☐ Visa ☐ MasterCard ☐ Amex ☐ Debit

Account Number: _____ - _____ - _____ - _____ Expiration Date:_____
Card Holder Name:_____ Security Code:_____
Address:_____ Billing Zip Code:_____
Telephone:_____ Email for receipt:_____
Signature:_____

I have read this Statement of Financial Responsibility. I understand that I am responsible for my bill, payable to Discover Counseling, LLC.

_____	_____	_____
Print Name	**Client Signature**	**Date**

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Income-Based Fee Structure for Intern Counselor

Since interns cannot accept your insurance, they work on a sliding fee scale that is based on your income and is comparable to what your insurance co-pay or coinsurance would be. The fee scale is listed below:

Net Income Per Month	Session Fee
Below $1,800	$15
$1,801-$2,100	$19
$2,101-$2,400	$22
$2,401-$2,700	$25
$2,701-$3,000	$28
$3,001-$3,300	$32
$3,301-$3,600	$35
$3,601-$3,900	$37
Above $3,901	$40

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Confidential Client Intake Information

GENERAL INFORMATION

Full Name: _____ Name You Prefer: _____
Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Referred by: _____

CONTACT INFORMATION

Street Address: _____ Suite / Apt. #: _____
City: _____ State: _____ Zip: _____ OK to send mail here? ☐ Yes ☐ No
Home Phone: (_____)_____ OK to leave message here? ☐ Yes ☐ No
Cell Phone: (_____)_____ OK to leave message here? ☐ Yes ☐ No
Work Phone: (_____)_____ OK to leave message here? ☐ Yes ☐ No
Email Address: _____ OK to send mail here? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____
Occupation: _____ Average Hours Worked Per Week: _____
Annual Salary:

☐ $0 - $30,000 ☐ $40,001 to $50,000 ☐ $60,001 to $70,000 ☐ $80,001 to $100,000
☐ $30,001 to $40,000 ☐ $50,001 to $60,000 ☐ $70,001 to $80,000 ☐ More than $100,001

EDUCATION INFORMATION

Years of School Completed: ☐9 ☐10 ☐11 ☐12 ☐GED College: ☐1 ☐2 ☐3 ☐4 ☐Other: _____
Are You Currently In School? ☐ Yes ☐ No If Yes, What Level: _____ Degree Pursuing: _____

RELIGIOUS BACKGROUND

Do you consider yourself: ☐ Atheist ☐ Agnostic ☐ Religious/Spiritual ☐ Other: _____
How would you describe your religious/spiritual beliefs: _____
Do you regularly attend a place of worship? ☐ Yes ☐ No If yes, where? _____
Briefly describe the religious environment of the home you grew up in: _____
Complete the following thought: "God is _____"

RELATIONAL INFORMATION

Current Marital Status:

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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If Married, How Long? _____ # of Previous Marriages for You: _____ For Spouse: _____
If Separated or Divorced, How Long? _____ If Widowed, How Long? _____
Who Do You Currently Live With? (Check All That Apply)

☐ Alone ☐ Spouse ☐ Parent(s) ☐ Sibling(s)
☐ Boyfriend ☐ Girlfriend ☐ Child(ren) ☐ Other: _____

PARTNER INFORMATION

Full Name: _____
How Long Have You Been Together? _____ Age: ____ Sex: ☐ Male ☐ Female
Occupation: _____ Average Hours Worked Per Week: _____
Years of School Completed: ☐9 ☐10 ☐11 ☐12 ☐GED College: ☐1 ☐2 ☐3 ☐4 ☐Other: _____

CHILDREN

Please list your children (living or deceased) as well as any children you have placed for adoption:

Name	Sex	Current Age or Year of Death	Relationship To You (Natural, Step, Adopted)	Living With You?	Briefly Describe Him/Her:

Have you ever had a miscarriage or medical abortion? ☐ Yes ☐ No If yes, when? _____

FAMILY OF ORIGIN

Please list family members (immediate or extended family) who affected you positively or negatively:

Name	Sex	Current Age or Year of Death	Relationship To You (Mom, Dad, Sibling, Step, etc.)	Occupation	Briefly Describe Him/Her:

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (_____)_____
Address: _____ City: _____ Zip: _____
Are you currently receiving medical treatment? ☐ Yes ☐ No If yes, please specify: _____
Please list conditions, illnesses, surgeries, hospitalizations, traumas, or related treatments you've had:

_____
_____

MEDICATION INFORMATION

Please list all current medications you are taking, including those you seldom take or only as needed:

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Medication	Dosage & Frequency	Improves, Prevents, or Controls (Symptoms)	Treating (Illness)

Are you taking these according to your doctor's recommendations? ☐ Yes ☐ No
If no, please briefly explain: _____

PHYSIOLOGICAL SYMPTOMS

Please check any of the following physiological symptoms/issues that apply to you presently or in the recent past:

Headaches:	☐ Past	☐ Present	**Sleeping:**	☐ Past	☐ Present	**Appetite Change:**	☐ Past	☐ Present
Dizziness	☐ Past	☐ Present	**Tension:**	☐ Past	☐ Present	**Weight Change:**	☐ Past	☐ Present
Vision:	☐ Past	☐ Present	**Breathing:**	☐ Past	☐ Present	**Hearing Noises:**	☐ Past	☐ Present
Hearing Voices:	☐ Past	☐ Present	**Tiredness:**	☐ Past	☐ Present	**Stomach Issues:**	☐ Past	☐ Present

CURRENT STATUS

Please check any of the following problems that apply to you or your family:

Abnormal Bleeding	☐	Fainting Spells	☐	Long-Term Memory	☐	Restlessness	☐
Addiction	☐	Fear Leaving Home	☐	Mania	☐	Seizures	☐
Aggression	☐	Financial Concerns	☐	Medication Issues	☐	Self-Harm	☐
Anemia	☐	Gastro-Intestinal	☐	Mood Swings	☐	Sexual Abuse	☐
Anger	☐	Hallucinations	☐	Nervousness	☐	Short-Term Memory	☐
Anxiety	☐	Headaches	☐	Nightmares	☐	Skin Problems	☐
Appetite Problems	☐	Head Injury	☐	Night Sweats	☐	Sleep Disturbances	☐
Asthma/Respiratory	☐	Heart/Circulatory	☐	Obsessions	☐	Social Anxiety	☐
Cancer/Tumors	☐	Hypersomnia	☐	Pacemaker	☐	Stress	☐
Compulsions	☐	Hypertension	☐	Panic	☐	TB	☐
Concentration	☐	Infections/HEP	☐	Paranoia	☐	Thoughts of Death	☐
Confusion	☐	Insomnia	☐	Personality Disorder	☐	Trauma	☐
Depression	☐	Intrusive Thoughts	☐	Phobias	☐	Trauma Flashbacks	☐
Diabetes	☐	Irritability	☐	Physical Abuse	☐	Veteran/Military	☐
Dietary Changes	☐	Irritable Bowel	☐	Pneumonia	☐	Visual Difficulties	☐
Disordered Eating	☐	Joint/Muscle	☐	Racing Thoughts	☐	Weight Gain/Loss	☐
Domestic Violence	☐	Kidney Disease	☐	Relationships	☐	Worry	☐
Emotional Abuse	☐	Learning/Focus	☐	Repeat Behaviors	☐	Worthlessness	☐
Employment	☐	Legal Difficulties	☐	Repeat Thoughts	☐	Other:	☐

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LEVEL OF DISTRESS

Indicate how distressed you currently are by placing an "X" on the scale below:

(0 = No Distress; 10 = Extreme Distress)

0 1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when and how? _____

Have any family or friends ever attempted or committed suicide? ☐ Yes ☐ No

If yes, who and when? _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (e.g., What are your issues/problems?)

_____

_____

Why did you decide to come to counseling now? _____

_____

What do you hope to gain by coming to counseling? _____

_____

How long do you believe counseling will (or should) last?_____

PREVIOUS COUNSELING

Please list any prior counseling, psychiatric treatment, or residential/inpatient care you have received:

Therapist: _____ Location: _____

Dates: _____ Reason: _____

Therapist: _____ Location: _____

Dates: _____ Reason: _____

Therapist: _____ Location: _____

Dates: _____ Reason: _____

Therapist: _____ Location: _____

Dates: _____ Reason: _____

Therapist: _____ Location: _____

Dates: _____ Reason: _____

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Authorization to Release Protected Health Information (Optional)

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	☐ Whether the client is in treatment or not ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) ☐ Brief statement regarding progress (client's denial, client's understanding of their condition, progress or lack of progress on goals, cooperation with treatment plan and rules) ☐ Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	☐ Referral to other services ☐ Coordination of care ☐ Consultation with Doctor ☐ Consultation with other mental health provider ☐ Transfer of care ☐ Other: _____

Signature of Client _____ **Date**_____

Signature of Clinician _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment. FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.