New Client Information Form

First Name: _____

Last Name: _____

Name you wish to be called: _____ Preferred Pronoun:_____

Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email (required): _____

Phone : _____

Relationship status: _____

Support system: _____

_____

Belief system/religion/worldview: _____

Emergency Contact Name & Phone: _____

Primary Care Physician Name and Phone: _____

How were you referred to us?_____

Please describe any current concerns about your physical health: _____

_____

_____

Please list any medications, vitamins, and supplements you are presently taking:

_____

_____

Have you ever been hospitalized for a mental health concern? _____

Have you had counseling previously? _____ If so, why did you discontinue therapy?

_____

_____

Have you ever taken medication for mental health concerns? _____

What medications did you take and when? _____

If you currently have a mental health prescriber, what is their name?_____

Lifestyle

Are you having any problems with your sleep habits? ( ) yes ( ) no
If yes, check where applicable: ( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____
Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes
If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting ( ) Purging ( ) Laxatives

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____

Tea _____ Energy Drinks _____

Substance Use

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months?

If yes, which ones? _____

Do you use any tobacco products? ( ) Yes ( ) No

If yes, what and how often? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Consequences of substance use

( ) hangovers ☐ ( ) seizures ☐ ( ) blackouts ☐ ( ) overdose ☐ ( ) withdrawal symptoms ☐ ( ) medical conditions ☐ ( ) tolerance changes ☐ ( ) loss of control over amount used ☐ ( ) sleep disturbance ☐ ( ) assaults ☐ ( ) suicidal impulse ☐ ( ) relationship conflicts ☐ ( ) binges ☐ ( ) job loss ☐ ( ) arrests ☐ ( ) other _____

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

Work Satisfaction Level: ( ) Completely Satisfied ( ) Somewhat Satisfied ( ) Somewhat Dissatisfied ( ) Completely Dissatisfied ( ) No opinion

Financial Situation: ( ) No current financial problems ( ) Large indebtedness ( ) Poverty or below-poverty income ( ) Impulsive spending ( ) Relationship conflicts over finances

Social Support System: ( ) Supportive network ( ) Few friends ( ) Substance-use-based friends ( ) No friends ( ) Distant from family of origin

Military History: ( ) Never in military ( ) Served in military - no incident ( ) Served in military - with incident

Legal History: Have you ever been convicted of a misdemeanor or felony? ( ) yes ( ) no
If so, please describe:_____

_____

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No. Please describe when, where and by whom:

_____

_____

Intimate Relationship: ( ) Never been in a serious relationship ◯ ( ) Not currently in a serious relationship ◯ ( ) Currently in a serious relationship

Relationship Satisfaction:

( ) ◯ very satisfied ◯ ( ) satisfied ◯ ( ) somewhat satisfied ◯ ( ) dissatisfied ◯ ( ) very dissatisfied

Describe any past or current significant issues in intimate relationships

_____

Family Background and Childhood History:

Where did you grow up? _____

Were you adopted? ( ) Yes ( ) No

List your siblings and their ages: _____

_____

Did your parents' divorce? ( ) Yes ( ) No

If so, how old were you when they divorced? _____

If your parents divorced, whom did you live with? _____

Briefly describe your father and your relationship with him: _____

_____

Briefly describe your mother and your relationship with her: _____

_____

Describe any past or current significant issues in other immediate family relationships:

_____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for: *Bipolar disorder* ( ) Yes ( ) No *Schizophrenia* ( ) Yes ( ) No *Depression* ( ) Yes ( ) No *Post-traumatic stress* ( ) Yes ( ) No *Anxiety* ( ) Yes ( ) No *Alcohol abuse* ( ) Yes ( ) No *Anger* ( ) Yes ( ) No *Other substance abuse* ( ) Yes ( ) No *Suicide* ( ) Yes ( ) No *Violence* ( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

Please give a brief description of the concerns you are seeking therapy for:

_____

_____

_____

_____

_____

Current Symptoms Checklist: *(check once for any symptoms present, twice for major symptoms)* ( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance ( ) Loss of interest ( ) Increased libido ( ) Hallucinations ( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt ( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido ( ) Compulsive Behaviors

Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If YES, please answer the following. If NO, please skip to the next section. Do you currently feel that you don't want to live? ( ) Yes ( ) No How often do you have these thoughts?

_____

When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____ Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? _____

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Please briefly list when, where and by whom: _____
_____
_____

Is there anything else that you would like me to know?
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____ Date _____

Katie Johnson Clark, LPC, NCC
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503-781-1997

PROFESSIONAL PSYCHOTHERAPY DISCLOSURE STATEMENT

Philosophy and Approach: Psychotherapy is a relationship between client and counselor, and each person in that relationship has rights and responsibilities that will be discussed here. The foundations of the psychotherapeutic relationship are confidentiality, trust, respect, and safety, but there are some limits to those elements. My goal as a therapist is to provide clients with support, tools, and a safe environment in which to work through any difficulties they experience, and I will do my utmost to fulfill that goal in a respectful and confidential manner. The client and I will work to resolve their presenting issues with educational, insight-oriented, and behavioral treatment methodologies.

Formal Education, Training and Intern Status: I have a Bachelor of Arts in Psychology with and emphasis in business from UCLA. I obtained my Master's degree in Counseling Psychology from Pacific University, with coursework in Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, neuro-counseling, mindfulness, and Dialectical Behavior Therapy, which are the primary methods of therapy I provide for clients. I am a Licensed Professional Counselor with the Oregon Board of Licensed Professional Counselors and Therapists, and will abide by its code of ethics. I participate in continuing education courses as required by the state, and report them as part of maintaining my licensure.

Fees: I provide initial intake services at $200 per clinical hour (50 minute-session), and therapy services at $125 per clinical hour. This payment represents a charge that is reasonable and customary for my training and location. If you would like to use health insurance, payment is expected at the time of service, and I will submit claims to your insurance for reimbursement on your behalf. On rare occasion, I do offer a negotiable sliding scale fee structure if the client has financial hardship. Phone consultations in non-emergency situations are $10 for each 10 minutes, and are payable at the next scheduled appointment, but consultations in emergency situations are free. Fees will be due at time of service and paid by cash, check, or credit card. Returned checks will have an additional $25 charge and 3% interest accrued monthly until paid. This clinician reserves the right to charge the client's credit card on file for any unpaid balance. By signing this form, clients agree to give at least 48 hours advance notice for cancellations, and this clinician reserves the right to charge for no-shows and short-notice cancellations.

Ethics: While the therapeutic relationship can feel very personal, professional boundaries are crucially important to therapeutic work. For this reason, I am unable to have pre-arranged social contact with you outside the therapeutic setting. Should we run into each other in a social/outside situation, I will protect your confidentiality and will not initiate contact unless you do so. As your therapist, I will adhere to the Oregon Code of Ethics for Counselors and Therapists at all times.

Involvement of Other Professionals: My role in this relationship is therapeutic and psychological in nature. All medical issues will need to be referred to a medical professional, and I will assist you in this if necessary. I am not able to prescribe medication, but am able, with your permission, to collaborate with other professionals to assist if medication becomes necessary. Any contacts with other professionals will require your written consent and release.

Records: Your mental health records will be kept in my office. Your records are confidential, and cannot be accessed by anyone besides me. I will retain your records for a minimum of seven years after completion of therapy. If for any reason I become incapacitated, you may contact the Oregon Board of Licensed Professional Counselors and Therapists for further information on contacting my designated custodian of records, who will be able to help you obtain your records if you wish.

As a client of an Oregon licensee, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
    - Reporting suspected child, elder and MI/DD abuse;
    - Reporting imminent danger to the client or others;
    - Reporting information required in court proceedings or by client's insurance company or other relevant agencies;
    - Providing information concerning licensee case consultation or supervision; and
    - Defending claims brought by the client against licensee;
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
- To discontinue therapy at any time. If no sessions take place for 60 days, your file will be closed, but can be reopened in the future at your request.

Evaluations:
Values Counseling provides therapy; we do not perform psychological or psychiatric evaluations for any purpose. We do not provide case notes and other records to General Assistance, Social Security, Children and Family Services, or for divorce and/or child custody, or for any other legal issue. By signing this form you waive your right to use our records or request my testimony in legal matter.

Communication Outside of Sessions: I utilize various forms of communication to maintain contact with clients, and phone contact is on a cellular phone. Email and text messages are not secure forms of communication, so there is potential for interception or misdirection of your information if you choose to communicate in this way. Please consider communicating any sensitive or private information in person, to protect your privacy. I do not interact with clients on any social networking sites, so please understand that contacts or requests on these sites will not be confirmed or acknowledged, to protect your privacy, as well as to eliminate a dual relationship. By signing this form, you agree that you understand the risks associated with using electronic communications, and do so at your own risk.

Grievance Procedure: I encourage you to discuss any complaints with me directly to resolve the problem or issue. I always strive to learn from these discussions. You may also contact the Board of Licensed Professional Counselors and Therapists at 3218 Pringle Road SE # 250, Salem, OR 97302-6312. Telephone: (503) 378-5499 Email: lpc.lmft@state.or.us or www.oregon.gov/OBLPCT

Acknowledgement of Understanding: By signing this disclosure statement, you acknowledge understanding of, and responsibility for, all information contained herein, and acknowledge you have had any and all questions answered to your satisfaction. Please maintain a copy of this form for your records.

Client Signature **Date**

Katie Johnson Clark, LPC
Values Counseling
5520 SW Macadam, Suite 270, Portland, OR 97239
503-781-1997 www.valuescounseling.com

FEE & PAYMENT AGREEMENT

Today's Date: _____ **Review After:** _____

A. Payments - *(Please read & initial your consent)*

_____ I am fully responsible for my account and understand that payment is due at the time of service. My insurance company may or may not reimburse me for the cost of my counseling. I intend to pay when services are rendered, with *(please circle preference)*: cash; check; Paypal; or credit card.

_____ I consent to the release of my name, account and contact information if there is a third-party payer or collector needed. I will keep this information current to prevent interruption of service.

_____ I understand that when I make an appointment, my therapist has reserved that time especially for me. In order to preserve fairness and goodwill in our working relationship, **I will give at least 48 hours notice before canceling a session**. Any "no-show" or "late-cancel" (less than 24 hours advance notice) of an appointment will be charged the full session fee of $135.

_____ I agree to pay retail price for any borrowed books or materials that I do not return.

_____ I will pay $_____ for the first visit and $_____ for future 50 minute sessions (please fill in co-pay amount if you are using in-network insurance).

B. Credit Card Information - *(Required)*

By my signature, I authorize Katie Johnson Clark (DBA Values Counseling) to charge this account for sessions, missed appointments, or lost books/materials as agreed in the above payment plan.

Credit Card Number: _____

Expiration Date (Month/Year): _____ 3 Digit Security Code: _____

Name of Cardholder: _____

Billing Address: _____

Signature of Cardholder: _____ Date: _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA is the Health Insurance Portability and Accountability Act of 1996. This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective immediately, all client information is protected and will only be released in accordance with state and federal laws and the ethics of the counseling profession. The use and disclosure of client healthcare information is restricted and limited to the following: "Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow use and disclose your health information for these purposes."

TREATMENT: Health information will be used and/or disclosed to provide, manage or coordinate care with your written release of information.
PAYMENT: Health information will be used and/or disclosed to verify insurance, process claims and collect fees with your written release of information.
HEALTHCARE OPERATIONS: Health information will be used and/or disclosed to review treatment procedures, compliance and licensing activities with clinical supervisor, with agreement of informed consent of Master's level therapist working toward licensure.
OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT: Health information will be used and/or disclosed in the following circumstances: Mandated reporting, emergencies, criminal damage and as required by law.
YOUR RIGHTS UNDER STATE AND FEDERAL LAW: You have the right to request where you can be contacted. If not, you may provide an alternate form of contact. You have the right to release your medical records with your written authorization to release records to others. You have the right to revoke a release in writing. (Revocation is not valid when acted in reliance on such previous authorization.) You have the right to inspect and copy your records. You may incur charges for copying, mailing, etc of your records. You have the right to add information or amend your medical records. Your amendment request must be in writing. You may request to amend records. If your request is denied, you have the right to file disagreement. This disagreement statement and response will be filled in the record. You have the right to accounting of disclosures made of your records for a six year period. Exceptions to this rule are for disclosures for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosure made to client or disclosures for national security or law enforcement. You have the right to request restrictions on uses and disclosures of your health information. These requests must be in writing and must be within scope of treatment. You have the right to file a grievance. Please consult with provider to allow for corrections. You have the right to grievance via the U.S. Dept. of Health & Human Services without retaliation. You have the right to receive changes in this policy. You may request any future changes and may request to speak with a privacy officer. Your signature indicates you have read, understood and agree to this statement.

Signature Date

Katie Johnson Clark, LPC, NCC
Values Counseling
5520 SW Macadam Ave, Ste. 270, Portland, OR 97239
Katie@valuescounseling.com
503-781-1997

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. There are various methods of contact with me including phone and email. I utilize text messaging in very limited circumstances for scheduling only, but nothing related to therapy itself will be discussed.

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, text 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 text or 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 emergency 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.

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

_____ I understand text and 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.

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date

Values Counseling – Katie Johnson Clark, LPC
5520 SW Macadam Ave, Suite 270, Portland, OR 97239 phone: 503-781-1997 fax: 503-200-1138

I, _____, authorize Katie Clark with Values Counseling to share the following specific information with:

Who I want to have my information:	Name: Phone Number: Fax:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

Presenting symptoms:	
Mental Health Diagnosis:	
Treatment Plan:	
Additional pertinent medial/psychiatric info:	

I understand:

- ☐ That I do not have to sign a release form. That this release is limited to what is written above. If I can revoke this release at any time.
- ☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Values Counseling.
- ☐ That Values Counseling and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.
- ☐ I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed:_____ **Date:_____**

Print name: _____ **Date of Birth: _____**