

### **Client Information**

Name: \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnicity/Race: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home street address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Can I leave a detailed message? \_\_Yes \_\_No

### **Referral Information**

Who referred you to me? \_\_\_\_\_

Reason for referral? \_\_\_\_\_

\_\_\_\_\_

Can I have permission to contact this person? \_\_Yes \_\_No

### **Emergency Contact**

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

### **Employment Information**

Name of current employer: \_\_\_\_\_

Position: \_\_\_\_\_

How long have you worked for this employer? \_\_\_\_\_

**Insurance Information**

Insurance Company: \_\_\_\_\_

Name of primary insured (if different from you): \_\_\_\_\_

Address for Primary Insured: \_\_\_\_\_

Date of Birth for Primary Insured: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Deductible: \_\_\_\_\_ Has it been met?  Yes  No Copay: \_\_\_\_\_

Any limits on number of sessions?  Yes  No

If yes, what are the limits? \_\_\_\_\_

Preauthorization needed?  Yes  No

If yes, name and number for preauthorization: \_\_\_\_\_

\_\_\_\_\_  
I give E. Breese Anderson, PsyD permission to bill my insurance company.  
Initial \_\_\_\_\_

I further give permission to Elizabeth Breese Anderson, PsyD to release any information obtained during assessment or treatment that is necessary to support any insurance claims on this account and secure timely payments.  
Initial \_\_\_\_\_

I understand that I am responsible for all charges if my insurance company denies claims for services or does not pay within 90 days.  
Initial \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

## **Informed Consent and Office Policy**

Please keep one copy of this office policy statement for your records. A second copy, signed and dated, will be kept in your file. It is very important that you read the entire statement carefully before signing.

### **General Standards**

As a clinical psychologist licensed by the Oregon Board of Psychologists Examiners I subscribe to the American Psychological Association Revised Ethical principles. A copy of this ethical code is available for your inspection.

I primarily use interventions based on Dialectical Behavior Therapy. I believe that sustainable change takes both insight and skills to do things differently. I work collaboratively with my clients as they learn to handle difficult emotions, relationship issues, and problematic behaviors.

Occasionally individuals may go through periods in therapy that may result in increased emotional discomfort, changes in their relationships, or a temporary worsening of their symptoms. These periods should subside as the work progresses. Remember that you always retain the right to request changes in treatment or to refuse treatment. I encourage you to discuss any personal doubts, concerns, or discomfort regarding your treatment with me, at any time.

### **Confidentiality**

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me, not even the fact that you are a client, without your written permission via a signed release of information form. There are a few exceptions to these standards:

1. It is legally required of me that I act so as to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. I am legally required to report cases of ongoing child, elder and disabled abuse.
3. I may have to release clinical information to insurance carriers as required for payment or review of your claim.
4. I may have to release your records when ordered to do so by court subpoena. However, I will discuss the details of privilege with you beforehand and request a written release from you if I judge this to be in your best interest.
5. I may use electronic transmission to send treatment plans, reports or evaluations to your insurance company, specific agencies or other providers.
6. Email correspondence is not confidential due to the security of these communications.

### **Appointments**

Individual sessions are arranged by appointment only. I will meet you at the exact time agreed upon. If you need to cancel an individual therapy appointment, you will not be charged for the appointment if you notify me at least 24 hours in advance of the scheduled appointment. No show/no call or late cancelled sessions are charged at \$50. Fees charged for missed sessions are not reimbursable by insurance companies. Please call 503.593.8731 if you need to cancel or reschedule your appointment.

### **Fees, Payments, and Billing**

My fees for services are as follows:

- Initial 60-minute intake session: \$200
- 50-minute individual therapy session: \$150
- 50-minute couples or family session: \$175
- 90-minute individual therapy session: \$200
- 90-minute couples or family session: \$225

Session fees are due at the time of service. If you elect to use your health insurance benefits, you will be responsible for your co-pay at the time of service. Co-pays will need to be paid by cash or check. Outstanding balances with an insurance carrier of more than 90 days will be charged to clients. If you think you may have trouble paying your bills on time, please discuss this with me. If your unpaid balance reaches \$250, I will notify you. Payment towards this balance must begin within 30 days of notification or therapy will be suspended. If payment towards this balance does not begin within 30 days services will be discontinued.

As a Licensed Clinical Psychologist many health insurance plans will help pay for services I offer. The contract for professional services is with you. If you chose to use your health insurance coverage, I will submit claims on your behalf. You are asked to pay your co-payment at the time of service. Mental health reimbursement policies differ dramatically from one third-party contract to another. It is often difficult to predict the services and fees different plans will cover. For this reason, it is important to discuss these issues in your early sessions or when there is any change in your insurance to avoid confusion and problems that could interfere with our work together. Regardless of the insurance company's handling of the claim, you are responsible for all fees.

### **Telephone Calls and Emergencies**

I will do my best to return your call within 24-hours, Monday through Friday. I will return any calls made over the weekend by Monday.

In the case of a life-threatening emergency call the Crisis Line at 503-988-4888 (Multnomah County, OR), 503-291-9111 (Washington County, OR), 503- 655-8401 (Clackamas County, OR), 360-696-9560 (Clark County, WA) or go to the nearest hospital emergency room. If you go to the emergency room for a psychiatric concern, please have your emergency room physician sign a release to speak with me.

**Consent to Treatment**

I have discussed and understand the fees for service. I agree to pay my co-pay and payment towards an outstanding balance at the time of service. I agree to initiate payment of balances over \$250 within 30 days of notification to avoid suspension of therapy. I understand that therapy will be discontinued if payment of balances over \$250 is not initiated by 30 days.

Initial \_\_\_\_\_

I acknowledge that I have received the Notice of Privacy Practices and HIPAA standards. I have been provided an opportunity to discuss any questions regarding this information, with the provider.

Initial \_\_\_\_\_

I have read the Informed Consent Statement and Office Policy form. I have had an opportunity to ask questions about the information provided. I understand my rights to privacy, the exceptions to my rights to privacy, and that there are risks associated with treatment.

\_\_\_\_\_  
Signature of client (or person acting on behalf of client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

I, Breese Anderson, PsyD, have discussed the issues above with the client and have answered any and all questions to the best of my knowledge.

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

## **Notice of Privacy Practices**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact E. Breese Anderson, PsyD, at the address above.

This notice applies to records and information I have about you, your health, your health status, and the health care and services you receive from me. Your health information may include information created and received by me, may be in the form of written or electronic records, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions, and similar types of health related information. This Notice will tell you the ways in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

### **Used and Disclosures of Protected Health Information (PHI)**

Treatment: I may use or disclose your PHI to a physician or other healthcare provider providing treatment to you.

Payment: I may use and disclose your PHI to obtain payment for services I provide to you.

Healthcare Operations: I may use and disclose your PHI in connection with the operation of my practice. Healthcare operations include quality assessment and improvement activities, business related matters such as audits of administrative services, and case management and care coordination.

To You, Your Family and Friends: I must disclose your PHI to you, as described in the Patient Rights section of this Notice. I may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Other Uses: In addition to my use of your PHI for treatment, payment, or healthcare operations, you may give me written authorization to use your PHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your PHI for any reason except those described in this Notice.

### **Uses and Disclosures of PHI with Neither Consent nor Authorization**

I may use or disclose PHI about you for the following purposes, subject to all applicable legal requirements and limitations:

Serious Threat to Health or Safety: I may use and disclose PHI about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. If you communicate a serious threat of violence against another person or if you are in imminent risk of inflicting serious harm to yourself, I may disclose information in order to reduce said risk.

Required by Law: I may use or disclose PHI about you if I am required to do so by federal, state or local law.

Public Health Risks: I may disclose PHI about you for public health reasons; in order to prevent or control disease, injury or disability; or to report suspected abuse or neglect, non-accidental physical injuries, or reactions to medications.

Health Oversight Activities: I may disclose PHI to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, I may disclose PHI about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose PHI about you in response to a subpoena.

Law Enforcement: I may release information if I am asked to do so by law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable: I am use or disclose PHI about you in a way that does not personally identify you or reveal who you are.

Appointment Reminders: I may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages or letters).

### **Your Rights Regarding your Health Information**

Access: You have the right to inspect and copy your PHI, such as clinical and billing records, that I keep and use to make decisions about your care. I may deny your access to PHI under certain circumstances. (For example, if I believe it may be harmful to you.) In some cases you may have this decision reviewed.

Accounting Disclosure: You have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.

Restriction: You have the right to request restrictions on certain uses and disclosures of PHI regarding yourself. However, I am not required to agree to a restriction or request.

Alternative Communication: You have the right to request that I communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: if you receive this Notice electronically, you are entitled to receive this Notice in written form.

### **Changes to this notice**

I am required by law to maintain the privacy of PHI and provide you with this Notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change this Notice and to make the revised or changed Notice effective for clinical information I already have about you, as well as information I receive in the future. I will post a summary of the current Notice in the waiting area with its effective date at the top right hand corner. You are entitled to a copy of the Notice currently in effect.

### **Complaints**

If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, please contact me about the complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services. I will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

### **Making Requests Related to your PHI**

Denial of Requests to Inspect and Copy Your PHI: I may deny your request to inspect and/or copy your PHI under certain circumstances. If this occurs, you may ask that your denial be reviewed. If the law gives you a right to have my denial reviewed, I will select a licensed health care professional to review the request and my denial. I will comply with the review outcome.

To Request an Amendment to Your PHI Record: You have the right to request an amendment as long as I keep the information. To request an amendment, complete and submit a Clinical Record Amendment/Correction Form to Elizabeth Breese Anderson, PsyD. I may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that (1) I did not create, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the health information that I keep; (3) you would not be permitted to inspect and copy the information; or (4) is inaccurate or incomplete.

To Request Restrictions of the Disclosure of Your Health Information: To request restrictions on the PHI I use or disclose about you for treatment, payment, or healthcare operations, you must complete and submit a REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Elizabeth Breese Anderson, PsyD.

To Request an Accounting of Disclosures: To obtain a list of the disclosures I made for information about you for purposes of treatment, payment, healthcare operations, and a limited number of other special circumstances, you must submit your request in writing to Elizabeth Breese Anderson, PsyD. It must state a time period. The time period may not be longer than six years and may not include dates before January 1, 2010. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, I will charge you the cost of providing the list. I will notify you of the costs involved, and you may choose to withdraw or modify your request before any costs are incurred.

*To Request a Change in the Manner or Confidential Communications:* To request a change in the manner in which I provide confidential communications, you may complete and submit the REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Elizabeth Breese Anderson, PsyD. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### Client Self Report

Please indicate if you are currently experiencing the following symptoms (C) or have experienced these symptoms in the past (P).

- |   |   |
|---|---|
| C <input type="checkbox"/> P <input type="checkbox"/> Sadness most of the day     | C <input type="checkbox"/> P <input type="checkbox"/> Feeling “keyed up”        |
| C <input type="checkbox"/> P <input type="checkbox"/> Loss of pleasure            | C <input type="checkbox"/> P <input type="checkbox"/> Irritability              |
| C <input type="checkbox"/> P <input type="checkbox"/> Increase in appetite        | C <input type="checkbox"/> P <input type="checkbox"/> Muscle tension            |
| C <input type="checkbox"/> P <input type="checkbox"/> Decrease in appetite        | C <input type="checkbox"/> P <input type="checkbox"/> Panic attacks             |
| C <input type="checkbox"/> P <input type="checkbox"/> Significant weight change   | C <input type="checkbox"/> P <input type="checkbox"/> Obsessive thoughts        |
| C <input type="checkbox"/> P <input type="checkbox"/> Sleep problems              | C <input type="checkbox"/> P <input type="checkbox"/> Compulsive behaviors      |
| C <input type="checkbox"/> P <input type="checkbox"/> Agitation                   | C <input type="checkbox"/> P <input type="checkbox"/> Suspicion/Paranoia        |
| C <input type="checkbox"/> P <input type="checkbox"/> Feeling “slowed down”       | C <input type="checkbox"/> P <input type="checkbox"/> Hearing voices            |
| C <input type="checkbox"/> P <input type="checkbox"/> Fatigue/loss of energy      | C <input type="checkbox"/> P <input type="checkbox"/> Visual hallucinations     |
| C <input type="checkbox"/> P <input type="checkbox"/> Worthlessness               | C <input type="checkbox"/> P <input type="checkbox"/> Self harm                 |
| C <input type="checkbox"/> P <input type="checkbox"/> Excessive guilt             | C <input type="checkbox"/> P <input type="checkbox"/> Impulsivity               |
| C <input type="checkbox"/> P <input type="checkbox"/> Poor concentration          | C <input type="checkbox"/> P <input type="checkbox"/> Aggressive behavior       |
| C <input type="checkbox"/> P <input type="checkbox"/> Difficulty making decisions | C <input type="checkbox"/> P <input type="checkbox"/> Work/School Problems      |
| C <input type="checkbox"/> P <input type="checkbox"/> Hopelessness                | C <input type="checkbox"/> P <input type="checkbox"/> Relationship problems     |
| C <input type="checkbox"/> P <input type="checkbox"/> Thoughts of death           | C <input type="checkbox"/> P <input type="checkbox"/> Problems with pornography |
| C <input type="checkbox"/> P <input type="checkbox"/> Thoughts of suicide         | C <input type="checkbox"/> P <input type="checkbox"/> Problems with gambling    |
| C <input type="checkbox"/> P <input type="checkbox"/> Thoughts of harming others  | C <input type="checkbox"/> P <input type="checkbox"/> Sexual problems           |
| C <input type="checkbox"/> P <input type="checkbox"/> Seasonal mood changes       | C <input type="checkbox"/> P <input type="checkbox"/> Problems with eating      |
| C <input type="checkbox"/> P <input type="checkbox"/> Wide mood swings            | C <input type="checkbox"/> P <input type="checkbox"/> Alcohol/Drug abuse        |
| C <input type="checkbox"/> P <input type="checkbox"/> Excessive worry             | C <input type="checkbox"/> P <input type="checkbox"/> Other: _____              |

**In the past 2 weeks were your sleep patterns (Check one)**

\_\_\_ Typical \_\_\_ Unusual

*Check all that apply:* \_\_ Nightmares \_\_ Insomnia \_\_ Early morning waking

\_\_ Difficulty falling asleep \_\_ Restless sleep

**In the past 2 weeks were your daily eating habits**

(Check one)\_\_\_ Typical \_\_\_ Unusual

**In what ways do your current problems affect your day to day functioning?**

\_\_\_ Work/School \_\_\_ Friendships \_\_\_ Family \_\_\_ Romantic relationship

\_\_\_ Hygiene \_\_\_ Other: \_\_\_\_\_

**HEALTH HISTORY**

**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**Address** \_\_\_\_\_

**Date of last visit** \_\_\_\_\_

**Current Health Problems** \_\_\_\_\_

**List all current medications and dosages** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have a history of head injuries or loss of consciousness?**

\_\_\_ Yes \_\_\_ No If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**COUNSELING HISTORY**

**Previous Psychiatric or Psychological Services:** \_\_\_ Yes \_\_\_ No

**Treatment Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Reason you were seeking care:** \_\_\_\_\_

**Treatment outcome:** \_\_\_\_\_

**Treatment Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Reason you were seeking care:** \_\_\_\_\_

**Treatment outcome:** \_\_\_\_\_

**Treatment Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Reason you were seeking care:** \_\_\_\_\_

**Treatment outcome:** \_\_\_\_\_

**DRUG/ALCOHOL HISTORY**

Have you ever used alcohol and/or drugs to change or alter your behavior or mood?

\_\_\_ No \_\_\_ Yes If yes, explain: \_\_\_\_\_

Have you ever received substance abuse treatment? \_\_\_ No \_\_\_ Yes

If yes, please give the treatment facility/provider, reason for treatment, and dates of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been charged with DWI/DUI? \_\_\_ No \_\_\_ Yes

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Complete the following for family members who use or have a history of alcohol/drug abuse.

Family Member: \_\_\_\_\_

Substance Used: \_\_\_\_\_

Are they currently using?: \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Family Member: \_\_\_\_\_

Substance Used: \_\_\_\_\_

Are they currently using?: \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Family Member: \_\_\_\_\_

Substance Used: \_\_\_\_\_

Are they currently using?: \_\_\_\_\_

Treatment Received: \_\_\_\_\_

**FAMILY & SOCIAL HISTORY**

FATHER: *Please answer questions as it was during your childhood*

Occupation \_\_\_\_\_

Highest Level of Education \_\_\_\_\_

Emotional Health \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Physical Health \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Describe your father/child relationship \_\_\_\_\_

\_\_\_\_\_

**MOTHER:** *Please answer questions as it was during your childhood*

**Occupation** \_\_\_\_\_

**Highest Level of Education** \_\_\_\_\_

**Emotional Health** \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

**Physical Health** \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

**Describe your mother/child relationship** \_\_\_\_\_

\_\_\_\_\_

**With whom did you live during your childhood?** \_\_\_\_\_

**Where did you grow up?** \_\_\_\_\_

**Were you adopted or raised by someone other than your biological parents?**

\_\_\_\_\_

**List brothers and sisters (including you) in birth order and give their current ages:**

\_\_\_\_\_

**Do you have any history of abuse?** \_\_\_ No \_\_\_ Yes

*(Check all that apply)* \_\_\_ Physically \_\_\_ Emotionally \_\_\_ Verbally \_\_\_ Sexually

**Is there a family history of:**

*(Check all that apply)* \_\_\_ Substance Abuse \_\_\_ Mental Illness

**Has anyone in your family been treated for a psychiatric disorder?**

\_\_\_ No \_\_\_ Yes **If yes, explain:** \_\_\_\_\_

\_\_\_\_\_

### **EDUCATIONAL HISTORY**

**Indicate your highest level of education:** \_\_\_\_\_

**Did you have academic difficulty in school?** \_\_\_ Yes \_\_\_ No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**Did you have social difficulty in school?** \_\_\_ Yes \_\_\_ No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**Do you have a history of diagnosed or undiagnosed learning disabilities?**

\_\_\_ No \_\_\_ Yes **If yes, explain:** \_\_\_\_\_

\_\_\_\_\_

**VOCATIONAL STATUS**

**Describe your employment history for the past five years beginning with your current position**

**(Employer Position, Time in Job, Reason for leaving)**

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**Describe any physical/emotional problems that prevent your being employed**

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**LEGAL HISTORY**

**Do you have any current or past involvement with the legal system? (If yes, please explain):**

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**What are you hoping to achieve by coming to therapy?**

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**Is there any other information you would like for me to know that was not asked?**

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