The Northwest Catholic Counseling Center

Providing help, creating hope…

Informed Consent and Notice of Privacy Practices

This Consent Form is to provide an explanation of treatment, the risks associated with treatment, and The Notice of Privacy Practices for Protected health information (PHI) regarding

_____.

(Print name of person to receive services)

In addition to the above reasons, this form is to also give consent for treatment at The Northwest Catholic Counseling Center (NCC). When we use the word "I" or "me" below, it will mean yourself, your child, relative, or other person you have legal guardianship of and for whom you can give consent to share information and to receive treatment.

I understand that as a client of NCC, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to establish the best course of treatment. The information you provide will remain confidential with some exceptions allowed by law and the prescriber and/or counselor code of ethics as described in the remainder of this document.

While getting services at NCC, it may be necessary for staff to communicate, consult, or coordinate with other NCC staff. Written authorization for such communication within NCC will not be requested. Prior to any discussion with other NCC staff, I understand that I will be informed as to what communications will be exchanged. In other circumstances for exchanging information outside of NCC, a written consent to release information will be obtained from you.

I further understand that there are specific exceptions to keeping confidentiality where a clinician is ethically and/or legally bound to take necessary steps to prevent harm to myself or to others:

1. When there is risk of harm to myself or someone else.
2. When there is suspicion that a child, person with a disability, or an elder is at risk of or is being sexually, physically, or emotionally abused or neglected.
3. When a valid court order is issued for disclosure of information or records

I understand that while mental health services, assessments, and/or medication, may provide significant benefits, they may also pose certain risks. Counseling and assessments may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Change may occur for the individual in treatment. The family or other relationships may resist the changes made. Assessments may reveal the need for more intensive treatment. Medications may have unwanted side effects.

(Signature required on second page)

The PHI we collect is used for treatment, consultation, billing, and care coordination, therefore, the law allows us to share this information with others who also provide treatment for you or to arrange payment for your treatment or for other business or government functions such as demographic data collection. The Notice of Privacy Practices explains in more detail your rights and how we are able to use and share this information. You received a copy of The Notice of Privacy Practices with your intake paperwork.

In the future, Federal law may require additional changes to our Notice of Privacy. If so we will notify you if you are still an active client at the Center. Any change will be posted on our web site, www.nwcounseling.org.

If you are concerned about some of your information, you have the right to ask us not to use or share that information for treatment, payment or administrative purposes. You will have to make your request in writing. If it is in regards to sharing information for payment purposes, you may be held responsible for payment. We will attempt to respect your wishes when in compliance with Federal law.

_____ _____

Typed name of client or his or her representative valid as signature Date

_____

Printed name of client or personal representative

Please initial: _____ I received a copy of the Notice Of Privacy Practices

For Clinician use only: _____ Initial

I have verbally discussed exceptions to confidentiality with client.

Updated 8/6/2019

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Client Consent and Guide to EMAIL Use

The decision to utilize email is strictly voluntary and your consent may be rescinded at any time. There are risks to using email to communicate with your counselor/prescriber. The risks are but not limited to:

- **NCC's Email is not encrypted, therefore, not confidential**
- Email may be seen by unintended viewers
- Email may be intercepted by hackers and redistributed
- Someone posing as you could communicate with the counselor and access information
- Email can be used to spread computer viruses
- Email may not be received by either party in a timely matter
- Email is discoverable in litigation and may be used as evidence in court
- Email can be circulated and stored by unintended recipients
- Statements made via email may be misunderstood creating miscommunication and/or negatively effecting treatment

When may I use email to communicate with my counselor?

- Appointment scheduling or rescheduling
- Clarification on therapeutic homework
- Other matters not requiring an immediate response

When should I <u>NOT</u> use email to communicate with my counselor?

1. **In an emergency:**
   - If you are experiencing any desire to harm yourself or others
   - If you are experiencing a severe medication reaction
2. If you need an immediate response about non-emergent issues

What can I expect from my counselor/prescriber around answering my emails?

- Your email will be read within 48 business hours.
- If the counselor/prescriber deems it to be clinically inappropriate to respond, a conversation about the email will be initiated at your next appointment.
- If the original email initiated by you is cc'd to a third party, NCC may chose not to respond or may not include the third party in the response.
- NCC counselor/prescriber will not initiate emails containing clinical content.
- **If you initiate an email with clinical content, you are accepting the risk.**

What happens to my messages?

- Email will be printed out and maintained as a permanent part of your medical record
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when NCC is legally required to do so
- Messages may be seen by staff for the purpose of filing or carrying out requests

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and my counselor/prescriber at NCC. I recognize there are risks to its use, and NCC cannot absolutely guarantee confidentiality. I understand and accept those risks. I further understand if I send too many emails, send inappropriate emails, or copy outsiders on the emails, NCC may not respond or cease to allow me to use email to communicate with NCC. I also understand that I may withdraw my consent to communicate via email at any time by notifying my counselor/prescriber in writing.

Print Name of Client _____

_____

Typed name of Patient/Guardian valid as signature Date

Email Address: _____

☐ I am choosing to opt out. I do not give consent for NCC to use email to communicate with me. I understand that if I change my mind and want to email NCC, I will need to sign a consent form (Check box and sign below).

Sign here if opting out: _____

The Northwest Catholic Counseling Center

Serving all regardless of faith or finances

Adult Psychosocial History

Date_____ Client ID_____
(office use only)

Please provide the following information. It will assist us in getting to know you and your concerns. It will be held to the same standards of confidentiality as an appointment.

Name _____
First M.I. Last

Address_____

_____
City State Zip

Birth date _____/_____/_____

Home Phone:_____
May we leave a message? ☐Yes ☐No
Do you prefer calling for appointment reminders? ☐Yes ☐No

Cell Phone: _____
May we leave a message? ☐Yes ☐No
Do you prefer texting for appointment reminders? ☐Yes ☐No

Email: _____
May we email you? ☐Yes ☐No
Do you prefer emailing for appointment reminders? ☐Yes ☐No

Relationship Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Gender: ☐Female ☐Male ☐Transgender ☐Other Pronouns: _____

Emergency contact-please list the name, telephone number and relationship_____

_____

Referred by _____

We would like to periodically send you newsletters and other information regarding the Center and its activities. Please check if you do not want to receive this information. ☐

8383 N.E. Sandy Boulevard, Suite 205 • Portland, Oregon 97220 • 503.253.0964
www.nwcounseling.org

Disability

Defined as substantially limiting movement, sensory, social, employment, or learning activities.

☐Yes ☐No _____

Ethnicity (Choose all that apply)

☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐White
☐Multi-Ethnic _____
☐Other _____
☐Prefer not to answer

Social Information

Please describe your primary support system (family, friends, support groups, church community, etc)

Do you identify as LGBTQ? ☐ Yes ☐ No

Education/Occupation Information:

Are you currently employed? ☐ Yes ☐ No

If yes, name of current employer/position:

Please indicate highest level of education:

Degree, if applicable:

Are you happy in your current position?

Please list any work-related stressors :

If unemployed, how long have you been unemployed?

Religious/Spiritual Information:

Do you consider yourself to be a religious person? ☐ Yes ☐ No

Do you consider yourself to be a spiritual person? ☐ Yes ☐ No

If yes, what is your faith/religious/spiritual path?

Office Use Only
☐ Entered in FM ☐ Entered in TH ☐ Scanned

Name: _____

Legal History

Are you currently or have you ever been involved in any legal proceedings (SSD, traffic, divorce, civil, criminal)?
If yes, please describe_____

Are you preparing for any legal proceedings? ☐Yes ☐No If yes, please explain_____

_____

Are you presently on probation or parole? ☐Yes ☐No If yes, please explain_____

_____

Mental Health History

Are you currently receiving any mental health treatment or prescribing services elsewhere?

☐Counseling: Name of counselor/agency: _____

☐Medications: Name of Prescriber: _____

Have you had previous counseling? ☐Yes ☐ No

If yes, previous therapist's name:

How long ago did you receive these services?

Have you ever engaged in self-harming behavior? ☐ Yes ☐ No

Describe when and the last time:

Have you ever attempted suicide: ☐ Yes ☐ No When:

Were you hospitalized for either self-harm or for an attempted suicide in the past? ☐ Yes ☐ No

What hospital: _____

In the last year, have you experienced any significant life changes or stressors (death of a loved one, divorce, loss of job, etc.)?

Have you experienced any traumatic events?

What coping strategies do you currently use and how effective are they?

What are your goals or concerns for therapy?

What do you consider to be your strengths? _____

Family Mental Health History

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? **Check any that apply and list family member** (sibling, parent, uncle, etc).

☐	Depression	_____
☐	Anxiety	_____
☐	Schizophrenia	_____
☐	Eating Disorder	_____
☐	Trauma	_____
☐	Bipolar Disorder	_____
☐	Panic Attacks	_____
☐	Alcohol/Substance Abuse	_____
☐	Completed Suicides	_____
☐	ADHD	_____

Health Information

Allergies: (List any meds, foods, etc.)

How would you describe your physical health at present?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Primary Care Provider_____Phone #_____

Date of last physical: _____

Please indicate if you experience now or in your history any of the following medical issues:

☐ Heart disease	☐ Seizures	☐ Pregnancy Issues
☐ Chronic Pain	☐ Diabetes	☐ Fibromyalgia
☐ Cancer	☐ Stroke	☐ Chronic Fatigue
☐ Thyroid Problems	☐ Hepatitis	☐ Urinary Tract Infections
☐ High Blood Sugar	☐ Migraines	☐ Binging/purging/food restriction
☐ Sleep Disturbances	☐ Premenstrual issues	☐ Unexplained weight fluctuations

Have you ever been hospitalized for any of these conditions and when:

Name: _____

Please list all medications (including over-the counter/herbal remedies) and dosages.

Meds	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What do you do for physical activity:

Substance Use

Do you use tobacco? ☐Yes ☐No How much per day: _____

Do you use Caffeine? ☐Yes ☐No How much per day: _____

Do you drink alcohol? ☐Yes ☐No How much per week: _____

Do you engage in recreational/street drugs? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

What kind?

Describe any history with recreational/street drugs:

If applicable, describe any treatment obtained for addiction:

Please check behaviors and symptoms that happen more often than you would like them to occur.

- ☐ Aggression
- ☐ Angry
- ☐ Concentration issues
- ☐ Crying spells
- ☐ Depressed Mood
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Elevated mood
- ☐ Excessive purchasing
- ☐ Exposure to traumatic event(s)
- ☐ Fatigue/low energy
- ☐ Fearful
- ☐ Gambling concerns
- ☐ Grief
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ Homicidal thoughts
- ☐ Hopelessness
- ☐ Indecisiveness
- ☐ Isolating from friends/family
- ☐ Jealousy
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Loss of interest in activities
- ☐ Memory impairment
- ☐ Inadequacy
- ☐ Insecurity
- ☐ Irritability
- ☐ Mood shifts
- ☐ Nightmares
- ☐ Obsessions
- ☐ Panic attacks
- ☐ Persistent urges or thoughts
- ☐ Physical discomfort
- ☐ Pornography concerns
- ☐ Racing thoughts
- ☐ Reckless or self-destructive
- ☐ Repetitive behaviors
- ☐ Restless or keyed up
- ☐ Revengeful
- ☐ Sadness
- ☐ Sexual addictions
- ☐ Sexual difficulties
- ☐ Shame/Guilt
- ☐ Shortness of breath
- ☐ Socially avoidant or isolating
- ☐ Stomachaches
- ☐ Suicidal thoughts
- ☐ Suspicious of others
- ☐ Tics
- ☐ Trembling
- ☐ Trauma
- ☐ Worrying excessively

- ☐ Other

The Northwest Catholic Counseling Center
8383 N.E. Sandy Blvd., Suite 205
Portland, Oregon 97220
Phone: (503)253-0964

FEE POLICY

The Northwest Catholic Counseling Center's primary interest is to provide you with quality and affordable care. For counseling our fee is $150.00 for the first session and $130.00 thereafter. In the event of financial difficulty, your fee can be negotiated to an amount you are more comfortable paying. For this reason, we wish to clarify the following policy regarding your fee.

Your fee is due and payable at the time of each session. If payment is not made at the time of the counseling session, your balance is not to exceed 30 days. There is a $20.00 service charge for all returned checks.

As a courtesy, we will make every effort to bill your insurance company. You are responsible for your deductible as well as any remaining balance the insurance company does not pay. If an overpayment is made to your account from an insurance payment, your account will be credited.

If cancellation of your appointment is not received 24 hours in advance you will be charged $45.00 for your missed appointment. Insurance cannot be billed for missed appointments.
I agree to the following (check all that apply):

☐ Insurance Payments (EAP, HMO, etc.):
I understand and agree to pay $_____ as my co-pay for each session. Co-pays are based on your insurance benefits.

☐ Self-Pay: Counseling Session:
For the initial appointment, I agree to pay $_____. This is a one-time fee due at time of service.
For follow up appointments I agree to pay$_____. This is due at time of service.

☐ Third-Party Payer (insurance excluded). It has been arranged that:

Name: _____ Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip:_____

I understand if they do not pay, I am responsible for the bill.

I HAVE READ THIS FEE POLICY AND AGREE TO PAY THE FEE NEGOTIATED AND WRITTEN ABOVE. I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE COVERAGE, OR THIRD-PARTY PAYER, THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT.

_____

Typed name of client valid as signature Date

The Northwest Catholic Counseling Center

Assignment of Medical Benefits

Client Name:_____

Date of Birth: _____

Primary Insurance Co:_____

Policyholder Name: _____

Date of Birth: _____

Member ID#:_____

Group #: _____

Insurance phone number for eligibility/benefits:_____

I authorize payment of medical benefits to The Northwest Catholic Counseling Center for any services rendered to me or my dependents while a client at the Center. This assignment will remain in effect until revoked by me in writing. I hereby authorize The Northwest Catholic Counseling Center to release all information necessary to secure the payment of my benefits.

_____ _____

Signature of client or his or her representative **Date**