



# 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)

*A State Certified Counseling Agency*

*Donations are tax-deductible. Tax ID 93-1088966*

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

[www.nwcounseling.org](http://www.nwcounseling.org)

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](http://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.

\_\_\_\_\_  
Signature of client or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

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

For Clinician use only: _____ I have verbally discussed exceptions to confidentiality with client.
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# The Northwest Catholic Counseling Center

*Providing help, creating hope...*

## 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 **NOT** 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.**

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

## **INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS**

This document contains important information about in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions.

### **Decision to Meet Face-to-Face**

We have agreed to meet in person for counseling sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about telehealth, we will talk about it try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being. If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

### **Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus or other public health risk. This risk may increase if you travel by public transportation, cab, or ridesharing service.

### **Your Responsibility to Minimize Your Exposure**

To obtain services in person, Initial each to indicate that you understand and agree to take certain precautions which will help keep everyone safer. Not following safeguards may result in a switch to a telehealth arrangement.

- You will only keep your in-person appointment if you are symptom free. \_\_\_\_
- If you have any symptoms of the coronavirus, you agree to cancel the appointment. If you cancel for this reason, you will not be charged the normal cancellation fee. \_\_\_\_
- You will wear a mask in all areas of the office. \_\_\_\_
- If you are bringing your child, you will make sure that your child follows masking and distancing protocols. \_\_\_\_

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

### **Our Commitment to Minimize Exposure**

Our clinic is taking the following precautions to protect our clients and help slow the spread of the coronavirus.

- Office seating in the waiting and therapy rooms have been arranged for physical distancing.
- All staff wears masks and maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

**If You or I Are Sick**

You understand that I am committed to keeping us and others safe from the spread of this virus. If you show up for an appointment with any symptoms or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

**Your Confidentiality in the Case of Infection**

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

---

Client Name

---

Date

---

Clinician Name

---

Date



# 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. ☐

## ***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).

- |                          |                         |       |
|--------------------------|-------------------------|-------|
| <input type="checkbox"/> | Depression              | _____ |
| <input type="checkbox"/> | Anxiety                 | _____ |
| <input type="checkbox"/> | Schizophrenia           | _____ |
| <input type="checkbox"/> | Eating Disorder         | _____ |
| <input type="checkbox"/> | Trauma                  | _____ |
| <input type="checkbox"/> | Bipolar Disorder        | _____ |
| <input type="checkbox"/> | Panic Attacks           | _____ |
| <input type="checkbox"/> | Alcohol/Substance Abuse | _____ |
| <input type="checkbox"/> | Completed Suicides      | _____ |
| <input type="checkbox"/> | 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:**

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Pregnancy Issues
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> Migraines	<input type="checkbox"/> Binging/purging/food restriction
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Premenstrual issues	<input type="checkbox"/> 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.**

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



National Center for

**PTSD**

POSTTRAUMATIC STRESS DISORDER

# PTSD Checklist for *DSM-5* (PCL-5)

**Version date:** 11 April 2018

**Reference:** Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. Available from <https://www.ptsd.va.gov/>

**URL:** <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

**Note:** This is a fillable form. You may complete it electronically.

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## PCL-5

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

## General Anxiety Disorder (GAD-7)

NAME \_\_\_\_\_

DATE \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or Irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>				
<b>TOTAL SCORE</b> <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

## Patient Health Questionnaire (PHQ-9)

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





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 \$160.00 for the first session and \$140.00 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. If your balance reaches four sessions, you will not be allowed to schedule additional sessions until there is some payment activity on your account. 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 \$60.00 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.**

---

Client Signature

Date

## PHQ-9\* Questionnaire for Depression Scoring and Interpretation Guide

### For physician use only

#### Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) \_\_\_\_\_ x 0 = \_\_\_\_\_  
Several days (#) \_\_\_\_\_ x 1 = \_\_\_\_\_  
More than half the days (#) \_\_\_\_\_ x 2 = \_\_\_\_\_  
Nearly every day (#) \_\_\_\_\_ x 3 = \_\_\_\_\_

**Total score:** \_\_\_\_\_

Interpreting PHQ-9 Scores		Actions Based on PH9 Score	
		Score	Action
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

\* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website  
[www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/)



## *The Northwest Catholic Counseling Center*

*\*Only fill out this form if you are using insurance. NCC does not accept Medicaid or Medicare*

*\*Please include a copy of the front & back of your insurance card.*

### **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 their representative**

\_\_\_\_\_  
**Date**