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.

_____ _____

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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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: _____

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

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Child/Adolescent Psychosocial History

Date_____ Client ID_____
(office use only)

Please provide the following information for your child/adolescent. It will be held to the same standards of confidentiality as the therapy itself.

Child/Adolescent Name_____
First Middle Last

Address_____

_____
City State Zip

Birth date:_____/_____/_____

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

Does your child/adolescent identify as LGBTQ? ☐ Yes ☐ No

Person completing this form:_____

Relationship to child/adolescent:_____

Mother's Name:_____

Best phone # to reach: ☐ (cell) ☐ (home) _____-_____-_____

May we leave a message? ☐ Yes ☐ No

Father's Name:

Best phone # : ☐ (cell) ☐ (home) _____ - _____ - _____

May we leave a message: ☐ Yes ☐ No

For appointment reminders, we can text, email, or call. Who should be notified for appointments and how do you want to receive notification?

Who: _____ How: _____

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

Legal Information

Who has custodial guardianship?_____
(You may be asked to provide copy of custodial guardianship)

Stepparent (if applicable)_____

Are you, as the parent or stepparent, involved in any legal proceedings such as divorce, custody disputes, etc? ☐ Yes ☐ No

If yes, please explain_____

Has your child been involved in the legal system? ☐ Yes ☐ No

If yes, please explain_____

_____

Medical, Psychological and Developmental History

List any pregnancy or delivery complications or problems._____

_____

Describe any significant medical/developmental history for your child/adolescent including hospitalizations (medical or psychiatric), significant losses, and gaps in living with attachment figures.

_____

_____

Has your child/adolescent experienced any traumatic events? _____

_____

Has your child/adolescent ever attempted or expressed the desire to commit suicide?

Explain: _____

_____

Has your child had any previous counseling? ☐ Yes ☐ No

If yes, with whom and when?_____

Do you have any concerns regarding your child/adolescent use of alcohol/drugs?_____

_____

Does your child/adolescent have a disability defined as substantially limiting movement, sensory, social, employment, or learning activities? ☐ No ☐ Yes Is it documented? ☐ No ☐ Yes

Office use only:		
___ Entered in FM	___ Entered in TH	___ Scanned

Name of pediatrician: _____

When was the last time your child/adolescent saw the pediatrician? _____

Does your child/adolescent take any medications? ☐ Yes ☐ No

If yes, please list all medications and dosages.

Medications:	Dosage:
_____	_____
_____	_____

List any allergies: _____

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	_____
☐	Panic Attacks	_____
☐	Alcohol/Substance Abuse	_____
☐	Suicide Attempts	_____

Social/Educational Information

Please list names and ages of other children living in the home.

Name	Age
_____	_____
_____	_____
_____	_____

Please describe your child/adolescent interaction with other family members._____

_____

Are there any family stressors (financial, marital, peers, etc) that might be affecting your child?
☐ Yes ☐ No

If yes, please explain._____

School:_____ Grade:_____

Please describe your child/adolescent's academic performance._____

_____

Please describe your child/adolescent's social interaction at school. _____

_____

List hobbies, sports, music, TV shows, toy preferences, etc._____

_____

How is discipline generally handled in the home?_____

_____

Describe your child/adolescent strengths._____

_____

Concerns and Symptoms

What are your specific concerns for your child/adolescent that have brought you to counseling?

_____

_____

_____

What are your goals for your child/adolescent's therapy?_____

_____

Is there any other information that you believe would assist the therapist in understanding your child?

_____

_____

Please check behaviors and symptoms that occur to your child/adolescent more often than you would like them to take place.

- ☐ Aggressive
- ☐ Angry
- ☐ Anxiety
- ☐ Bedwetting
- ☐ Blinking, jerking
- ☐ Bullies, threatens
- ☐ Careless, reckless
- ☐ Chest pains
- ☐ Clumsy
- ☐ Cyber addiction
- ☐ Defiant
- ☐ Depression
- ☐ Destructive
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Eating disorder
- ☐ Excessive masturbation
- ☐ Expects failure
- ☐ Fatigue
- ☐ Fearful
- ☐ Frequent injuries
- ☐ Frustrated easily
- ☐ Hallucinations
- ☐ Head banging
- ☐ Heart problems
- ☐ Hopelessness
- ☐ Hurts animals
- ☐ Imaginary friends
- ☐ Impulsive
- ☐ Irritable
- ☐ Lazy
- ☐ Learning problems
- ☐ Lies frequently
- ☐ Loner
- ☐ Low self-esteem
- ☐ Messy
- ☐ Moody
- ☐ Nightmares
- ☐ Oppositional
- ☐ Overactive
- ☐ Overweight
- ☐ Panic attacks
- ☐ Phobias
- ☐ Poor appetite
- ☐ Quarrels
- ☐ Sad
- ☐ Selfish
- ☐ Separation anxiety
- ☐ Sets fires
- ☐ Sexual acting out
- ☐ Sick often
- ☐ Short attention span
- ☐ Shy, timid
- ☐ Sleeping problems
- ☐ Slow moving
- ☐ Soiling
- ☐ Speech problems
- ☐ Steals
- ☐ Stomach aches
- ☐ Suicidal threats
- ☐ Suicidal attempts
- ☐ Talks back
- ☐ Teeth grinding
- ☐ Thumb sucking
- ☐ Ticks or twitching
- ☐ Unsafe behaviors
- ☐ Unusual thinking
- ☐ Weight loss or gain
- ☐ Withdrawn
- ☐ Worries excessively
- ☐ Other

_____

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.

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	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	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?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Patient Health Questionnaire (PHQ-9)

Patient Name: **Date:**

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling/staying asleep, sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
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.	○	○	○	○
i. Thoughts that you would be better off dead or of hurting yourself in some way.	○	○	○	○
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
	○	○	○	○

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

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**