

SALEM PASTORAL COUNSELING CENTER
GENERAL INFORMATION AND OFFICE POLICIES
Bob Lewis, M.A., L.M.F.T

Prior to beginning treatment it is important for you to familiarize yourself with my approach to treatment, your rights and responsibilities, and our office policies. This document, along with my **Professional Disclosure Statement** and our **Notice of Privacy Practices**, discusses these topics. Please take time to review the information contained in these three documents and ask any questions you may have. After your questions and concerns have been answered, please sign and date on the reverse side of this page.

Approach to Treatment: To provide the best care possible, it is important that I have a clear understanding of what brings you to treatment. In order to gain that understanding, I will ask detailed questions about your past and current functioning, along with questions about any previous treatment. Following this, we will develop a treatment plan with specific goals to address the concerns you have. The treatment plan will outline what we work on, the approach we will take, and approximately how long we will work together. It is very important that you actively participate in treatment planning and candidly discuss with me your treatment needs.

Risks and Alternatives to Treatment: It is important for you to know that there are risks involved in treatment. For example, some people experience an increase in stress, particularly during the early stages of treatment. In some cases, discussing longstanding unresolved problems can seem to aggravate rather than help with a problem. These are natural occurrences but you should be aware of them. Not all clients are well suited to my approach to treatment, and therefore I cannot guarantee successful treatment. If I determine that I cannot provide the treatment best suited to your concern, I will inform you at the earliest opportunity and assist you in finding more appropriate services.

Appointments and Cancellations: I work variable hours Tuesday through Friday, with evening appointments generally available on Tuesdays and Wednesdays. Counseling sessions are by appointment only and are typically 45-50 minutes in duration. Appointments may be canceled or rescheduled by calling my voice mail at (503) 370-8050 ext. 2. You will be charged \$60.00 for a missed appointment if you fail to provide at least 24 hour advanced notice. There will be no charge for cancellations due to emergencies. Insurance companies will reimburse only for appointments actually kept, therefore the client is billed directly for missed sessions.

Phone Calls and Emergencies: Salem Pastoral Counseling Center has a 24 hour/day, 7 day/week voice mail system. The system can be reached by dialing (503) 370-8050. All calls are routed through the confidential voice mail. If you have an emergency situation that is life threatening, please dial 911. Our counselors rotate on-call for other urgent matters. If you have an urgent situation, please page the on-call counselor by dialing (503) 918-2180. A counselor will return your call as soon as they are able and will make an effort to contact me.

Confidentiality and Legal Proceedings: Sessions are confidential except where I am bound by state law to report. Those incidents which require reporting are: (1) A report of child abuse; (2) Threats against persons, including yourself; (3) Threats of violence against persons; (4) Abuse of elderly persons; (5) An acknowledged waiver of the privilege by the client; and (6) By court order. Please refer to our **Notice of Privacy Practices** for a more complete outline of how your confidential information is handled. My goal is to support my clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing to not involve me in legal/court proceedings. If you need a court evaluation or a counselor who will testify in court or legal situations, I will assist you in finding a provider that offers those services.

Payment and Billing: You are asked to pay your fee at each office visit unless other arrangements are made in advance. If your sessions are being subsidized (by a family member, a church, an employer, etc.), please be aware you will be billed for any session missed or cancelled with fewer than 24 hours notice. All balances past due 60 days will be assessed a monthly 1.5% finance charge. An income-dependent adjusted fee schedule is also available. If you believe you may qualify for the adjusted fee schedule (and are willing to provide documentation upon request) please complete the following:

(1) Total family gross monthly income _____

(Include all income before taxes, including child support, spousal support, school grants, and state-assistance programs.)

(2) Number of persons this income supports _____

Please keep your counselor informed of any changes in your financial status, as an increase or decrease of income will affect your adjusted fee.

Additional Office Information: (to be entered by counselor) _____

Consent to Treatment: I have read the above information and have had the opportunity to ask questions about it. I understand my rights to privacy and the risks associated with treatment. If there are children involved in treatment, I hereby give my consent for their treatment and affirm that I am the legal guardian with the authority to consent to treatment. I also agree to the payment and billing policies outlined above and accept full responsibility for any and all fees incurred. I consent to participate in treatment and I understand that I may refuse services at any time. I hereby authorize the Salem Pastoral Counseling Center to provide all information necessary to process all insurance claims. I am also aware that my counselor may periodically consult with other therapists at Salem Pastoral Counseling Center, and/or with clinical supervisors on client issues. **My signature below indicates that I have received a copy of my counselor's Professional Disclosure Statement, Notice of Privacy Practices, and have read, understand and agree to abide with the policies outlined on both sides of this document, and have obtained copies of these documents for future reference.**

(1) _____
Client signature

(2) _____
Client signature

Date

Date

PROFESSIONAL DISCLOSURE STATEMENT

Bob Lewis, M.A., L.M.F.T.

Place of Business:

Address: Salem Pastoral Counseling Center
1300 Broadway St. NE Suite 409
Salem, OR 97301-1426

Telephone: (503) 370-8050

My professional development involved studies at Loyola University Chicago and Wesley Theological Seminary. I received an M.A. degree in Pastoral Counseling from Loyola University Chicago. The primary area of my training was marriage and family therapy. Developmental psychology, family systems, and brief therapy provide the theoretical framework for my practice.

My work is guided by the vision of the developing human person in the context of his or her interpersonal relationships. I believe that counseling is most effective when both client and counselor have the same well-defined goals, and that these goals are explicitly stated. I hold the following assumptions:

- ✓ change is inevitable
- ✓ clients possess inherent strengths
- ✓ there are many ways to view problems
- ✓ collaboration is necessary
- ✓ change is action-based
- ✓ therapy is short-term

I am currently a Member of the American Association for Marriage and Family Therapy and a licensee of the Oregon Board of Licensed Professional Counselors and Therapists. As such, I abide by the Code of Ethics of both organizations.

To maintain my status as a licensed therapist, I am required to participate in continuing education, attending seminars dealing with subjects relevant to this profession. I may substitute professional consultation for part of this requirement. I would be happy to discuss with you how this consultation relates to your counseling experience.

Fee Schedule

Fees for counseling services are \$155.00 for the initial session and \$105.00 for each subsequent individual session. Some adjustment in fees is possible in cases of need and when discussed in advance with the counselor.

Client Bill of Rights

As a client working with me, you have the following rights:

1. To obtain a copy of the Code of Ethics for either the American Association for Marriage and Family Therapy or the Oregon Board of Licensed Professional Counselors and Therapists.
2. To privacy as defined by rule and law, including the exceptions to confidentiality of information obtained in the course of services that include the following: *reporting suspected child or elder abuse, *reporting imminent danger to clients or others, *court-ordered release of information, *providing information concerning licensee case consultation or supervision, and *defending claims brought by client against licensee.
3. To be informed of the cost of professional services before receiving the services.
4. To be free from discrimination on the basis of race, religion, gender, or other unlawful category in receiving services.
5. To participate fully in developing your counseling plan.
6. To expect that a licensed therapist has met minimal qualifications required by state law.
7. To examine public records maintained by the Oregon Board of Licensed Professional Counselors and Therapists and to have the Board confirm credentials of a licensee.
8. To report complaints to the Executive Board through either of the Co-Director(s) of Salem Pastoral Counseling Center, and/or to report complaints to the Oregon Board of Licensed Professional Counselors and Therapists.

You may contact the Oregon Board at the address below:

Oregon Board of Licensed
Professional Counselors and Therapists
3218 Pringle Road SE #250
Salem, Oregon 97302-6312
(503) 378-5499

SALEM PASTORAL COUNSELING CENTER
NOTICE OF PRIVACY PRACTICES

Recognizing that certain information you provide to us is confidential, Salem Pastoral Counseling Center has adopted formal policies regarding access to confidential counseling and medical information. THE FOLLOWING NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ BOTH SIDES OF THIS NOTICE CAREFULLY.

I. Uses and Disclosures that Do Not Require Written Authorization

In certain situations, we will not require your written authorization in order to use and disclose your protected health information. These situations are based on professional judgment and may include:

- ◆ Treatment, payment and health care operations. We may use and disclose PHI, in order to treat you, obtain payment for services provided to you and conduct our health care operations.
- ◆ Public health activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report victims of domestic violence, child abuse or neglect to the Oregon Department of Human Services; (3) to law enforcement agencies in order to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
- ◆ Health oversight activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs.
- ◆ Law enforcement officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
- ◆ Judicial and administrative proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process including a court order or a grand jury or administrative subpoena.
- ◆ As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.
- ◆ Appointment reminders. We may use or disclose your health information to provide you with appointment reminders or confirmation such as voice mail messages or letter.
- ◆ Disclosure to family and friends. We may use or disclose your PHI to a family member, close personal friend or caregiver if we (1) obtain your agreement, (2) provide you with the opportunity to object to the disclosure and you do not object, or (3) reasonably infer that you do not object to the disclosure, (4) determine that a disclosure to a family or friend is in your best interest.

II. Uses and Disclosures Requiring Written Authorization

For any purpose other than the ones described above in Section I, we may only use or disclose your PHI when you give us written authorization. Typical situations in which we will request authorization to disclose PHI include coordination of care with community-based service providers and referrals for appropriate aftercare planning.

III. Your Rights Regarding Protected Health Information

- ◆ For further information; complaints. If you want further information about your privacy rights, or wish to register a complaint you may contact our privacy officer (contact information below). You may also file a complaint with the Office for Civil Rights, U.S. Dept. of Health and Human Services. Salem Pastoral Counseling Center will not retaliate if you choose to file a complaint.
- ◆ Right to request additional restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals involved with your care or with payment related to your care. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.
- ◆ Right to receive confidential communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- ◆ Right to revoke your authorization. You may revoke your authorization, except to the extent that we have taken action upon it, by delivering a written revocation to the SPPC Privacy Officer, or to your counselor.
- ◆ Right to inspect and copy your health information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we will charge you \$0.25 for each page plus postage cost, plus \$50 an hour for staff time to locate and copy your PHI.
- ◆ Right to amend your records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, your request must be in writing and it must explain why the information should be amended. We will comply with your request unless we do not believe that the information that your request be amended is accurate and complete or other special circumstances apply.
- ◆ Right to receive an accounting of disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.

IV. Effective Date and Duration of This Notice

This Notice is effective on April 14, 2003. We may change the terms of this Notice at any time. If we change this Notice, we may make the new terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in the waiting area and on our website, <http://www.salempastoralcounseling.org>.

V. Privacy officer for SPCC is Bob Lewis, Co-director. He may be contacted at 503-370-8050, or FAX 503-370-9982.

SALEM PASTORAL COUNSELING CENTER
CONFIDENTIAL INFORMATION SHEET

Date _____

Counselor _____

Person #1: Full Name _____ Social Security # _____

Drivers License # _____ Age _____ Birth Date _____ Marital Status _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Okay to leave message at home _____ at work _____ cell _____

Occupation _____ Employer _____

Employer Address _____

Length of Employment _____

Name/Address of person responsible for your payment _____

Names/Ages of Children _____

Church Affiliation _____

Primary Physician _____

Previous Counselor(s) _____

How did you find us? _____

Person #2: Full Name _____ Social Security # _____

Drivers License # _____ Age _____ Birth Date _____ Marital Status _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Okay to leave message at home _____ at work _____ cell _____

Occupation _____ Employer _____

Employer Address _____

Length of Employment _____

Name/Address of person responsible for your payment _____

Names/Ages of Children _____

Church Affiliation _____

Primary Physician _____

Previous Counselor(s) _____

Referred by _____

Confidentiality Policy: All communication between counselor and client is confidential. However, in accordance with Oregon and Federal law, there may be circumstances in which communications between a client and their counselor is not confidential and requires disclosure. Those incidents which require reporting are: (1) A report of child abuse, ORS; (2) Threats against persons, including yourself, ORS; (3) Threats of violence against persons, ORS; (4) Abuse of elderly persons, ORS, (5) An acknowledge waiver of the privilege by the client; and (6) By court order. If you have any questions about confidentiality, please ask your counselor.

SALEM PASTORAL COUNSELING CENTER
1300 Broadway St NE Suite 409
Salem OR 97301-1426
503-370-8050

In order to help us provide the best care, please complete this form. If you are not sure about any item, or feel uncomfortable answering, please leave that part blank. Answer what you are able, and speak with your counselor about any areas of concern.

Client information:

Today's date _____

Client full name _____ Date of birth _____

Please describe your reasons for seeking counseling. _____

What do you want to accomplish as a result of your counseling here?

Current Situation:

Relationship status: Married _____ Separated _____ Divorced _____ Single _____

Long term relationship _____ How long? _____

If in a committed relationship, how would you describe your relationship? _____

Children: names and ages _____

How would you describe your relationship with your children? _____

Other people living with you: names and relationship _____

Do you or anyone in your living situation possess or carry guns?

No _____ Yes _____ If yes, number of guns _____

Areas of concerns: please check all that apply:

Emotional issues	Current problem	problem in past	no problem
anxiety (worry, fear, excessive guilt)			
depression (unhappiness, lack of energy, drive)			
thinking problems (disorganized, confused, unable to focus)			
uncontrolled repetition in thinking and/or behavior			
mood swings (change quickly, hard to control, feeling "numb")			
anger (hard to control, inappropriate anger, resentment)			
grief (feelings of loss, sadness, crying)			
suicidal thinking or action			
nightmares/sleep disturbances			
withdrawn/few friends			
panic attacks			
nervous or repetitive habits			
Behavioral issues			
employment			
legal problems			
gambling			
stealing			
lying			
sexual problems			
obsessions/compulsions			
problems with attention			
eating problems			
learning problems			
pornography			
alcohol			
drugs			
tobacco			
setting fires			

Have you been in therapy before? _____

counselor's name _____ when ? _____

counselor's name _____ when ? _____

Have you ever been hospitalized for psychiatric problems? No _____ Yes _____

If so, when ? _____

Medical background:

Name of primary care physician _____

Are you currently under medical care? _____

Please describe _____

Are you currently on prescription medication? _____

Please describe _____

Do you take over-the-counter medicine? _____

Please describe _____

Have you ever had a head injury? Yes____ If so, when_____ No_____

List any serious medical concerns you are having currently or any medical conditions you've had in the past. _____

Family History:

Parents:	Mother	Father
alive or deceased?	_____	_____
age	_____	_____
if alive where do they now live?	_____	_____
use of alcohol/other drugs now or In the past?	_____	_____
abusive to you or other family members ? (physically, sexually, mentally, spiritually)	_____	_____
history of mental illness in the family ?	_____	_____
medical problems? If so what?	_____	_____

Siblings: names and ages _____

Are you adopted? _____

Your highest level of school completed _____

How would you describe your family when you were a child (example: how parents got along, were they available to you, significant problems, finances, etc) _____

How would you describe your current relationships with your family of origin? _____

Social History:

Describe briefly where you receive emotional or social support (example: church, social events, family, work, hobbies, clubs?) _____

Describe briefly your history of making and keeping friends (easy? difficult? many friends? a few close friends? no friends?) _____

Additional Information:

Is there any other information you think would be helpful for me to know? _____

SALEM PASTORAL COUNSELING CENTER AUTHORIZATION FOR INSURANCE BILLING

Counselor: _____ Client: _____

Primary Insurance _____ ID# _____ Group# _____

Subscriber (Name on policy) _____ DOB _____

Address (if different than client) _____

Employer _____

Secondary Insurance _____ ID# _____ Group# _____

Subscriber (Name on policy) _____ DOB _____

Address (If different than client) _____

Employer _____

I authorize my insurance company to pay directly to Salem Pastoral Counseling Center all benefits due for my mental health care, and hereby consider this an assignment of benefits. I authorize Salem Pastoral Counseling to provide all information my insurance company(ies) request(s) concerning my treatment.

I understand that I am responsible for pre-authorization or doctor's referral if required. I understand that I am financially responsible for services performed whether or not paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. **I understand I am responsible for full payment for any missed sessions, or sessions canceled without 24 hour notice.**

___ Copy of insurance card has been provided

___ Pre-authorization received: # _____

___ Doctor's referral completed

Signature of client or responsible party

Address _____

This authorization is valid for one year effective this date unless revoked in writing.

Date _____