

**SALEM PASTORAL COUNSELING CENTER**  
**GENERAL INFORMATION AND OFFICE POLICIES**  
George Olson, M.A., L.P.C., N.C.C.

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 on Thursdays and Fridays with evening appointments generally available. Counseling sessions are by appointment only and are typically 45-50 minutes in duration. Appointments may be cancelled or rescheduled by calling my voicemail at (503) 370-8050 Ext 8. You will be charged \$50.00 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.

**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. Our fee is \$105 per session. 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

George Olson, M.A., L.P.C., N.C.C.

Place of Business:

Address: Salem Pastoral Counseling Center  
1300 Broadway St. NE Suite 409  
Salem, OR 97301-1426  
Telephone: (503) 370-8050

[My Website: GeorgeOlsonCounselor.com](http://GeorgeOlsonCounselor.com)

## Philosophy and Approach to Counseling

I believe that individuals are capable of change when given the right tools, a heightened self-awareness and empowerment to take control of their lives. I recognize and affirm the wholeness of the individual: mentally, emotionally, physically, socially and spiritually. I generally believe that the person is not the problem; the problem is the problem. I work collaboratively with clients to find solutions and strategies to solve the problem. I am aware of my values as a Christian and I do not impose my values on my clients. I practice helping clients understand and clarify their own values as applied to their life needs.

I employ an integrative and strength-based approach to counseling with a strong reliance on **Cognitive Behavioral Therapy, Solution Focused Brief Therapy, and Positive Psychotherapy** utilizing individual, couples and group counseling, biblio-therapy and homework assignments.

If for any reason I determine that I do not have the experience, training or knowledge to work with your particular concerns, I will refer you to another professional who is prepared to work with your presenting concerns.

## Formal Education, Training and Affiliations

I hold a Masters Degree in Counseling from **George Fox University** in Portland, Oregon. I am certified as a **National Certified Counselor** from the National Board for Certified Counselors. I am trained in the **PREPARE/Enrich assessment** and the **Taylor-Johnson Temperament Analysis**. I am a certified facilitator for the ***Am I Hungry? Weight Maintenance Program***.

Major coursework has included human growth and development, human sexuality, marriage and family therapy, personality and counseling theories, career development and lifestyle counseling, group theory and principles and techniques of counseling, psychopathology, psychopharmacology, and professional orientation and ethics.

To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to my profession.

I am a member of the **American Counseling Association, the Oregon Counseling Association, the National Association of Cognitive Behavioral Therapists** and the **International Positive Psychology Association**.

### **Code of Ethics**

As a Licensee of the **Oregon Board of Licensed Professional Counselors and Therapists**, I abide by its Code of Ethics as well as the Code of Ethics of **The American Counseling Association** and the **National Board for Certified Counselors**.

### **Fee Schedule**

Fees for counseling services are \$105.00 per 50-minute 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 of an Oregon licensee, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee.
- To obtain a copy of the Code of Ethics;
- 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;
- To be informed of the cost of professional services before receiving the services;
- To participate fully in developing your counseling plan;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to client or others; 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; 5) Defending claims brought by client against licensee;
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

**You may contact the Oregon Board at:**

Oregon Board of Licensed Professional Counselors and Therapists

3218 Pringle Road SE #250

Salem, Oregon 97302-6312

(503) 378-5499

Email: [lpc.lmft@state.or.us](mailto:lpc.lmft@state.or.us)

Website: [www.oregon.gov/OBLPCT](http://www.oregon.gov/OBLPCT)

5/25/2010

**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. \_\_\_\_\_

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

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Current Situation:

Relationship status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_

Long term relationship \_\_\_\_\_ How long? \_\_\_\_\_

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

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Children: names and ages \_\_\_\_\_

How would you describe your relationship with your children? \_\_\_\_\_

Other people living with you: names and relationship \_\_\_\_\_

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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:

<b>Emotional issues</b>	<b>Current problem</b>	<b>problem in past</b>	<b>no problem</b>
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			
<b>Behavioral issues</b>			
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 \_\_\_\_\_

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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 \_\_\_\_\_