

SALEM PASTORAL COUNSELING CENTER
OFFICE POLICIES AND GENERAL INFORMATION
Judy Tuttle Zollner, MEd, Special Education; MA, NCC, LPC

Thank you for choosing our office to provide your counseling. The statements below will help outline office policies and are provided for your information. Please do not hesitate to ask if you have questions about them.

Appointments: I work Monday through Friday, with some available evening appointments. Counseling sessions are by appointment only and are typically 50 minutes in duration.

Phone calls: Salem Pastoral Counseling Center has a 24 hour/day, 7 day/week voice mail system. All calls are routed through the confidential voice mail. Leave your name and number, and a message if you like. I check my messages several times each day, and will return your call as promptly as my schedule allows.

Emergencies: If you have an emergency situation that is life threatening, please dial 911. Our counselors rotate on-call for other serious emergencies. If you have an emergency situation, please dial 503-918-2180, to page the on-call counselor. A counselor will return your call as soon as they are able and will make an effort to contact me.

Confidentiality: 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, ORS; (2) Threats against persons, including yourself, ORS; (3) Threats of violence against persons, ORS; (4) Abuse of elderly persons, ORS, (5) An acknowledged waiver of the privilege by the client; and (6) By court order. Written permission from you is necessary in order for me to release information to another person. I am unwilling and unavailable to testify or advocate in legal situations. If you need support or testimony in court or legal situations of any kind I will give you names of counselors who may accept that responsibility.

Insurance: Please review your insurance policy for coverage of outpatient mental health benefits. While most group plans cover outpatient mental health visits, many individual plans do not. Frequently insurance companies require pre-authorization. It is your responsibility to receive such pre-authorization or the insurance company will not pay. Our office will provide the client information you need for you to file a claim. We will file the claim for you, however, this is a courtesy on our part. You are personally responsible for the entire insurance process. We cannot guarantee that the insurance company will reimburse, and it is important to understand that you, as the client, remain responsible for whatever portion of the bill your insurance company does not pay. Should there be an overpayment, we will refund the difference either to you or your insurance company, depending on who overpaid.

Canceled or missed appointments: Please try to keep appointments you make, even if it is inconvenient. Appointments may be canceled or rescheduled by calling my voice mail. Since I do my own scheduling, I will contact you to reschedule if you desire to do so. There is no charge for appointments canceled more than 24 hours in advance. However, except for genuine emergencies, missed appointments and those canceled with fewer than 24 hours notice will be billed the usual

fee for the time scheduled. Since insurance companies will accept billings only for appointments actually kept, the client is billed directly the full amount for missed sessions. I wait a maximum of 15 minutes for clients who are late, at which time the appointment is canceled and the client is billed for the entire session.

Payment: Payment is expected at the time of service unless other arrangements are made in advance. If your sessions are being subsidized (by a family member, a church, an employer, etc.), be aware you will be billed for the total cost of any session missed or canceled with fewer than 24 hours notice. 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) _____

I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I understand and agree to the Financial and Confidentiality Policies as outlined. 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. I understand that I will be held responsible for any amount not covered by my insurance company, which includes missed or late canceled appointments and lack of pre-authorization and/or referral from my PCP. All balances past due 60 days will be assessed a monthly 1.5% finance charge. **My signature below indicates that I have received a copy of my counselor's disclosure statement, and have read, understand and agree to abide with the policies outlined on both sides of this document, and have obtained a copy for future reference.**

(1) _____ (2) _____
Client signature Client signature

Date _____ Date _____

Please verify that you have received a copy of our **Notice of Privacy Practices** by signing your initials here _____.

PROFESSIONAL DISCLOSURE STATEMENT

Judith Tuttle Zollner, MA, Counseling;

MEd, Special Education
National Certified Counselor (NCC)
Licensed Professional Counselor (LPC)

Place of Business:

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

Approach to Counseling

I am a trained marriage, family and individual therapist. My approach to counseling is based on "family systems" theory which emphasizes problem-solving therapy within the context of the family-of-origin, the marital family and the social system. I have had 31 years experience as a special education teacher and counselor for the Salem-Keizer School District working with handicapped and difficult children. I have a particular emphasis on helping parents access resources and develop appropriate parenting skills. As well as family systems theory, I also use cognitive-behavioral and solution focused therapy. I have worked with children with mental health issues and my particular areas of emphasis are marriage and family counseling, children and adolescents, ADHD, and adoption issues. I am a member of Salem Alliance Church.

Code of Ethics

I am a National Certified Counselor and a clinical member of the American Association of Marriage and Family Therapists. I abide by the Code of Ethics of the National Board For Certified Counselors and the AAMFT. As a licensee of the Oregon State Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics.

Education

I hold a Master of Arts in Counseling from Portland State University with additional course work from George Fox University in Marriage and Family Therapy. I also hold a Master of Education in Special Education (Learning Disabilities) from William Patterson College in Wayne, New Jersey.

Continuing Education

To maintain my license, I am required by the State to participate in annual classes and conferences concerned with subjects relevant to my profession. I participate in professional consultation for part of this requirement. I would be happy to explain what this entails and how that relates to you as my client.

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 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

Speaking Topics for Workshops, Retreats & Sermons

I am also available for workshops, retreats, and sermons. Please go to <http://www.salempastoralcounseling.org/topics.htm> or click the following link for a [list of speaking topics](#).

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 _____