

Professional Disclosure Statement
Melanie Lute, LPC
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Philosophy and Approach: I believe that everyone can reach an optimal state of health and well-being. I employ an eclectic approach with a focus on the relationship between how people think and how it impacts behavior and one's experience in their world. I believe past and present experiences have a strong influence on one's thinking, relationships, level of function, and behavior. I enjoy working with clients of all ages to resolve life's challenges through education, skill-building, developing self-awareness, and relationship building. I utilize aspects of cognitive-behavioral therapy, child-centered play therapy, attachment therapy, EMDR, and Neurofeedback.

Formal Education and Training: I hold a master's degree in counseling from Oregon State University. Major course work included human growth and development with a strong emphasis on adolescent development and adjustment, childhood trauma, group dynamics, multiculturalism, working with families, and theory. In addition to talk counseling, I am trained in Neurofeedback and EMDR and have taken many courses in Child Centered Play Therapy. I am a licensed school counselor as well and have worked at the middle school level.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession

Fees: Fees for counseling services are \$195.00 for the initial session and \$165.00 for each subsequent individual session. Some adjustment in fees is possible in cases of need and when discussed in advance with the counselor.

Cancellation Policy: 24-hour notice is required. Without 24 hours' notice, the session fee in full will be charged. If you will more than 10 minutes late, please notify me. Sessions will not start after 15 minutes of the original start time. If you are more than 15 minutes late, the full session fee will be charged. If 3 or more appointments are missed or canceled, treatment will be discontinued.

As a client of an Oregon licensee, you have the following rights:

- To expect that a licensee has met the 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 (Oregon Administrative Rules 833.100);
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;

- To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions: 1) reporting suspected child abuse; 2) reporting imminent danger to you or others; 3) reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) providing information concerning licensee case consultation or supervision; 5) and defending claims brought by you against me;
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

You may contact the Board of Licensed Professional Counselors and Therapists at 3218 Pringle Rd SE, #120, Salem, OR 97302-6312 Telephone: (503) 378-5499
Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT
For additional information about this counselor or therapist, consult the Board's website.

SALEM PASTORAL COUNSELING CENTER
CONFIDENTIAL INFORMATION SHEET

First Appointment Date _____ **Counselor:** _____

Client: Full Name _____

*** Appointment reminders will be sent to the email and cell ph# listed below.**

*** Cell Ph#** _____ **Ok to Contact and leave message?** **Please Initial Yes** ___ **No** ___

*** I authorize SPCC to send information/correspondence via text message.** **Please Initial Yes** ___ **No** ___

*** E-Mail** _____ **Ok to Contact by e-mail?** **Please Initial Yes** ___ **No** ___

Client Address _____ **City** _____ **Zip** _____

Ok to mail correspondence to this address? **Please Initial Yes** ___ **No** ___

Client Age _____ **Client Birth Date** _____ **Social Security# (opt)** _____

Marital Status _____ **Occupation** _____ **Employer** _____

Emergency Contact:

Name _____ **Phone** _____ **Relationship** _____

Name/Address of person responsible for your payment (if not the client) _____

Names/Ages of Children _____

How did you hear about us? _____

Person #2/Legal Guardian: Full Name _____

Address _____ **City** _____ **Zip** _____

Ok to mail correspondence to this address? **Please Initial Yes** ___ **No** ___

Cell Ph# _____ **Ok to Contact and leave message?** **Please Initial Yes** ___ **No** ___

I authorize SPCC to send information/correspondence via text message. **Please Initial Yes** ___ **No** ___

E-Mail _____ **Ok to Contact by e-mail?** **Please Initial Yes** ___ **No** ___

Age _____ **Birth Date** _____ **Social Security#(opt)** _____

Marital Status _____ **Occupation** _____ **Employer** _____

Names/Ages of Children _____

SALEM PASTORAL COUNSELING CENTER
OFFICE POLICIES/INFORMED CONSENT

Prior to beginning treatment, it is important for you to familiarize yourself with your counselor's approach to treatment, your rights and responsibilities, and Salem Pastoral Counseling Center's (SPCC) office policies. This document, along with your counselor's Professional Disclosure Statement and our Notice of Privacy Practices, discusses these topics. Please take the 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 your counselor has a clear understanding of what brings you to treatment. In order to gain that understanding about your past and current functioning, a thorough assessment will be completed. Following the assessment, a treatment plan will be formulated and together with your counselor you will work towards the goals established. It is crucial that you are an active participant in therapy and candidly express with your counselor your treatment needs.

Risks and Alternatives to Treatment: It is important for you to know that there are risks involved in therapy. For example, some people experience an increase in stress particularly during the early stages of therapy. In some instances, discussing longstanding, unresolved problems can seem to aggravate rather than help with a problem. It is normal and understandable that it will be uncomfortable facing difficult feelings and situations. Keep in mind that, often, "the best way out is through", and your counselor will endeavor to walk through it with you. Your counselor may ask, "what will be different if counseling is successful for you?" You get to define that, and to a large degree are in charge of the pace and progress of your healing journey. If you or your counselor feel at any time that the professional relationship is not a good fit, your counselor will be willing to assist you in finding other options.

Appointments and Cancellations: Counselors work variable hours Monday through Friday with some evening appointments available. Counseling sessions are typically 45-55 minutes in duration. Please try to keep appointments you make, even if it is inconvenient. Appointments may be canceled or rescheduled by calling the voice mail of your counselor at 503-370-8050 and entering their extension. Because our counselors do their own scheduling, your counselor will contact you to reschedule. There is no charge for appointments canceled more than 24 hours in advance. However, except for genuine emergencies or illness, missed appointments and those canceled with fewer than 24 hours notice will be billed up to the usual fee (\$165) for the time scheduled. Insurance companies will accept billing only for appointments actually kept, the client is billed directly the full amount for missed sessions.

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

Confidentiality: Sessions are confidential with the following exceptions: (1) A report of suspected child abuse; (2) Threats to commit suicide; (3) Threats of violence against another person, (4) Abuse of elderly persons; (5) An acknowledged waiver of the privilege by the client; (6) By court order (7) When contacting a collection agency for nonpayment of fees. Written permission from you is necessary in order for your counselor to release information to another person. Please refer to our Notice of Privacy Practices for a more complete outline of how your confidential information is handled.

Communications and Your Privacy: Please know that despite all security efforts, email, cell phone including text messages, and fax communication can be relatively easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication. If you convey sensitive personal information by cell phone, email, or fax, your counselor and SPCC assumes that you have made an informed decision accepting this risk. To protect your privacy, we strongly suggest communicating sensitive information in person or on your counselor's confidential voice mail and limiting email or cell phone communication to scheduling issues only. Please also understand that any requests for contact related to social networking will not be confirmed or acknowledged to protect your privacy.

Legal Issues: ALL COUNSELORS of Salem Pastoral Counseling Center are unwilling and unavailable to testify or advocate in legal situations, disability determination and custody studies. If you need a court evaluation, testimony in court, or any legal support, your counselor will assist you in finding someone who can provide those services.

Insurance: Please review your insurance policy for coverage of outpatient mental health services. Sometimes insurance companies will require pre-authorization and it is your responsibility to obtain this prior to treatment or the insurance will not pay. SPCC will file insurance claims 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 has overpaid.

Payment and Billing: You are expected to pay your fee or co-pay at each office visit unless other arrangements are made in advance. Our first session intake fee is \$195.00 and all subsequent fees are \$165.00 per session. All balances past due 60 days will be assessed a monthly 1.5% finance charge.

Adjusted Fee Schedule An income-dependent adjusted fee schedule is also available for those **without insurance**. 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 therapist): _____
If you have any questions, please don't hesitate to ask your counselor or the office staff.

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 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 counselors at SPCC and/or with clinical supervisors on client issues. **My signature below indicates I have received a copy of my therapist'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 (Legal Guardian) Signature

2) _____
Client (Legal Guardian) Signature

Date

Date

**SALEM PASTORAL COUNSELING CENTER
CONFIDENTIAL PERSONAL HISTORY FORM**

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 _____ Counselor's Name _____

Client full name _____ Date of birth _____

Church Affiliation _____

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

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 and/or Drugs			
Tobacco			
Setting Fires			
Trauma and/or Abuse			

Have you been in therapy before? No Yes

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? No _____ Yes _____ If so, when _____

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

Family History:

Parent Information	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: _____

Please check with your insurance company prior to receiving services to answer the following questions:

\$ _____ Deductible Amount- How much of your deductible have you met for the current year? \$ _____

\$ _____ CoPay Amount

_____ Does your insurance require pre-authorization? Authorization Number _____

_____ Anniversary date of Coverage

_____ Copy of insurance card has been (or will be) provided (copy of card is preferred)

_____ Will payments for services be issued directly from a health spending account?

(Fill out the following ONLY if copy of card is NOT provided.)

Client's Primary Insurance Company _____

ID# _____ Group# _____

Subscriber (Name on policy) _____ Subscriber DOB _____

Subscriber Employer _____

Client's Secondary Insurance Company _____

ID# _____ Group# _____

Subscriber (Name on policy) _____ Subscriber DOB _____

Subscriber Employer _____

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Salem Pastoral Counseling Center directly for services rendered according to my mental health coverage. 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.**

Signature of client or responsible party _____

**SALEM PASTORAL COUNSELING CENTER
AUTHORIZATION FOR THIRD PARTY BILLING
(Non-Insurance)**

Client Name _____

Counselor Name _____

I hereby authorize the Salem Pastoral Counseling Center to bill the company, agency, organization, or person(s) listed below for sessions I or my family member have attended at the Center.

Send Bills To _____

Limits of Billing _____

I understand I am responsible for full payment for any missed sessions, sessions canceled without 24 hours notice, or any payments refused by third party payer.

Client Signature _____ Date _____

Salem Pastoral Counseling Center

2001 Commercial St. SE Suite 200 Salem, OR 97302
Telephone 503-370-8050 Fax 503-370-9982

AUTHORIZATION TO DISCLOSE RECORDS

I authorize _____ to release a copy
(Name of person releasing records)
of the applicable information for _____
(Name of client) (Date of birth)
to _____
(Name and address of recipient)

The information will be used on my behalf for the following purpose(s):

By **initialing** the spaces below, I specifically authorize the release of the following records, if such records exist:

_____ Mental health records	_____ School records
_____ Medical records needed for continuity of care	_____ Summary letter
_____ Drug/alcohol evaluation and/or treatment	_____ Progress notes
_____ Employment records	_____ Billing statements
_____ Most recent five-year history	_____ History/evaluation
_____ Other _____	

_____ Please send the entire record (all information) to the above named recipient. The undersigned understands these records may be voluminous and agrees to pay all reasonable charges associated with providing these records.

_____ This authorization is limited to the following treatment:

_____ This authorization is limited to the following time period:

_____ This authorization is limited to a workers' compensation claim for injuries of _____ (Date).

I agree that the agencies and individuals listed above may share and **exchange** information about my circumstances. Initial one: _____yes _____no

(Please complete both sides of this release)

(Print name of client)

****NOTICE** Records can only be released if all parties in attendance of the sessions have signed this authorization.**

I can cancel this authorization for release at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. Unless revoked earlier, in writing, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

(Date) (Signature of client)

(Date) (Signature of client)

(Date) (Signature of person authorized by law)

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed from records which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release, is prohibited, and may carry penalties.