Professional Disclosure Statement

Melanie Lute, LPC
2001 Commercial St SE, Suite 200 Salem, Or 97302
815 E. Jackson St. Medford, Or 97504
541.450.1763

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
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
_____Medical records needed for continuity of care
_____Drug/alcohol evaluation and/or treatment
_____Employment records
_____Most recent five-year history
_____Other _____
_____School records
_____Summary letter
_____Progress notes
_____Billing statements
_____History/evaluation

_____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.