

Rex R. Glazner, MA, LPC

Salem Pastoral Counseling Center
2001 Commercial St. SE, Suite 200
Salem, OR 97302
(503) 370-8050 ext. 112

Philosophy and Approach

My therapeutic style is varied and integrated, and I believe in doing therapy *with* people, not *to* them. I use several evidence-based practices, including Cognitive-Behavioral Therapy (CBT), Trauma-Focused CBT, Collaborative Problem Solving (CPS), Eco-systemic Structural Family Therapy, Collaborative Assessment and Management of Suicidality (CAMS), Motivational Interviewing, and Solution-Focused Therapy, all within the context of a therapeutic relationship. My role is to provide a safe, collaborative environment, to assist clients in identifying and changing thoughts and beliefs underlying problem emotions and behavior, facilitate insight, understanding and recovery, and provide tools for positive coping. For six years I worked in a church as a youth pastor, then an associate pastor. As a mental health professional, I worked with adolescents in a day treatment center for 12 years, then in an outpatient office for 11 years with children, adolescents, families and adults. I have worked with people having problems related to parenting, Autism Spectrum Disorder, AD/HD, anger, defiance, depression, anxiety, and trauma. I also have some experience working with cooccurring disorders where both mental health and addiction issues are present.

Formal Education and Training

M.A. Biblical Counseling, Colorado Christian University, Denver, CO 1993;
B.S. Biblical Education, Multnomah University, Portland, OR 1983

Major course work included counseling theory and practice, cultural diversity, marriage and family therapy and human development.

Continuing Education and Licensure

As a Licensed Professional Counselor in Oregon, I am required to complete at least 40 hours of appropriate training every two years

Billing information, practices and cost:

Sessions are typically 45-55 minutes and fees for counseling services are \$195 for the initial assessment and \$165 for subsequent sessions. For clients paying out-of-pocket, a reduction of cost is possible as needed when discussed in advance with the counselor. A fee may also be charged for missed appointments if not cancelled 24 hours ahead of the appointment.

Client Rights

As a Licensed Professional Counselor with the Oregon Board of Licensed Professional Counselors and Therapists, I am committed to following the American Counseling Association Code of Ethics. As a client in the State of Oregon, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experiences 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 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 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; and 5) Defending claims brought by clients against licensee.
- To be free from discrimination because of age, race, color, ethnicity, religion, disability, sexual orientation, gender, socioeconomic status or other unlawful category, while receiving services.

You may contact the Board of Licensed Professional Counselors & Therapists at 3218 Pringle Rd., SE #120, Salem, OR 97302; (503)378-5499 ; lpct.board@oregon.gov; www.oregon.gov/OBLPCT

By signing this, I agree that I have read, or someone has read to me, and understand this Professional Disclosure Statement, and have access to a copy.

Client Signature:

_____ Date _____.

Parent/Guardian Signature:

_____ Date _____.

**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	_____ 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.