

Diane Moskowitz, M.A.

Licensed Professional Counselor

4000 Kruse Way Place, Bldg 2, Ste 330, Lake Oswego, OR 97035 503-624-2737 FAX 503-624-7976

TO MY NEW CLIENTS:

Welcome to my practice. Please read the following policies, and feel free to discuss with me any questions or concerns you may have before signing below.

CONFIDENTIALITY: The confidentiality of your therapy is protected by law. Your written consent is required to release any information. Exceptions to confidentiality are limited to extreme circumstances: threat of serious harm to you or others; suspected child or elderly abuse or neglect; a medical emergency; or a court order. Also, if you are using insurance, you will be required to authorize the release of any treatment information necessary to process claims or obtain authorizations for treatment. Depending on your insurance or managed care company, information may range from a psychiatric diagnosis (the minimum) to a treatment plan and other records that include description of the problem, personal background information, treatment goals, treatment methods, and progress along the course of therapy. I will, of course, discuss with you any information I am sending to your insurance company. Couples confidentiality: If you are being seen with a partner or family member, I will require signed releases from both of you before I will release information or consult with a third party.

APPOINTMENTS: Each session is usually 50 minutes in length. Appointment times are held exclusively for you. If you are unable to keep your appointment, please give me as much notice as possible. If you do not call my voice mail at least 24 hours in advance, you will be charged at the usual fee. If you are using insurance for your treatment, please note that they will not pay for a missed session. Emergencies will be considered on a case by case basis.

TELEPHONE COMMUNICATION: My telephone is connected to a 24-hour voice mail, with an answering service for emergencies. I check for messages several times a day during working hours, and I will return your call as soon as possible. If your call is urgent, tell the answering service and they will try to reach me. If I am not available, one of my associates will be on call. In an extreme emergency, call Crisis Intervention at 503-988-4888.

FEES AND INSURANCE: My fee is \$110 for individuals, \$120 for couples, for a 50-minute session. There are additional charges for letters, reports and extended telephone time. I accept payment by check, cash, or VISA and MasterCard. The fee is payable at each session unless I have a contract with your insurance company that requires me to bill them directly. In that case I will collect your co-payment at each session. Otherwise I will provide an insurance claim form for you to submit directly to your company. Please carefully consult your insurance company's mental health coverage. Insurance companies vary greatly in the types of problems they cover, the length of treatment provided, and the therapists you can select from in order to receive reimbursement. I am a Licensed Professional Counselor and a provider for several preferred provider groups. I will assist you in clarifying your insurance company's coverage for my services. Please note that I reserve the right to submit delinquent accounts to an attorney or collection agency. In that event, your confidentiality will, by necessity, be breached.

CONSENT TO TREATMENT: Your signature below indicates that you have read and agree to the policies stated above. If, at any time, you have concerns or questions regarding your therapy, please discuss them with me. Remember that you have the right to refuse treatment at any time, and to request a referral to another therapist.

Thank you for choosing me as your therapist.

Signature _____ Date _____

BACKGROUND INFORMATION

Today's Date _____

Name _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Telephone #'s: Work _____ Home _____ Cell _____

e-mail _____

What's the easiest way to reach you? Please check one: Phone _____ or e-mail _____

Emergency Notification _____ Relationship _____ Phone _____

Names/Ages of Children _____

Relationship Status: Single _____ Married _____ Divorced _____ Separated _____ Other _____

Occupation _____ Employer _____

Social Security Number _____ Education _____

By whom were you referred? _____ Phone _____

May I send a thank you note to the person who referred you? Yes _____ No _____

MEDICAL INFORMATION

Name of your physician _____ Date last seen _____

What prescription and non-prescription medications are you currently taking?

<u>Drug Name</u>	<u>Dose</u>	<u>Prescribed for</u>	<u>Date of initial Rx</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other significant medical problems _____

Please describe the following

Frequency and amount of alcohol use _____

Quantity of cigarette smoking _____

Amount of caffeine use _____

Frequency and type of exercise _____

Amount of sleep per night _____

PREVIOUS COUNSELING EXPERIENCE:

Have you ever been in counseling before? Yes___ No___ If yes, please describe below.

1. Therapist's name_____Approx. dates seen_____

2. Therapist's name_____Approx. dates seen_____

Psychiatric hospitalizations? Yes___No___ Dates_____

CURRENT PROBLEMS:

Please describe briefly what changes you are hoping to make in coming to counseling now.

Please check any of the following symptoms you have experienced in the past month.

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Obsessions or compulsions |
| <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Change in sleeping habits |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Feelings of extreme happiness |
| <input type="checkbox"/> Self-esteem problems | <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Change in sexual interest or function |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Problems getting along with family |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Trouble performing your job |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Acting violently | <input type="checkbox"/> Lack of enjoyment of usual activities |
| <input type="checkbox"/> Feeling tearful | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Impulsive behaviors |
| <input type="checkbox"/> Physical pain | <input type="checkbox"/> Feelings of panic | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Thoughts of hurting yourself or others | | <input type="checkbox"/> Thoughts of killing yourself or others |

INSURANCE INFORMATION:

Name of insurance company_____Phone_____

Name of insured_____Employer_____

Insured's ID# _____Group#_____

Relationship to insured ___Self ___Spouse ___Child ___Other

I authorize payment of medical benefits to the provider of services and the release of any treatment information necessary to process claims or obtain authorizations for treatment.

Signature_____Date_____