Diane Moskowitz, M.A. Licensed Professional Counselor

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T0 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: Day_____________________Evening____________________Cell________________________

May I leave a message for you at home? Yes_______No________ At work? Yes ________No_________

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?

Drug Name	Dose	Prescribed for	Date of initial Rx
___________________________	______________	________________________	_________________
___________________________	______________	________________________	_________________
___________________________	______________	________________________	_________________

Other significant medical problems____

Are you allergic to any medications?____

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.

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

__Depression
__Extreme sadness
__Memory problems
__Weight changes
__Self-esteem problems
__Perfectionism
__Problems with anger
__Feeling anxious
__Feeling tearful
__Physical pain
__Thoughts of hurting yourself or others

__Feeling hopeless
__Trouble concentrating
__Lack of energy
__Feeling stressed
__Easily irritated
__Feeling guilty
__Feeling fearful
__Acting violently
__Muscle tension
__Feelings of panic

__Obsessions or compulsions
__Change in sleeping habits
__Change in eating habits
__Feelings of extreme happiness
__Change in sexual interest or function
__Problems getting along with family
__Trouble performing your job
__Lack of enjoyment of usual activities
__Impulsive behaviors
__Poor judgment
__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_____________________________