Intake Information

Upper Circle Inc

Date_____

1. Identifying Information

Name _____ Partner's Name_____

Address_____ ZIP_____

Phone _____ _____ _____ _____

home work Cellular partner work or parents

DOB_____ SSN_____ ODL _____

People living in your home _____

name, age, relationship to you

_____

Your Children _____

name, age, relationship to you

Employer_____ Job _____Income _____

Other Sources & Amount of Income (disability, VA, retirement, SSI, support, etc)_____

Insurance

Name of Primary Insured _____ Their DOB _____ Pre-Author Req Y N

Insurance Company _____ SSN _____

Group Policy Number_____ ID # _____

Name of Secondary Insured _____Their DOB _____ Pre-Author Req Y N

Insurance Company _____ SSN _____

Group Policy Number_____ ID # _____

Personal Background Information

Education _____ Military _____

Hobbies, Skills, Interests _____

_____

Spiritual or Religious beliefs_____

How are these beliefs practiced in your life_____

When did the difficulty **start** that you are seeing me about_____

How **much** is this difficulty interfering with your life_____

What do you think it will take to **resolve** this problem_____

_____

What is the **ideal** resolution for this difficulty_____

_____

What motivates you in your life_____

Who may we thank for your referral_____

2. Presenting Problems

Describe the problem(s) that brought you here today:

Please Check any of the Symptoms that you are having:

- ☐ Depression
- ☐ Extreme Sadness
- ☐ Trouble Concentrating
- ☐ Memory problems
- ☐ Change in Eating habits
- ☐ Feeling extreme happiness
- ☐ Trouble performing in job
- ☐ Lack of enjoyment of usual activities
- ☐ Self-Esteem Problem
- ☐ Perfectionism
- ☐ Obsessions or compulsion
- ☐ Feeling fearful
- ☐ Physical complaints of pain
- ☐ Problems with anger
- ☐ Bed wetting
- ☐ Running Away
- ☐ Substance Use
- ☐ Has hurt or cut on self
- ☐ Harm to other children
- ☐ Skipping school
- ☐ Suspended or expelled from school
- ☐ Missing Work
- ☐ No sexual interest
- ☐ Thoughts about hurting yourself or others
- ☐ Feeling Hopeless
- ☐ Feeling tearful
- ☐ Change in sleeping habits
- ☐ Lack of energy
- ☐ Weight changes
- ☐ Change in sexual interest or function
- ☐ Problems getting along with family or friends
- ☐ Feeling Stressed
- ☐ Easily irritated
- ☐ Feeling guilty
- ☐ Feeling nervous
- ☐ Sudden feelings of Panic
- ☐ Muscle tension
- ☐ Acting violently
- ☐ Thumb sucking
- ☐ Isolation or withdrawal
- ☐ Fire-setting
- ☐ Harm to animals
- ☐ School work has deteriorated
- ☐ Doesn't mind parents, or ignores teachers
- ☐ Sexually promiscuous
- ☐ Falling asleep at work/school
- ☐ Unable to fall asleep or stay asleep
- ☐ Thoughts about killing yourself or others

Are there any agencies involved in your life?

Have you recently experienced a traumatic event?

What were the traumatic events you experienced in your life?

3. Have you ever been in Counseling before? Yes ☐ No ☐

If you have been in counseling before, please describe it below. Start with the most recent time first.

When did you have counseling? Date(s):
Who did you see? Name:
Explain what happened:

When did you have counseling? Date(s):
Who did you see? Name:
Explain what happened:

4. Medical Information

Who is your doctor?
What are you seeing a doctor for?

What medications are you taking?

What are you allergic to?

Do you have a VA doctor or other specialist you see?

5. Substance Use History

Do you use/have you used tobacco in any form	Current	☐	Past	☐	No	☐
Do you use/have you used alcohol	Current	☐	Past	☐	No	☐
Do you use/have you used caffeine in any form	Current	☐	Past	☐	No	☐
Do you use/have you used recreational drugs	Current	☐	Past	☐	No	☐

Which ones_____
When did you last use any of these substances_____
What quantity of substance did you last use _____ for how long _____
Do you currently attend AA, NA, SA, ALANON or any other addiction program_____
Are you in a recovery program now or have you ever participated in one (please list when and where and the results) _____
Have you ever been in trouble legally, with family, work or church due to substances_____
_____
Use of any other substances not listed _____

Upper Circle Inc. 1300 Boone Rd SE Salem, OR 97306 Beth Doyle, M.A. 503-391-1300

Treatment Philosophy

Welcome to therapy. The following pages answer some frequently asked questions regarding therapy. Please read this information carefully and let me know if there is any part you do not understand.

During the course of therapy it is common for issues to arise that create discomfort. Clients new to therapy are often surprised when unexpected feelings or memories emerge which may be confusing or uninvited. Problems may temporarily worsen before they get better. In therapy, major life decisions are sometimes made, including calling into question some of your beliefs and values. You may recall unpleasant memories, or feelings that may bother you at home, or work. Your emotional experience may seem too intense to deal with at this time; you may not accept or forgive yourself; family secrets may be told and therapy may alter your relationships or lead to life changing decisions. This may or may not be the process you experience during your healing. These are but some of the "risks" that the psychotherapeutic process can generate. If questions or concerns come up for you at any time during the counseling process, I encourage you to discuss them with me immediately.

The first session is used for gathering information and discussing any questions you may have regarding the policy and procedures. In this initial session I will want to know as much as possible about the specific problems you need help with. This is in addition to the information you have already provided me from the printed forms filled out by you. I need all of this information to develop a complete understanding of how I may help you. I will then share with you a proposed treatment plan, anticipated benefits and risks, as well as, projected prognosis and outcome. Since therapy is a process, it is not always possible to predict just exactly how long your particular problem will take to resolve. Please be sure to discuss these matters with me so I can let you know what treatment methods may be used in your specific case.

Treatment methods may include but are not limited to the following: Neuro- Linguistic Programming (NLP); cognitive and solution-focused therapy; Energetic Healing; process-oriented psychotherapy; Ericksonian hypnosis; guided imagery; role play; drama therapy; sound, color or movement therapy; meditation or breath work; integration of spiritual beliefs; past life regressions; HeartMath; psychodynamic therapy which involves discussions of family of origin connections to present day problems; couple or relationship counseling; Applied Kinesiology, play therapy (using toys, sand, art etc) and family therapy which may include mediation.

Please be sure to ask me any questions you may have about any of the treatment methods we may be using. It is my intention to have a very open and honest therapeutic relationship, which requires that you be informed about where we are starting from and where we are going at each step in the process. Please make me aware of your spiritual beliefs so that our work can include your beliefs.

Policies and Procedures

Hours

I may be reached between 9:00 am to 6:00 pm Monday through Friday. Monday and Friday I am frequently scheduled out of the office. Often I am with clients and may not return your call immediately. I check messages during the day and will make every effort to return your call within a day. If I cannot reach you that same day, please call me again. If you are having an emergency you may always call the **Adult Mental Health Crisis Center** at **503-585-4949** for immediate assistance.

Fees

The fee for a standard 50-minute hour appointment is $126.00 for individual, couple, or family therapy. Depending on the different therapy needs of each client, longer appointments may be necessary and you will be billed at 10 minute increments for the additional time. The fee for group therapy is $45-$60.00 for a 90-120 minute session. The initial assessment appointment is billed at $150 - $250 depending on the purpose of the initial assessment appointment. The cash payment discount for clients is $90.00 for individual and $45.00 for group.

Payment Policy
You are expected to pay your fee in full at the time of each visit, including co-pay. Should insurance not pay the full payment of the fees, you are expected to pay the entire remaining amount.

Cancellation Policy
If you need to reschedule or cancel an appointment, please let me know as soon as possible. Others are waiting for appointments. If I do not have a ***24-hour notice of cancellation***, you will be charged the normal hourly appointment fee. This fee must be paid prior to your next appointment.

Confidentially
I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me, nor even the fact that I have seen you without your written permission by way of a signed release of information form. There are few exceptions to these standards:

- It is legally required of me that I act so as to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
- I am legally required to report cases of on-going child, elder or disabled abuse.
- I may have to release clinical information about you to an official on request.
- I may have to release your records when ordered to do so by a Court.
- On occasion I consult with colleagues about their work. If your case were ever discussed it would be confidential and without your name or identifying information.

Consent for Treatment

Please sign below to show that you have read and understand this *Informed Consent Statement*. I consent to participate in therapy and may voluntarily withdraw from therapy at any time. I will give 24 hour notification for any appointments I must cancel due to conflicts or illness. I understand that if I do not I will be liable for costs for the appointment. I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits directly to the provider. I also agree to pay for all services received at time rendered unless payment options have been mutually agreed upon in writing.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian Date

HIPPA
Consent to Use and Disclose Your Health Information

This form is an agreement between you the client, _____ and the therapist, Beth Doyle.

When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When I examine, diagnose, treat, or refer you we will be collecting what the law calls *Protected Health Information* (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The **Notice of Privacy Practices** explains in more detail your rights and how we can use and share your information. Please read and sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information, this may change our **Notice of Privacy Practices.** If we do change it, you may obtain a copy by calling us at 503-391-1300.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

Date of NPP_____ ☐ Copy given to client/parent/personal representative

Upper Circle Inc 1300 Boone Rd SE, Salem OR 97306 503-391-1300 beth@uppercircle.com

Authorization to Use and Disclose Protected Health Information

I authorize _____ to use or disclose to and from ***Upper Circle Inc.***, or its duly authorized representatives, all of the following information:

Kind of Information:

❑ Social	❑ Psychological	❑ Psychiatric	❑ Mental Health
❑ Financial	❑ Employment	❑ Educational or School	❑ Medical
❑ PSI - Presentence Investigations	❑ Workers Comp	❑ Probation/Parole Records	❑ Health
❑ Supervision Conditions	❑ Criminal	❑ Legal (court, police, polygraph, etc)	
❑ Child Welfare	❑ Other_____		

This release is for the purpose of case planning, evaluation and treatment or _____

I understand and agree that this authorization will be valid and in effect from_____ and expires _____ or the end of supervision/treatment. I understand that after that date or event, no more of this information can be used or disclosed to the person or organization unless I sign a new Authorization like this one.

I understand that I can revoke or cancel this authorization at any time by giving written notice delivered by certified mail to all parties including Upper Circle, Inc. If I do this it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.

I understand that *I do not have to sign this authorization* and that my refusal to sign will not affect my abilities to obtain treatment from the professional listed above, nor will it affect my eligibility for benefits.
I understand that I may inspect and have a copy of the health information described in this form.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I am completing this form to allow the use and sharing of protected health information about:

_____ _____
Signature of client or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

I have discussed the issues with the above client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

_____ ____ Beth Doyle, M.A., LPC _____ _____
Signature of professional Printed name of professional Date

Upper Circle Inc
1300 Boone Rd SE
Salem, OR 97306

Beth Doyle M.A., LPC
503.391.1300

Professional Disclosure Statement

Philosophy and Approach: My theoretical foundation is humanistic and existential therapy, with cognitive-emotive-behavioral therapy and holistic energy therapy. My philosophy in treatment is that most of our present difficulties have roots in traumas from our past. When we find the root cause of the trauma, unlock the blocked energy, then dissolve and release the difficulty, then true healing can occur. We each have the capacity, wisdom, and compassion to heal our deepest traumas and to achieve our true heart's desire. We may be guided and helped by others, the most powerful healing occurs when we access our own deepest truth and wisdom.

Most therapy sessions focus on your self-talk, expression of self statements verbally and non-verbally, including meta-language; self-awareness, choice, problem solving, and setting goals for the present and future; focusing on responsibility, meaning of life, your strengths, limitations, self-concept, acceptance, and change. A part of our work together is on identifying & understanding the "themes" which shape and guide your experiences in life.

I will challenge you in a caring and empathetic manner to look at yourself and seek alternative options and strategies for creating and responding to your life. My goal is to assist you to alter themes or patterns which no longer work for you in order for you to create and live a more fulfilling life.

Formal Education and Training: I hold a Masters Degree in Counseling and Educational Psychology from the University of Missouri-Columbia. Major course interests were group therapy and holistic approaches. I completed the 18 month National Training Laboratory program for group therapists and organizational development specialists. I have specialized in the treatment of sexual abuse, addictions, trauma, stress-related conditions and violence. I am licensed to conduct the Abel Assessment of Sexual Interest Screening and HeartMath.

As a Licensee of the Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics. To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession. I may substitute professional supervision for part of this requirement. I continue to participate in ongoing clinical supervision, which I will be happy to explain.

Fees: My fee is $126.00 per 50 minute therapy session and $60 per group therapy session; reports, testimony or consultation is billed at the hourly rate. Initial appointment $150 -$225. Cash discounts for both individual and group therapy are at the rate of $90 and $45. A $500 retainer is required for court appearances and is paid in advance. Books and treatment materials are sold individually, separate from treatment fees and are not billed to insurance. Fees are assessed at 10 minute increments and if insurance does not pay the full fee, it is the clients responsibility to pay the full fee for the session.

As a Client of an Oregon Licensee You Have the Following Rights:

- To expect that a licensee has met the minimal 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**;
- 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;
  5) Defending claims brought by client against licensee;

- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the Board of Licensed Professional Counselors and Therapists at
3218 Pringle Rd SE #250, Salem OR 97302-6312 Phone: 503-378-5499

Upper Circle Inc 1300 Boone Rd SE Salem OR 97306 503-391-1300

Please take this document with you and retain for your own use.

This Notice Describes How Medical Information about You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it Carefully.

Notice of Privacy Practices

Privacy is a very important concern for all those who come to this office. If you have any questions our Privacy Officer Beth Doyle, will be happy to help you. You may contact her at the office number and address given above. This notice takes effect January 31, 2003 and remains in effect until we replace it.

A. Our Pledge Regarding Medical Information to Our Clients

The privacy of your medical and psychotherapy information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

B. Your Personal Medical Information

Each time you visit us or any doctor's office, hospital, clinic, or any other "healthcare provider" information is collected about you and your physical and mental health. It may be information about your past, present or future health conditions, or the treatment or other services you got from me or from others, or about payment for healthcare. In this office PHI is likely to include these kinds of information:

- Your history, childhood, in school and at work, and marital and personal history.
- Reasons you came for treatment. Your problems, complaints, symptoms, needs, goals.
- Diagnoses. Diagnoses are the medical terms for your problems and symptoms.
- A treatment plan. These are the treatments and other services which I think will best help you.
- Progress notes and Progress Reports; Information about medications you took or are taking.
- Records received from others who treated or evaluated you.
- Psychological test scores, school records, etc.
- Polygraphs, Abel Assessments or other evaluations.
- Billing and insurance information.

This list is to give you an idea of the types of information that goes into your healthcare record here.

We use this information for many purposes. For example, we may use it:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other healthcare professionals who are also treating you such as your family doctor or another therapist. Also, when we talk with your P.O. or Child Welfare caseworker.
- To show that you actually received the services from me which were billed to you or to your health insurance company.
- To improve the way I do my job by measuring the results of my work.

Although your health record is the *physical property of the healthcare practitioner* or facility that collected it, the information belongs to you. You can inspect, read, or review it. If you want a copy we can make one for you but will charge you for the costs of copying and mailing. In some very unusual situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or something important is missing you can ask us to amend or add information to your record although in some rare situations we don't have to agree to do that.

C. Our Legal Duty

Law Requires Us To:

1. Keep your medical info private
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current Notice

We Have the Right to:

1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

D. Use and Disclosure of Your Medical Information

1. Uses and Disclosures of PHI in Healthcare with Your Consent

The following section describes different ways that we use and disclose medical information. Not every use or disclosure is listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address on the first page.

After you have read this Notice you will be asked to sign a separate **Consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for our services, or some other business functions called health care **operations**.

Treatment, Payment, and Health Care Operations

We need information about you, your situation and your condition to provide care to you. You have to agree to let us collect the information and to use it and share it as necessary to care for you properly. Therefore you must sign the Consent form ***before*** I begin to treat you because if you do not agree then consent to treatment, then I cannot treat you.

When you come to see me, other people in the office may collect information about you for your healthcare records here. We use your PHI for three purposes: **treatment, obtaining your payment**, and what are called **healthcare operations**.

For Treatment

We use your medical information to provide you with psychological treatment or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the effects of my services.

We may share or your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. We may refer you to other professionals or consultants for services we cannot offer such as special testing or treatments. When we do this we need to tell them some things about you and your conditions.

We will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For Payment

Your information is used to bill you, your insurance, or others to be paid for the treatment we provide to you. We may contact your insurance company to check on exactly what your insurance covers. Information includes your diagnoses, what treatments you have received, and your prognosis.

For Health Care Operations

There are some ways we may use or disclose your PHI which are called health care operations.

Appointment reminders. Calls to remind you about appointments. If you want us to call or write to you only at your home or work or prefer some other way to reach you, we can arrange that - just tell us.
Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of use to you.
Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
Research. We may use or share your information to do research or improve treatments. In all cases your name, address and other information that reveals who you are will be removed from the information given to researchers.
Business Associates. There are some jobs we hire other businesses to do for us. This include collection agencies. If we release information to a collection agency or small claims court, only the minimum will be sent: Name, dates of service, amounts owed, and last address. These businesses need to receive some of your PHI to do their jobs properly.

2. Uses and Disclosures Requiring Your *Authorization*

If we want to use your information for any purpose besides the TPO or those we described above we need your permission on an **Authorization form**. We don't expect to need this very often.
If you do authorize us to use or disclose your PHI, you can revoke that permission, in writing at any time. We cannot take back any information we already disclosed with your permission or that is used here.

3. Uses and Disclosures of PHI from Mental Health Records *Not Requiring* Consent or Authorization

The laws let us use and disclose some of your PHI without your consent or authorization in some cases.

When Required by Law:

1. Suspected child abuse.
2. If you are involved in lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process we may have to release some of your PHI.
3. We have to release some information to the government agencies which check on us to see that we are obeying the privacy laws.

For Law Enforcement Purposes

We may release medical information to law enforcement official to investigate a crime or criminal.

For Public Health Activities

We might disclose some of your PHI to agencies which investigate diseases or injuries.

For Specific Government Functions

We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to Worker's Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety

If we come to believe that there is a serious risk to your health or safety or that of another person or the public we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and Disclosures Requiring You to Have an Opportunity to Object

We can share information about you with your family or others who are close to you. We will only share information with those involved in your care and anyone else you choose such as close friends or clergy. We will ask you about who you want us to tell both general and specific information about your situation, conditions or treatment. We will honor your wishes as long as it is not against the law.

If it is an emergency -- we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information in an emergency, we will tell you as soon as we can.

5. An Accounting of Disclosures

When we disclose your PHI we keep records of whom we sent it to, when we sent it, and what we sent. You can get an accounting or a list of these disclosures. We have a log book this is kept in, which is in a locked area for safe-keeping.

E. If You Have Questions or Problems

If you need more information or have questions about the privacy practices described above please ask. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with us and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions if you complain.

Your Rights:

1. Copies of your medical information. There will be a charge for doing this.
2. A list of our business associates with whom we share medical information.
3. Request additional restrictions on your records.
4. Request changes to your medical records.
5. Request an address or phone number contact different from the ones we currently use.

If you have any questions regarding this notice or our privacy policies,
contact Beth Doyle at 503-391-1300 or by e-mail at beth@uppercircle.com