Intake Information

Upper Circle Inc

Date_____

1. Identifying Information

Name _____ Partner's Name_____

Address_____ City_____

ZIP_____ Mailing Address: _____

Phone _____ _____ _____ _____

Cellular work Home partner work or parents

DOB_____ SSN_____ SID _____

People living in your home _____

name, age, relationship to you

_____

Names of All of Your Children _____

name, age, relationship to you

Employer_____ Job _____Income _____

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

Current Offense(s)_____

Expiration of each Probation/Parole _____

What Drugs or Alcohol involved in offense?_____

Current and Prior Criminal History/Offenses _____

_____

Are you required to Register with State Police? ❍ Yes ❍ No

Is this conviction a plea bargain? ❍ Yes ❍ No

Did you commit this offense ? ❍ Yes ❍ No

How long have you had sexual difficulties? _____

Parole or Probation Officer _____ Phone_____

Attorney_____ Phone _____

DHS Case Worker_____ Phone_____

VA Case Worker_____ Phone _____

Mental Health Case Worker_____ Phone _____

Vocational Rehabilitation Worker_____ Phone _____

Substance Abuse Therapy Program _____ Phone _____

Other programs you are attending or involved in_____

Emergency Contact Person_____ Phone _____

When did the difficulty start that you are seeing me about_____

How much is this difficulty interfering with your life_____

What is the ideal resolution for this difficulty_____

Who is there to support you?_____

What are your spiritual beliefs?_____

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 currently experiencing in the past 90 days:

- ☐ Depression
- ☐ Extreme Sadness
- ☐ Trouble Concentrating
- ☐ Memory problems
- ☐ Change in Eating habits
- ☐ Feeling extreme happiness
- ☐ Unable to relax
- ☐ Lack of enjoyment of usual activities
- ☐ Self-Esteem Problem
- ☐ Perfectionism
- ☐ Obsessions or compulsion
- ☐ Feeling fearful
- ☐ Physical complaints of pain
- ☐ Problems with anger
- ☐ Feelings Easily Hurt
- ☐ Substance Use
- ☐ Hurting or cutting on self
- ☐ Upset with children or spouse frequently
- ☐ Racing, busy, or unquiet mind
- ☐ Suspended or expelled from school/work
- ☐ Missing Work or late for work
- ☐ No sexual interest
- ☐ Thoughts about hurting yourself or others
- ☐ Overly sensitive
- ☐ Worried about health
- ☐ Feeling Hopeless
- ☐ Feeling tearful
- ☐ Change in sleeping habits ( ) More ( ) Less
- ☐ 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 or twitching
- ☐ Acting violently
- ☐ Isolation or withdrawal
- ☐ Too Easily Persuaded
- ☐ Feeling Resentment
- ☐ Work has deteriorated
- ☐ Ignoring the needs or requests of partner
- ☐ Sexually promiscuous
- ☐ Falling asleep at work or school
- ☐ Unable to fall asleep or stay asleep
- ☐ Thoughts about killing yourself or others
- ☐ Dislike being alone
- ☐ Lack of friends or support from 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 ☐

Including: Family, EAP, Work Related counseling, Alcohol and Drug Counseling, Marital, Individual, Group, Diversion

When did you have counseling?

Who did you see?

What did you see them for?

Was this a good experience for you?

4. Medical Information

Who is your doctor?

What are you seeing a doctor for?

What medications are you taking?

Are you allergic to anything including medications or foods?

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 (circle) Meth Pot Crank Heroin Mushrooms LSD/Acid Peyote
MDMA Cocaine Prescription Drug abuse Inhalants Steroids

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, GA, ALANON or any other addiction program_____

Name of recovery programs you have participated in (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 _____

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 Beth Doyle M.A., LPC 1300 Boone Rd SE Salem, OR 97306 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, however, 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/wellness 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, sexuality, 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 regularly attend training and workshops to continue to update my skills and knowledge, I participate in organizations that increase my skills and support the work I conduct. 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; report, testimony or consultation is billed at the hourly rate. Initial appointment is $225.00. Cash discounts are given for both individual and group therapy. Reports for court are billed separately at $200 per hour fee and must be paid in advance. A $1500 Retainer for court appearances paid in advance. Unpaid balances are assessed a monthly finance charge and may be turned over to collections after 90 days. Books and treatment materials are sold individually at a separate fee from therapy fees, materials are sold for the use of client's and their families and no client is under any obligation to buy materials directly from the therapist, they are welcome to purchase materials from any store.

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

_____

Client Name Printed and Signature Date

_____

Client Name Printed and Signature Date

_____

Beth Doyle, LPC C1630 Signature Date

Provider Policy on Insurance and Billing Practices

We, your "provider," seek to communicate in clear terms the policies at UCI that will govern the range of billing, insurance billing and collection practices. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

1. By scheduling and attending appointments you are entering into a therapy and business relationship with the therapist, the therapist is providing a service for which you agree to pay regardless of whether your insurance pays a full or partial payment on the service.

2. Therapy fees are adjusted on an annual basis, and notification is given to all clients a month ahead.

3. Meetings requested on your behalf with other care professionals are billed at the current standard hourly rate.

4. Your insurance will **not** cover the cost of any of your sex offense related therapy.

5. A service charge of $25 is assessed for all checks returned by your bank for non-sufficient funds or written on a closed account. Over-payments are sometimes held over for a future visit if you are continuing to see us. We don't accept any other checks if one has bounced.

6. At the Coast location charge cards are not accepted, cash, check, money orders are accepted.

7. All unpaid balances after 90 days will be considered in default. This could result in your account being turned over to a collection agency. In the event you do not pay for the services provided to you, you will be required to pay for collection costs, as well.

8. If you are on a "payment plan" or have a special arrangement made with our billing department, it is expected that you will make monthly payments as agreed upon. Payments not received according to the plan will be considered in default and appropriate collection steps could be taken. Please provide a written plan to us to bring your bill current.

9. You are responsible to pay the full fee for any scheduled appointment canceled without at least 24 business hours notice. *For a Monday appointment you would need to cancel on Friday, etc*.

10. Frequent late cancellations or no-shows will result in termination of therapy.

11. Finance charges and late fees will be placed against accounts that are 30 days past due and on a monthly basis until the balance is paid in full. Additional Collection fees and Attorney/Court fees will be added to bills turned over to Collections up to a fee of thirty percent of the bill including all finance charges assessed at that point in time. Please pay your bill at each session and keep it current to avoid this situation.

I have reviewed the above policies and had all my questions answered to my satisfaction and understanding. My signature indicates I understand, agree to and will abide by these policies. I understand how the insurance and fees work. If I have insurance, I authorize Beth Doyle, LPC and UCI to release the information necessary to my insurance company to obtain payment.

_____ _____

Signature Print Name Date

_____ _____

Signature Print Name Date

Upper Circle Inc
503.391.1300

1300 Boone Rd SE
Salem, OR 97306

UCI Office Policy Statement

Appointments and Cancellations

Appointment times are scheduled on the hour or half hour and run 45-50 minutes for standard sessions, or 60+ minutes for extended therapy sessions. Your scheduled time is reserved just for you. If you know that you need to change your appointment please call at the earliest possible time to change it. **Cancellations are required 24 hours in advance.** For Monday appointments cancellations need to be received on Friday. The therapy session fee is charged in full for appointment missed or canceled at a later time. If you fail to show to an appointment without calling at least 24 hours in advance to cancel an appointment two times and do not call within 30 days to reschedule, it will be considered that you have terminated treatment with UCI. *Please keep track of your scheduled appointment days and times.*

Description and Length of Treatment

Individual therapy usually involves regularly scheduled weekly or bi-weekly sessions. The duration of treatment varies depending on the nature of the treatment and the individual client needs. I provide psychotherapy services to clients age 5 - 95 years of age. These services include initial assessment, individual, group, couple, and family therapy. A variety of therapies addressing mind, body, spirit and emotion are available to provide relief

Telephone Calls, Texts, or Emails

You can reach me by phone when I am available, otherwise you will reach voice mail or an answering/scheduling service. There is no charge for ***brief phone calls***. Prolonged or frequent calls will be billed at the current hourly rate and quarter hour increments. I do not accept text messages. Emails to schedule appointments are an acceptable manner of contacting me and to share information. Email is not a proper method for us to discuss important and sensitive personal issues.

Emergencies

The scope of my practice does not permit me to respond to calls outside regular hours except by prior arrangement. I do not provide crisis or emergency services or constantly check my voice mail. If you need immediate support before I am able to return your call, I recommend you call one of the 24 hour crisis lines such as Marion County Crisis at 503.581.5535 or 911.

Fees and Payments

My fee is **$100** for a 45-50 minute session sexual abuse therapy, group is **$50**, payment is expected in full on the day of your session. In Salem by check, cash, money order or credit card, which is not available to Coast.

Confidentiality

State Law protects confidentially between a client and counselor with some exceptions. If I am ethically or legally bound to breach confidentiality I would attempt to do so with your understanding and input.

Exceptions to Confidentiality: harm to self or others; custodial and non-custodial parents have access to information equally; insurance may inspect your file; compelled records for a subpoena; court hearing where records are involved.

With Children under 18:

When I work with children I let them know that I may share specific information at my discretion with their parents/guardian/caregiver if there is a serious concern or danger of them being harmed by another. I like to meet with the child alone, without meeting with the parents at the same time before or after the session. Parents are welcome to meet with me after every three - four sessions with their child to discuss updates and changes and assess the progress of therapy.

HIPPA

UCI is compliant with HIPPA. A privacy policy is available to you on-line or in the office. Signing this document indicates that you understand your records are private unless you sign a release of information.

Ethical Guidelines

It is my commitment to conduct a relationship with you abiding by the highest ethical and professional standards, as specified by American Counseling Association Code for therapists. Please be assured that I view the purpose of the therapist-client relationship to exist solely to enhance the client's welfare and the achievement of therapeutic goals. Accordingly, boundaries, including physical and emotional, will be respected at all times. When we create treatment goals we will discuss the scope of our relationship. *Please understand that I can only be your therapist.* I cannot have other roles in your life such as friend, romantic partner or become a client of your work or services. Be assured that any contact you have with a therapist or physician should be free of sexual contact, dating, sexual pressure and any violations should be reported.

Access to Information

You have every right to be fully informed about your treatment. I urge you to ask any questions. If something is not clear please discuss it with your therapist first to resolve and get clarification.

Informed Consent

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 in addition to the forms you filled out. I need all of this information to develop a complete understanding of how I may help you. We will discuss your goals, a plan, the anticipated benefits and risks, and 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.

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 may 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.

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.

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 a minimum of 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.

I have read and understand the policies described and agree to these policies. I have received the Professional Disclosure Statement (PDS), Office Policy Statement, Provider Policy on Insurance and Billing Practices and have had my questions fully answered to my satisfaction.

_____ _____

Signature Printed Name Date

_____

Beth Doyle, MA, Clinical Certified Sex Offender Therapist Date

Upper Circle, Inc.
1300 Boone Road SE
503-391-1300

Beth Doyle, M.A.
Salem, Or 97306
Fax 503-391-0476

Agreement to Pay for Professional Services

I request that the therapist named below provide professional services to me and I agree to pay this therapist's fee of $100 per individual therapy hour for these services and $50 per group therapy session. Generally this results in a $200 fee per month, payable at each session or by arrangements and written agreement. Individual, family, clarification, drama, couple therapy are billed separately at individual rates for those services and payment is expected at the time of service.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person, in writing, or by certified mail, that I wish to end therapy. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me although other persons may make payments on my account and I may file these charges with my insurance company.

I have also read this therapist's Treatment Contract or Brochure, and agree to act according to the stated guidelines. Any collection, court or attorney costs related to collecting payment for these fees are my responsibility. An 18% finance charge is added to unpaid bills each month, termination or suspension from therapy may result from unpaid bills.

When groups or individual therapy sessions are scheduled, failing to attend does not result in no fee, you are still liable for the full fees, that includes times when you may be in custody and will need to pay for the fees.

_____

Signature of client Date

_____

Printed name

_____

Parent or Guardian Signature Date

I have discussed the issues above with this client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to engage in therapy.

_____ _____

Beth Doyle, LPC Date