Licensed Psychology Associates, LLC
P: (855) 583-2842 F: (503) 678-9751

INTAKE FORM

Name: _____ Today's Date_____

Address: _____
(Street) (City) (Zip)

Telephone Number: (H)_____ (C)_____ (W) _____

May I leave confidential messages for you at your home and/or cell numbers? Yes ☐ No ☐

Would you like to receive system-generated appointment reminders on your cell phone? Yes ☐ No

SSN: _____ Age: _____ Date of Birth: _____

Education Level: _____ Occupation: _____

Employer: _____

Marital /Relationship Status: _____How long? _____

Emergency Contact: 1. _____
(Name) (Phone)

Emergency Contact 2: _____

Who lives in your home with you? _____

_____

Have you been in therapy before? Yes ☐ No ☐ If yes, please list dates (month/year).

_____

Are You Currently Experiencing Any Suicidal Thoughts? Yes ☐ No ☐

Have You Experienced Them in the Past? Yes ☐ No ☐

Have You Ever Attempted Suicide? Yes ☐ No ☐

Do you smoke? Yes☐ No☐ How many cigarettes a day?_____

Do you drink alcohol? Yes☐ No☐ How much/how often? _____

Do you drink caffeinated products? Yes☐ No ☐ How many a day?_____

Do you use other types of drugs? Yes ☐ No ☐ Including marijuana and prescription narcotics, what drugs do you use and how often?

_____

Have you had drug or alcohol problems? Yes☐ No ☐

Were you ever convicted of a crime? Yes☐ No☐ If yes, when and what?_____

_____

Are there any guns or weapons in your home? Yes ☐ No ☐

Do you have any chronic medical conditions? Yes ☐ No☐ If yes, please describe. _____

_____

Please list medications you are currently taking. _____

_____

What are sources of stress in your life at the present time?

1._____

2._____

3._____

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Place an "X" on the following scale to indicate how well you are coping at the present time. 100% means you are coping the best you ever have.

I----------I----------I----------I----------I----------I----------I----------I----------I----------I---------I
0 10 20 30 40 50 60 70 80 90 100%

YOUR GOALS IN THERAPY

What would you like to change or achieve by coming to therapy?

1._____

2._____

3._____

INSURANCE

If you are using insurance, who is your insurance provider? _____

Insurance Member ID _____ Group Number _____

Who carries the insurance? Name: _____ Date of Birth _____

SSN _____ Employer _____

Address _____
(Street) (City) (Zip)

Are you carried on another insurance policy? Yes☐ No ☐

Thank you. Please sign and date below to indicate your consent for treatment.

CONSENT TO TREATMENT

I hereby consent to participate in treatment.

_____
(Signature) (Date)

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AGREEMENT FOR SERVICE/INFORMED CONSENT

Introduction

This agreement is intended to provide you with important information regarding the practices, policies and procedures of Licensed Psychology Associates, LLC and to clarify the terms of the professional relationship between your therapist and you, the client. Any questions or concerns regarding this Agreement should be discussed with your therapist prior to signing it.

Therapist Background and Qualifications

Therapists at Licensed Psychology Associates have achieved a minimum of a Master's Degree in Psychology, Social Work, or Counseling. Your therapist has completed an internship under licensed supervision and passed a licensing exam. He or she has achieved and maintains a license in good standing under the licensing Boards of Oregon and/or Washington.

Risks and Benefits of Therapy

Participating in therapy may result in a greater capacity for joy, compassion, acceptance and well-being. Such benefits may require substantial effort on your part including active participation in the therapeutic process. There is no guarantee that therapy will yield these results.

The therapeutic process may also include feelings of discomfort along the way. This is normal in a healing process. Please tell your therapist about any discomfort you experience so that you may work together to safeguard your self-care, adjust the process, and/or plan for increased frequency of sessions as needed.

Psychotherapist-Client Privilege

The information you disclose in therapy, as well as any records created, are subject to psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between you and your therapist in the eyes of the law. Typically, you are the holder of the psychotherapist-client privilege. That means if your therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, he or she will assert the psychotherapist-client privilege and refuse to provide any information until instructed by you in writing to do so. An exception to this can occur if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding psychotherapist-client privilege with an attorney.

Fee and Fee Arrangements

The usual and customary feel for face-to-face service is $135 for a 60-minute session and $175 for the initial Intake session. These fees may be adjusted by contract with your insurance company, managed care organization, or other third-party payer, or by agreement between you and your therapist.

From time-to-time, you and your therapist may engage in telephone contact for purposes other than scheduling sessions. In addition, upon your request, and with your written authorization, your therapist may engage in telephone contact with third parties. You are responsible for payment of the agree-upon fee on a pro rata basis for telephone calls longer than ten minutes.

You are expected to pay for services at the time they are rendered. Exceptions are for clients who are using insurance companies with whom the therapist has a contractual or out-of-network relationship. In these cases, you may be required to pay a copay or coinsurance amount for each session and your therapist will bill the insurance company on your behalf. If your insurance company pays you directly, you will be responsible to pay for your sessions at the time services are rendered. You will be responsible to pay for services until any insurance deductible is met and for services that are not covered or for which payment is denied. You are responsible for verifying and understanding the limits of your insurance coverage, as well as your co-payments and deductibles.

For clients referred by the Veteran's Choice program, all fees are waived.

Cancellation Policy

As a client, you are responsible to pay the full session fee for sessions you miss without cancelling within 24 hours unless the cancellation is due to serious illness or emergency. Most insurance companies do not pay for cancelled sessions, so it is important that you remain aware of the need to cancel to avoid being charged. The same-day cancellation fee may be waived by the therapist if you and your therapist are able to reschedule your session within the same week. Cancellation notice should be left on your therapist's voicemail at 855-583-2842.

Therapist's Availability

Your therapist's office is equipped with a voice mail system that allows you to leave a message at any time. Your therapist will make every effort to return calls within 24 hours (or by the next business day). Your therapist does not provide 24-hour crisis service, so if you require immediate medical or psychiatric assistance, please call 911 or go to the nearest emergency room.

Social Media and Electronic Communication

Your therapist will have no relationship with you over social media platforms. With the exception of system-generated appointment reminders authorized by you, your therapist will not contact you via unsecured email or text messaging. Your therapist is not responsible for breaches of information that occur as a result of your use of electronic communication.

Termination of Therapy

Your therapist may terminate therapy at his or her discretion. Reasons for termination include but are not limited to having met your goals in therapy, non-payment of fees, conflict of interest, lack of participation or progress over time, or if your needs are outside the therapist's scope of practice or competence.

You have the right to terminate therapy at your discretion for any reason. Upon either party's decision to terminate therapy, your therapist will recommend sharing at least one termination session. Termination sessions are intended to facilitate a positive end of the therapeutic relationship and to reflect on the work that has been done. In cases where you may continue therapy with another provider, your therapist will provide three referrals.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands this Agreement. Client agrees to abide by the Agreement and consents to participate in psychotherapy. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client Name (please print)

Signature of Client

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payer. (**Does not apply to Tri-West Veterans.)**

Name of Client or Responsible Party (please print)

Signature of Client or Responsible Party

Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your therapist is required by law to maintain the privacy and security of your Protected Health Information (PHI) and to provide you with this Notice of Privacy Practices Your therapist must abide by the terms of this Notice, and notify you if a breach occurs.

Except for the specific purposes set forth below, your therapist will use and disclose your PHI only with your written authorization. It is your right to revoke authorization at any time by providing written notice.

PHI may be disclosed without your Authorization for the following reasons:

1. **For Your Treatment.** I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a psychiatrist, I can disclose your PHI to them to help coordinate your care. In addition, Licensed Psychology Associates, LLC works with a Practice Manager for scheduling and billing. The Practice Manager does not have access to your clinical records or psychotherapy notes.
2. **To obtain payment for your treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided, or to a collections agency due to non-payment.
3. **For health care operations.** I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice. For example, I may need to disclose your PHI to an attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require your Authorization

1. **Psychotherapy Notes**. Any use or disclosure of psychotherapy notes requires your Authorization unless the use or disclosure is:
    a. For my use in treating you.
    b. For my use in training, consulting with, or supervising other mental health practitioners. (Your name is not used in this case, and all parties to the disclosure are bound by law to protect your PHI.)
    c. For my use in defending myself in legal proceedings brought by you.
    d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPPA.
    e. Required by law, and the use or disclosure is limited to the requirements of such law.
    f. Required by a coroner who is performing duties authorized by law.
    g. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes.** As a Psychotherapist and pertaining to Licensed Psychology Associates, LLC, we will not use or disclose your PHI for marketing purposes.

3. **Sale of PHI**. As a Psychotherapist, and pertaining to Licensed Psychology Associates, LLC, we will not sell your PHI at any time.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court order.
5. For law enforcement purposes, such as reporting crimes occurring on my premises.
6. To coroners or medical examiners, when performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition. (In this case your name or contact information is not disclosed.)
8. Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations, or, helping to ensure the safety of those working within or housed in correctional institutions.
9. To comply with workers' compensation laws.
10. For appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment.

Certain uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your health care or the payment for your health care, unless you object in whole or in part. Your consent may be obtained retroactively in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations if the PHI pertains solely to a health care item or service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
4. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, within 30 days of receiving your written request. I may charge a reasonable, cost based fee for doing so.

5. **The Right to Get a List of the Disclosures I Have Made.** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request.
6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper and/or email copy of this Notice.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you think I may have violated your privacy rights, you may file a complaint with your therapist and/or with Dr, Judatha Kline, Licensed Psychology Associates, LLC at 9123 SE St. Helens St. Ste. 270B, Clackamas, OR 97015.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on 10/09/2017.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices*. Please review and ask any questions you may have before signing.

I acknowledge receipt of the *Notice of Privacy Practices* of Licensed Psychology Associates, LLC and

_____.
(therapist name)

Signature: _____ Date: _____
(client/parent/conservator/guardian)