**I N T A K E F O RM** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status: □ Never Married □ Domestic Partnership □ Married□ Separated □ Divorced □ Widowed □ Child**

 Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pt’s birthdate: \_\_\_ /\_\_\_/\_\_\_

Parent’s Name: (If under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we leave a **message**? □ Yes □ No **TEXT** □ Yes □ No

Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Member ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Group#** **\_\_\_\_\_\_ Co-pay:** \_\_\_\_ W**ho is the subscriber? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Relationship? \_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_**

***Did your meet deductible? Yes \_\_\_ NO \_\_ If not are you able to pay full fee of $80.00 for per session***

**Reason for coming into counseling today:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past experience with counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What significant life changes or stressful events have you experienced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_**

Any recent losses or changes recently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If client is under 18**: Describe your school experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Significant other/other parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any siblings/ children/age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION: Counseling History… Medications, etc. >>>**

|  |  |  |  |
| --- | --- | --- | --- |
| **Therapist Name** | **Reason** | **Type: Couples/self** |  **Year- for how long?**  |
|  |  |  |  |
|  |  |  |  |
|  **Medications** | **Who is prescribing** | **Reason** | **Year (s) Date?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Last seen Doctor /Psychiatrist** | **Why?**  | **Date:** |
|  |  |  |
|  |  |  |

List medical concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you getting treatment for your medical concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any specific sleep problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of exercise do you do and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Any difficulties with your eating or appetite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Suicidal thoughts□ No □ Yes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ please describe: \_\_\_\_\_\_\_\_\_\_Plan: □ No □ Yes \_\_ Attempts in past or Psychiatric Hospitalization? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any panic, attacks, phobias and for how long? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ any chronic pain and are you taking medications? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do your drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marijuana usage □ No □ Yes how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have a Marijuana Medical Card □ No □ yes and for what medical issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you in a relationship? □ No □ Yes for how long: \_\_\_. On a scale from 1 (poor) - 10 (great) rate your relationship: \_\_\_\_\_\_ any domestic violence or control issues in this relationship? □ No □ Yes Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Alcohol Usage** | **Last Use:** | **How often:** | **How Many:** |
|  |  |  |  |
| **Any DUI?**  | **Year of DUI** | **Past TREATMENT** | **Current Treatment:** |
| **Drug (s) Problem** | **Yes No**  |  |  |
| **Any family members****With alcohol or drug problems?** | **List family members here:** | **Impact on you:**  | **Comment:** |
| **Any illegal drug usage?** | **Yes NO**  | **Type of drugs(S)** | **Prescription Drug Use?** |
| **Weapons in Home** | **Yes No** | **Family members have guns or knife collections?**  | **Describe:**  |
| **Sexual Problems** | **Self: Yes No** **Family member Who?** | Describe:  | **Describe:** |
| **Gambling issues** | **Self-Yes NO**  | Describe: |  |
| **Gambling Issues**  | **Family: Who?** | Describe: |  |
|  |  |  |  |
|  |
|  |

HIPAA Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations:

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

• Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

For more information about HIPPA or to file a complaint, please contact:

• The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(877) 696-6775 (TOLL FREE)

I, (client name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of Notice of Privacy Practices. Katherina Alexandre, M.A. Licensed Marriage and Family Therapist.

 Signature (your legally binding signature here):

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Limits OF CONFIDENTIALITY**

Contents of all therapy sessions are considered to be confidential. Both verbal information and

Written records about a client cannot be shared with another party without the written consent of

The client or the client’s legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health

Professional is required to warn the intended victim and report this information to legal authorities.

In cases in which the client discloses or implies a plan for suicide, the health care professional is

Required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently

Abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the

Mental health professional is required to report this information to the appropriate social service

And/or legal authorities. That are potentially harmful.

**Minors/Guardianship** Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers and Billing Services (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. I use Heritage Billing Services for billing your insurance or responsible party.

**I agree to the above limits of confidentiality and understand their meanings and ramifications.**

**Client Signature (s) (Client’s Parent/Guardian if under 18)**

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, experiences and memories for the purpose of creating positive change so Patient can experience life more fully. It provides an opportunity to better and more deeply understand one self and any difficulties one may be experiencing.

Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular issues being addressed, as well as many other factors. Therapy may result in a number of benefits to Patient, including but not limited to less stress/anxiety, fewer negative thoughts/behaviors, better relationships, more comfort in social/work/family settings, and more self-confidence.

Such benefits may require substantial effort by Patient, including active participation in therapy, honesty, and openness to change feelings/thoughts/behaviors. There is no guarantee therapy will yield any or all of the benefits above. It may involve some discomfort, including recalling and discussing unpleasant feelings/experiences, and may evoke strong feelings of sadness, anger, fear, etc. At times Therapist may challenge

Patient’s perceptions and offer different perspectives. Issues Patient presents may result in unintended outcomes, such as relationship change. Any decision as to his/her personal relationships is Patient’s responsibility. During the therapy process, many find that they feel worse before they feel better; this is normal. Patient should discuss any concerns with Therapist.

**Acknowledgment and Consent to treat:**

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed the terms and conditions with therapist and any questions have been answered to Patient’s satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient 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.

I understand that I have the right not to sign this form. I hereby agree to enter into therapy with Katherina Alexandre (or to have my child or children) as shown by my signature

There.

This agreement contains important information about our professional services and business policies. You may revoke this agreement in writing at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or authorized representative) Date

**Office Policies for Katherina Alexandre, LMFT 503-890-2454**

**Welcome: Sessions generally are 45 minutes long.**

**Payment for Service: Please check with your insurance company what your co-pay is, or if you need to meet the deductible. Thank you. Copay’s and deductible are due at the time of the appointment.**

You are expected to pay for services at the time they are rendered unless other arrangements have been made. My standard office fee is $ **80.00 for 45 minute session, 60 Minutes $ 100.00 Intake Session $140.00.** If you cannot afford my standard fee, please discuss the matter with me.

 Employee Assistance Program: Who is your EAP provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many sessions have you been authorized? \_\_\_\_Authorization #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment and Billing:** You agree to pay all fees due at the time services are delivered and authorize this office to file claims for all reimbursable services, as identified under Name of Insurance Company above, which includes releasing any and all medical information necessary to process a service claim and request third party payment of benefits to the office of Katherina Alexandre, LMFT. Insurance will be verified, however, if insurance denies coverage and/or there is an out of pocket deductible to be met, you agree that you are responsible for the fees for services rendered directly. *Payable at time of each visit, unless otherwise arranged.*

**Cancellation:** Since an appointment reserves time specifically for you, a minimum of 24-hour notice is required for rescheduling or cancellation of an appointment. Two missed appointments or cancelled appointments with no contact will result in closing your case. You are welcome to return to counseling. Therapist may need to cancel and reschedule sessions as needed due to emergencies, illness or scheduling error or double booking. Please keep in mind that sometimes a session may not start at your scheduled time.

**Office Hours:** My office hours are from 12: OO PM to 7:00 PM, Monday, Tuesday and Wednesdays and some Saturdays. If you need to contact me between sessions, please leave a message and I will return your call as soon as I am able.

**Cell phones**: It is important for you to know that cell phones may not be completely secure and confidential. If you would like for me not to use a cell phone when contacting you, please let me know. **Text Messaging and Email:** Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. Please know though that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations, administrative tasks and short messages. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. Due to e-mail volume if you do not get a response in a timely fashion note it may not have been received or read. Leave a phone message to alert me to it.

**Emergency Procedure:** An emergency is an unexpected event that requires immediate attention and can be a threat to your health call 911 or to your closest Hospital. Please call these local resources below for additional support during a crisis.

***24 Hour County Crisis Lines: Clackamas: 503-655-8585 Washington: 503-291-9111***

***Marion County 503-585-4949 Yamhill County 800-735-2900***

**County Domestic Violence Lines: Clackamas Women’s Services (503) 654-2288 Washington Domestic violence Resource Center *503-469-8620* Marion Mid Valley: (503) 399-7722 Yamhill County Henderson House 503-472-1503**

A satisfaction survey will be sent to your address, when sessions are missed or cancelled and/or services are terminated to help improve services.

**I understand the office Policies**. Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Professional Disclosure Statement**

**Katherina Alexandre, M.A. Licensed Marriage and Family Therapist #T0533**

8855 Holly Lane #101 Wilsonville OR 97070

503-890-2454

**Philosophy and Approach to Counseling**

My approach to counseling is based in client-centered, cognitive-behavioral, and solution-focused theory. I believe that counseling provides opportunities for self-awareness and personal growth within the context of a safe and supportive therapeutic relationship. I employ a collaborative approach where together we will identify treatment goals and work toward achieving those goals.

**Formal Education and Training**

I hold a Master’s Degree in Clinical psychology from New College of California in San Francisco, CA... Major course work included: intro to psychotherapy, human development, psychopathology, family therapy, social and cultural foundations, group dynamics, and treatment of anxiety and childhood disorders. I have experience counseling adolescents, adults, couples, and groups. My work with clients include crisis management, adolescent issues and development, depression, stress management, parenting, posttraumatic stress, sexual abuse, and grief.

I am a Licensed Marriage and Family Therapist with the Oregon Board of Licensed Professional Counselors and Therapists; I am required to participate in continuing education. I will abide by its Code of Ethics.

**The fee for counseling sessions are as follows: 45 minutes is $80.00, 60 Minutes $100.00 Intake Session is $140.00 . Sliding Scale Available**

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; and 5) Defending claims brought by client against licensee;

To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

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

**Email:** **lpct.board@state.or.us** **Website:** [**www.oregon.gov/OBLPCT**](http://www.oregon.gov/OBLPCT)

Electronic Records, Billing and Payment

I keep and store records for each client in a record-keeping system produced and maintained by Office Alley, Therapy Notes and Therapy appointments. These systems are “cloud-based,” meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

* I have entered into a HIPAA Business Associate Agreement with Office Alley, Therapy Notes and Therapy Appointments. Because of this agreement, by Office Alley, Therapy Notes and Therapy appointments are obligated by federal law to protect these records from unauthorized use or disclosure.
* The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
* By Office Alley, Therapy Notes and Therapy appointmentsemploys various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
* I have my own security measures for protecting the devices that I use to access these records:
	+ On computers, I employ firewalls, antivirus software, and passwords to protect the computer from unauthorized access and thus to protect the records from unauthorized access.
	+ With mobile devices, I use passwordsto maintain the security of the device and prevent unauthorized persons from using it to access my records.

Here are things to keep in mind about my record-keeping system:

* While my record-keeping company and I both use security measures to protect these records, their security cannot be guaranteed.
* Some workforce members at by Office Alley, Therapy Notes and Therapy appointments, such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate by Office Alley, Therapy Notes and Therapy appointment are obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.

Payments using your credit/debit card:

 I do use Square for payments and some invoicing and is not secure. I also use Heritage Billing Service.

I understand and have read this information:

Please sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Private Practice Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**Social Media Policy** My primary concern is your privacy. If you share this concern, there are more private ways to follow me on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate you’re having a public link to my content. You are welcome to use your own discretion in choosing whether to follow me.

Note that I will not follow you back. I only follow other health professionals on Twitter and I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients’ online content outside of the therapy hour can create confusion in regard to whether it’s being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

If you need to contact me between sessions, the best way to do so is by phone or texting for administrative matters. Direct email at therapistpdx@mail.com for administrative matters only or scheduling can be done on [www.therapyappointments.com](http://www.therapyappointments.com) See the email section below for more information regarding email interactions.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions

**Please sign if you are wanting couples or family counseling.**

**“No Secrets” Policy for Family Therapy and Couple Therapy**

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing

Confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(the therapist), and that we enter couple/family therapy in agreement with this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name of Patient (*please print) (please sign)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name of Patient (*please print) (please sign)*

Katherina Alexandre, LMFT \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name of Therapist/Counselor

**Please sign if I am seeing your child:**

**MINORS & PARENTS**

Clients under 18 years of age and their parents: be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to

Successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they

Agree, during treatment, your counselor would provide them (if requested) only with general information about the progress of your treatment, and your attendance at scheduled sessions. Any other communication to your parents will require your Authorization, unless we feel that you are in danger or are a danger to someone else, In which case, we will notify the parents of our concern. Before giving parents any information, your counselor will discuss the matter with you, if possible, and do her/his best to handle any objections you may have. In cases of divorce, a copy of the divorce decree indicating parental rights to view records and participate in treatment will be required.

**Parental Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**