Jacquelyn Ekern, MS, LPC
Licensed Professional Counselor
11358 Highcrest Court
Redmond, Oregon 97756
(541) 256-2923 office

Statement of Understanding and Consent for Treatment

It is important that you are a willing participant in your treatment. If you have any questions or concerns about this document or the services provided, please inquire about it. Feel free to seek other professional opinions and options so that you feel that you are engaged on the best course of action to meet your needs. I am generally available by phone and appointment. You may call and leave a message at any time and I will return your call as soon as possible. My policy for after-hours coverage is to leave a message and I will return your call the next business day. If you are in need of urgent or emergency services after hours and are unable to reach me, contact your local social services, crisis line, or dial 911.

Please understand that information obtained from you is confidential under Oregon law. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.

2. When there is reasonable cause to believe that you will hurt yourself or someone else.

3. When there is reasonable suspicion to believe that abuse and/or neglect of a child, an elderly person, disabled person, or any animal is occurring or has occurred.

4. Information necessary for billing purposes, justification of treatment, and resolution of a complaint.

Your initial beside each of the following indicates your understanding and consent for treatment: _____ I understand that I may withdraw consent for treatment at any time. If I have not been in contact over a 60-day period, my treatment will be considered closed but can be reopened at any time with mutual consent.

_____ I understand and have reviewed statement of financial responsibilities.
_____ I have received a professional disclosure statement.
_____ I have received a copy of HIPAA's Notice of Privacy Practices.
_____ I understand that any records sent to or retrieved from other professionals will be marked and directed as "NO FURTHER DISCLOSURE" to protect your privacy.

Your signature indicates that you understand this "Statement of Understanding and Consent for Treatment" and agree to the above. I hereby give Jacquelyn Ekern, MS, LPC consent to provide my treatment.

_____ _____ _____
Print Name Client Signature Date

_____ _____
Clinician Signature Date

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Statement of Understanding and Consent for Electronic Communication

I utilize various methods of communication to maintain contact with clients. Please understand my office is portable and thus phone contact with me will be on a cellular phone through a secure router in my office. There are various methods of contact with me including phone, text, and email. I use text messaging in limited circumstances.

Please be aware that electronic communication via telephone or the internet may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone, video, or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Unless it is a part of a treatment plan, information transmitted via email should be used for scheduling or other incidental issues only. Contacts to discuss all other issues should be made preferably in person, in hippa compliant online session, or via phone if an emergency arises.

As a general rule, I do not have contact with clients outside of the office that is unrelated to mental health treatment. This rule applies to various internet messaging sites, social networking sites, and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

_____ I understand the risks associated with utilizing electronic methods of communication and agree to do so at my own risk.

_____ I understand email contacts will be for scheduling and incidental purposes. All other forms of communication will be made preferably in person, in hippa compliant online session, or via phone if an emergency arises.

_____ _____

Client Signature Date

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Statement of Financial Responsibility

Insurance: I am not in-network with any insurance providers, at this time. However, I will provide an invoice to you each month which may possibly be accepted by your insurance carrier as out of network. The balance due is your responsibility at the time of service, whether your insurance company pays for services or not. Please be aware of your insurance policy provisions and benefits available to you. Your insurance policy is a contract between you and your insurance company and you should contact them for exact benefits, authorization, and network/non-network coverage. I do not guarantee a payment made by your insurance company.

Fees: I provide these services: Intake services at $175.00 per 50-minute session, and therapy services at $160.00 per 50-minute session. This payment represents a charge that is reasonable and customary for services rendered. If your insurance pays a lower reimbursement of "reasonable and customary" charges, you will be responsible for the difference. Payment is generally due in full by credit card at each session. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

Cancellation Policy: Please call 24 hours in advance to change or cancel an appointment to allow that time for another person. You are able to leave a message 24 hours a day. If you do not show for an appointment and do not call to cancel, you may be billed for that session. This charge is not covered by insurance.

Payment Policy and Agreement: I authorize Jacquelyn Ekern, MS, LPC to charge the following account for services according to the financial policies and payment agreement above.

Type of card: Visa___ MasterCard___ American Express___ Debit___

Account Number:_____Expiration Date:_____
Card Holder Name:_____ Security Code:_____
Address:_____ Billing Zip Code:_____
Signature:_____

I have read this Statement of Financial Responsibility. I understand that I am responsible for my bill, payable to Jacquelyn Ekern, MS, LPC

_____ _____
Signature Date

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CLIENT INFORMATION/HEALTH HISTORY

Name: _____Date:_____
Address: _____
Phone: _____Home _____Cell
Authorization to send mail: Yes____No____Authorization to leave messages: Yes____No____
Preferred method to contact: _____
Birth date: _____
Emergency Contact: _____Relationship:_____Phone: _____
Marital Status:__ single __ married __ widowed __ divorced__ separated __ living as married
Children: (Age/Sex)_____
Employment Status:__ working__ unemployed__ retired__ disability Employer:_____

Health History

Adverse Drug Reactions/Allergies: _____
Primary Care Physician: _____Phone: _____
Height: _____Weight: _____
Describe current concerns about your physical health: _____
_____
Past illnesses and treatment: _____
Past medical procedures or surgeries? _____
History of accidents/outcome: _____
Past/current menstrual, prenatal, pregnancy, labor/delivery, postnatal issues:
_____
Physical impairment/limitations/disability:_____
Recent hospitalizations in past 2 years:_____

Current Medications including over the counter drugs, vitamins, herbal supplements

Dosage	Condition Treated	Prescribed by	Comments

Have you had counseling previously? ___ Have you ever received other mental health treatment other than counseling, such as inpatient, hospitalization, etc? _____

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RISK ASSESSMENT

Suicidal thoughts □Past □Current Thoughts □Plan □Intent □Attempts Method_____
Self harm □Past □Current □Thoughts □Plan □Intent Method_____
Aggression □Past □Current □Thoughts □Plan □Intent Method_____
Have you ever had any criminal legal difficulties?_____
Ever lived in □Jail □Detention □Prison □Nursing Facility □Shelter □Homeless

SUBSTANCE ABUSE AND ADDICTION ASSESSMENT

Do you think you have a problem with □drugs or □alcohol?
Do others believe you have a problem with □drugs or □alcohol?
Do you have a problem with another type of addiction such as □gambling, □shopping, □sex, □food, □money, or □work?
Do you have these concerns with addiction or substance abuse: □health problems, □legal problems, □increased tolerance to substances, □family history of addiction, □black-outs or memory loss, □difficulties in family, friends, work, or school, □tried to cut down or quit, □received help for addiction?

Please tell me about any issues not noted above:
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