Melinda Reynolds Peña LPC
Licensed Professional Counselor
14523 Westlake Drive Suite 3
Lake Oswego, OR 97035
503-816-8618 office
503-266-1983 fax
email@melindareynolds.net

Client Information and Health History:

Today's Date: _____

Name: _____Birth Date: _____
Address: _____
Best Contact Phone: _____
Email: _____
Emergency Contact Name: _____
Relationship: _____
Emergency Contact Phone: _____

If you are filling these forms out for your teenage child, please have them check their own boxes in the Health History section on the next page and have both parent and child sign the forms.

Health History

Primary Care Physician: _____Phone: _____
Please describe any current concerns about your physical health:

_____
_____
_____

Significant medical experiences:

_____
_____
_____
_____
_____

Current Medications

Medication & Dosage Condition Treated Prescriber

_____
_____
_____
_____
_____

Are you experiencing any chronic pain? _____ Are you receiving treatment? _____

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Please check if you have difficulty or history of any of the following:

Abnormal Bleeding		Fainting Spells		Long term memory		Seizures	
Addiction		Fear leaving home		Mania		Self harm	
Aggression		Financial concerns		Medication issues		Sexual abuse	
Anemia		Gastro-intestinal		Mood swings		Short term memory	
Anger		Hallucinations		Nervousness		Skin Problems	
Anxiety		Headaches		Nightmares		Sleep disturbances	
Appetite problems		Head Injury		Night sweats		Social anxiety	
Asthma/Respiratory		Heart/Circulatory		Obsessions		Stress	
Cancer/Tumors		Hypertension		Pain		Thoughts of death	
Compulsions		Hypervigilance		Panic		Trauma	
Concentration		Infections/HEP		Paranoia		Trauma flashbacks	
Confusion		Insomnia		Personality Disorder		Veteran/Military	
Depression		Intrusive thoughts		Phobias		Visual difficulties	
Diabetes		Irritability		Physical abuse		Hearing difficulties	
Dietary changes		Joint/Muscle		Pneumonia		Tinnitus	
Disordered eating		Kidney Disease		Racing thoughts		Weight gain/loss	
Domestic Violence		Learning/Focus		Relationships		Worry	
Emotional abuse		Legal difficulties		Restlessness		Employment	
Other:		Other:		Other:		Other:	

Have you had counseling previously? _____ If yes, was it helpful? _____
Other than counseling, have you ever received other mental health treatment such as inpatient, hospitalization, etc.? _____
Are you having current legal difficulties? _____
_____

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Risk Assessment:

Have you experienced any of the following:
Suicidal thoughts: □Past □Current □Plan □Intent □Attempts
Method_____
Self harm: □Past □Current □Thoughts □Plan □Intention/Action
Method_____
Aggression towards others: □Past □Current □Thoughts □Plan □Attempts
Method_____
Lived in: □Jail □Détention □Prison □Foster Home □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 relationships, work or school, □tried to cut down or quit, □received help for addiction?

Have you had a family member or significant person in your life commit suicide or make attempt/s? _____
If yes, what was/is your relationship with that person?

Thank you for answering all these questions 😊

Is there anything else you would like me to know before we start talking?

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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 services provided, please inquire. 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, Monday through Thursday. 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 next business day. If you are in need of urgent or emergency services after hours, contact your local emergency room, 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 you understand and give 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 have been given a No Surprises Document
_____ 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 Melinda Reynolds Peña, LPC consent to provide my treatment.

_____ _____
Client Signature Date

_____
Parent Signature

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Statement of Understanding and Consent for Electronic Communication

Specific methods of communication are used to maintain contact with clients. Please understand this office is portable and thus phone contact with me will be on a cellular phone, and emails through a secure router in this office. Text messaging is utilized in limited circumstances such as appointments and scheduling changes. **Texting will not be used to discuss situations and circumstances that are intended for the therapy session.**
Please be aware that electronic communication via telephone or email 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 or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy. The type of 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 or via phone if 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 any electronic methods of communication and agree to do so at my own risk.

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

_____ _____
Client Signature Date

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HIPAA Notice of Privacy Practices:

HIPAA is the Health Insurance Portability and Accountability Act of 1996. This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. **This notice describes how clinical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.**

Your Rights

You have the right to:

- Copies of your health records
- Correct errors in your health records
- Request confidential communication
- Ask to limit the information shared
- Get a list of those who have received your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Uses and Disclosures

Your information may be shared and used to:

- Provide treatment
- Bill for your services
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights for Clinical Records

Get an electronic or paper copy of your clinical record: You can ask to obtain an electronic or paper copy of your records. Encryption is preferred for electronic transmission. Your request for a copy or a summary of your health information will be issued, usually within 30 days of your request.

Requests to correct errors on your clinical record: You may ask to correct health information about you that you think is incorrect or incomplete. Your request for changes may or may not be granted. You will be informed in writing within 60 days of the reason changes were made or were not made.

Request confidential communication: You may ask to be contacted in a specific way (for example, home or office phone) or to send mail to a different address to protect your privacy.

Requests to limit information used or shared: You may ask not to share your health information. Your request may not be granted if it would impact your care, insurance billing, or any law that requires release of that information.

Request a list of parties receiving shared information: You may ask for a list (accounting) of the times your health information has been shared. This accounting can be for six years prior to the date you ask, who it was shared with, and why. For most disclosures, you will be asked to sign a release of information, or you will be informed of any disclosures related to mandatory reporting. Therefore, any information shared should not be unknown to you. Accounting for a year is provided for free, but a reasonable and cost-based fee may be imposed if you ask for another one within 12 months.

Request a copy of this notice: You may ask for a copy of this notice at any time and will receive it in a prompt manner.

Choose someone to act for you: If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. It will be ensured that this designated person has this authority before taking any action on your behalf.

File a complaint if you feel your rights are violated: You can address a complaint if you feel your rights have been violated by contacting first this provider at the contact info listed at the top of the page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a

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letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** There will be no retaliation for filing any complaint.

Your Choices

For certain health information, you may decide what information is shared. If you have a clear preference for how your information would be shared in the situations described below, please share how you would like each to be addressed and your instructions will be followed. In these cases, you have both the right and choice to inform how you would like each situation addressed:

- Share information with your family, close friends, or others involved in your care
- Share information in a crisis, traumatic, or life threatening situation

If you are not able to report your preference, for example if you are unconscious, some information may be shared if it is believed to be in your best interest. Your information may also be shared when needed to lessen a serious and imminent threat to health or safety.

Uses and Disclosures

How your health information is shared:

Treatment: Your health information can be shared with other professionals who are treating you, generally with your written consent.

Practice Management: Your health information may be used to manage and improve your care, and to contact you when necessary.

Bill for Services: Your health information will be used and shared to bill and obtain payment from health plans or other entities.

Other methods to use or share your health information: Reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Comply with the law: Information may be shared if state or federal laws require it, including with the Department of Health and Human Services if it wants to confirm compliance with federal privacy law. Information regarding abuse and/or neglect of a child falls under the State of Oregon's Mandatory Reporting laws for Counselors and Therapists. Any disclosure of child abuse and neglect, or suspicion thereof, would require disclosure of information with Oregon DHS Child Welfare.

Address workers 'compensation, law enforcement, and other government requests: Health information may be shared about you for workers 'compensation claims, law enforcement purposes, **w**ith health oversight agencies for activities authorized by law**,** and for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: Your health information may be shared in response to a court or administrative order, or in response to a subpoena.

Responsibilities: Maintaining the privacy and security of your protected health information is required by law. If a breach occurs that may have compromised the privacy or security of your information, you will be promptly notified. The duties and privacy practices described in this notice must be followed, and you will receive a copy of it. Your information will not be used or shared in ways other than as described here unless you request changes in writing. You may also change or revoke your request(s) at any time, with a written authorization. For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

The terms of this notice may change, and the changes will apply to your health information on file. The new notice will be available upon request, and online at www.melindareynolds.net under HIPAA Notice of Privacy Practices.

I have read and fully understand my privacy rights under HIPAA Notice of Privacy Practices

Client Signature_____

Date

Parent Signature_____

Date

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Professional Disclosure Form and Guidelines

Thank you for choosing me as your therapist. So as to better serve you, and in keeping with Oregon State law, I am providing you with the following information. We can review this document together at which time I will answer any questions you may have.

As a Licensee of the Oregon 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.

Philosophy and Approach: I believe that, regardless of your present circumstances, you have the potential to have satisfying work and personal relationships, and a life you feel good about. Past experiences often compel us to rely on ineffective behaviors to cope simply because they are familiar. While at one time these behaviors may have provided temporary relief, they can eventually become harmful and make our problems worse. My goal as a therapist is to collaborate with my clients to replace ineffective strategies with effective skills that promote greater life satisfaction and success. I offer a varied approach toward therapy, utilizing therapeutic interventions most appropriate for your needs. The techniques used are generally best practices that are supported by the counseling and therapeutic community and are supported through current research studies. I generally utilize an integrative approach to therapy, meaning the skills used are varied and applied with clinical judgment based on client needs.

Formal Training and Education: I hold a Bachelor of Science in Psychology, Portland State University 2006, and a Master of Arts in Counseling Psychology, Pacific University 2009. Culturally competent and empirically supported treatments were the emphasis of this program. Major Coursework included assessment, research, treatment planning, counseling theories, group counseling, behavior therapy, and human development. My areas of focus were mood disorders (depression and anxiety) spanning from a general experience of feeling anxious to traumatic stress and obsessive thinking. My training involved extensive clinical group and individual psychotherapy with people suffering from moderate to severe depression and anxiety and psychosis.

Structure of Therapy Session and Fees: I provide intake sessions (first appointment) at $215.00per clinical hour (53-minute sessions) and intake therapy services at $195.00 per 53-minute session. My fee for couple's sessions is $215.00 per 53-minute session. A fee of $215.00 per clock hour is charged for work that is "on-location" or otherwise not in my office. A pro-rated version of my fees will be applied to other services such as email, phone consultation, and travel time. If you need a diagnostic assessment, my fee for this service is $350.00 in addition to the fees for the sessions necessary to obtain the relevant information. These payments represent charges that are reasonable and customary for my experience and area. These rates are subject to change.

If you would like to use health insurance, I use a billing service to submit insurance claims and manage your account. If you provide health insurance information, all of your sessions/claims will be submitted for you. Please know that when using health insurance, a diagnosis is required. For that reason, many people do not wish to use their health insurance for counseling sessions and prefer to pay out of pocket. Please let me know if this is something you wish to discuss. If my office is out of network with your insurance company, and those OON benefits are not cost effective or available for you, I may be able to provide referrals, or direction for referrals that are in network with your insurance.

****If you choose to decline using health insurance, please sign here**_____

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Cancellation and Late Arrival Policy: Please be aware that, should you cancel an appointment with less than 24 hours 'notice or fail to arrive to your appointment, you will be charged the full fee for that appointment as described above. This fee will not be billed to insurance. Should you arrive late for your appointment, we will meet for whatever time remains in your scheduled appointment, and you will be charged the full fee for the session.

Ethics: While the therapeutic relationship is very personal, professional boundaries are crucially important to therapeutic work. For this reason, I am unable to have pre-arranged social contact with you outside the therapeutic relationship. Should we run into each other in a social situation, I will protect your confidentiality and will not initiate contact with you.

Diagnoses, Tests and Written Reports: You have the ability to review and discuss your records, treatment and treatment planning. You have the right to know what treatment techniques and methods are used and why. These are used solely to aide in diagnosis and treatment planning. Any diagnosis, tests or reports are strictly confidential and cannot be released without your written approval unless there are circumstances related to limitations listed below.

Confidentiality Rights and Limitations: While most matters discussed during treatment are kept strictly confidential, there are limitations that must be addressed at the time of consent. If at any time during treatment you disclose the abuse or neglect of a child, the elderly or any animal, or disclose the intent to harm yourself or others, I am legally and ethically responsible to immediately report it to the proper authorities. Any requests from a third party to release your information will only be released with your consent. You have the right to request and understand information shared, with whom, and for what reason.

Involvement of Other Professionals: My role in this relationship is therapeutic and psychological in nature. All medical issues will need to be referred to a medical professional. I will assist you in this manner if necessary. I am not able to prescribe medication but am able, with your permission, to collaborate with other professionals to assist if medication becomes necessary. Any contact with other professionals will require your prior consent and release.
If you plan to use your health insurance benefits, my billing company will need access to your insurance information, diagnostic code, dates of service, and contact information, which are the required elements for submitting insurance claims.

Access to Records: Your mental health records will be kept in my office. While your records will be kept confidential, you have the right to review your records if you wish to do so. You have the right to understand what is kept in your records and the right to fully understand plans for treatment. I

Custodian of Records: If for any reason I become incapacitated by illness or death, my Custodian of Record is currently Tracie McDowell, LPC. She may be reached at 503-539-2760. You may also contact the Oregon Board of Licensed Professional Counselors and Therapists for further information.

Client Rights: You have the right to stop treatment at any time if you feel the work is no longer needed/beneficial. If at any time you would like to pursue counseling with another clinician, I will be available to provide resources should you want them. You have the right to be fully informed before you begin a counseling relationship. Any questions or concerns are welcomed and encouraged.

As a client of a Licensed Professional Counselor of the Oregon Board of Licensed Professional Counselors and Therapists, you have the following rights:

- To expect that I have 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.

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- 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 those services.
- To be assured of privacy and confidentiality as defined by rule and law, with the following exceptions:
    - Reporting suspected abuse of child, elder or animal
    - Reporting an imminent danger to self or others.
    - Reporting information required in court proceedings, by an insurance company or other relevant agencies.
    - Providing information concerning case consultation or supervision.
    - Defending claims brought by client.
- To be free from discrimination on the basis of race, religion, gender or another unlawful category.

You may contact the Oregon Board of Licensed Professional Counselors and Therapists at:
3218 Pringle Rd., Suite #120, Salem, OR 97302-6312 or call (503) 378-5499

Acknowledgement of Understanding: By signing this disclosure statement, you acknowledge understanding of and responsibility for all information contained herein and acknowledge that you have had any questions answered to your satisfaction. Please maintain a copy of this form for your records.

Thank you for taking the time to read and sign these forms. Please do ask me if you have any questions about them. I look forward to working with you.

_____	_____	_____
Client's Signature	Client's Printed Name	Date

_____	_____
Clinician's Signature	Date

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Good Faith Estimate for Healthcare

The following is a detailed list of expected charges for psychotherapy services. This is for recurring services. Estimated costs are valid for 12 months from the date of this Good Faith Estimate.

Frequency of service	Description	Service code	Amount to be billed
_____	Intake Session	90791	$ 215.00
_____	Individual Therapy	90837	$ 195.00
_____	Couple's Therapy	90847	$ 215.00

Annual costs estimated for sessions would depend on how often you came.
Example: One Intake Session ($215) and 12 Individual Sessions ($195) would be:
(195x12) = 2,340+215= $2,555.00
Please note: If insurance covers a portion, your amount due will be what remains.

Notes about estimation: You agree to this estimate and report you will authorize changes in frequency if needed. This does not indicate any presumption of clinical need for treatment for 12 months. However, the guidelines require a 12-month estimation for the cost of services.

**Very occasionally there may be additional services as part of the course of care that may be scheduled or requested separately that may not reflected in the good faith estimate. The information provided in this good faith estimate is only an estimate and some services or charges may differ from the good faith estimate.

Provider info:

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NPI: 11811266621
Tax ID: 461650703

Billing codes

90791 Diagnostic Evaluation/Intake Session 1hour billed at $215.00
90837 Individual Psychotherapy, 53 minutes billed at $195.00.
90847 Couple's Therapy, 53 minutes billed at $215.00
Any late cancellation, no show fees, or extenuation of therapy will have an impact on the good faith estimate. Those policies and fees are described in the following Financial Responsibility Form.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

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The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. You will be informed of all fees before you are charged. Federal law allows you to dispute or appeal your bill. There may at times be an unknown to some mental health treatment. However, it's your choice to go beyond or below the good faith estimate by changing your treatment schedule frequency. I can assist with this with no issues or concerns. I will simply make a statement about any potential difference in price.

If you are billed for more than this Good Faith Estimate that you have not agreed to, you have the right to dispute the bill.

You may contact your health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit **www.cms.gov/nosurprises** or call HHS at 1-877-696-6775.

I acknowledge I have read the above information, have an opportunity to ask questions, and agree I understand what's stated above.

Client signature: _____

Date: _____

Provider signature and date: _____

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Statement of Financial Responsibility

Fees: I provide counseling services at $195.00 per clinical hour (53 minute session). Initial intake sessions are at the rate of $215 per clinical hour. Couple's therapy is at the rate of $215.00 per clinical hour. These payments represent a charge that is reasonable and customary for my experience and location**.** Payment and insurance co-pay are due in full each session unless prior arrangements have been made. 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. These rates are subject to change. Notice will be given before any rate change is implemented.

Insurance: If you would like to use your health insurance, my billing manager is able to bill all insurance companies. Insurance co-payments or coinsurance are due in full at the time of service. Please be reminded that this will require me to provide your insurance company with a working diagnosis.
The balance due is your responsibility whether your insurance company pays for services or not. Please be aware of your insurance policy provisions, and the 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/out of network coverage. If your insurance company denies payment the balance will be due in full and the card on file will be charged. If you are using your out of network benefits for counseling, payment in full will be collected at the beginning of each session until your insurance company provides explanation of benefits/reimbursement. If there is a credit owed to you from this office, you will be notified and given the choice to be refunded, or roll any credit over into future copays or balances.
My billing manager will have access to your insurance information, date of birth, diagnosis and contact information, which is strictly used for billing purposes.
Cancellation Policy: Please allow 24 hours in advance to change or cancel an appointment to allow the session to be given to another person. **If you do not show for an appointment or do not call to cancel 24 hours in advance, your card will be charged for that session at the rates described above.** Any late cancellation or no-show fees cannot be billed to insurance. You may leave a message 24 hours a day.
Payment Policy and Agreement: In the event that my account shows a patient balance at the end of the month, I authorize Melinda Reynolds Peña, LPC to charge the following card for services according to the financial policies and payment agreement above. At which time, my account will be charged any unpaid balance. The card on file will be charged for copays/session rate if other payment is not given.

Your information is confidential and securely stored. We can go over any of your concerns you have.
Please do not leave this section blank.

Card Holder Name: _____ Card Number: _____

Expiration Date: _____ Security code: _____ Billing Zip Code: _____

_____ **Initial here if** card above belongs to someone other than you, indicating they are aware of purpose and use. Your relationship with that person: _____

_____**Initial here if** you are a current client and would like the current card on file transferred to this document.

I have read this Statement of Financial Responsibility. I understand that I am responsible for my bill, payable to Melinda Reynolds Peña LPC.

_____ _____
Signature Date