**Upper Circle Inc.**

Office Use only:
Co-Pay ___________
Deductible __________
Diagnosis __________
GAF __________

Date ______________

# Face Sheet
## Referral and Case Assignment
## Child Form

**CHILD Information**

Child's Name_________________________________________ Date of Birth ______________ Gender _____ Age _____

Address__________________________________________ City______________________ State _____ Zip _____________

Home Phone______________________________ Cell # ____________________ Parent Work # _________________

SSN ______________________ School Attending and Grade ________________________________________________

**Parent Information:** Single ___ Married ___ Divorced ___ Widow___ Partner____ **On an IEP**: Y N

**Parent Name** ________________________________________ Your job____________________ How long? _______

Partner/Spouse Name _________________________________________________ Age________ DOB _____________

Home Phone______________________________ Cell # _____________________ Work # _______________________

**Parent Employer** ___________________________________ Your job_______________________ How long? _______

Other Children and their ages _____________________________________________________________________________

Who lives with you?___________________________________________ Pets _____________________________________

**Insurance Information** Please Provide all Insurance cards at the first appointment and pay co pay/deductible

*Name of Primary Insured* __________________________Their DOB ________________ Employer _______________

Insurance Company ________________________________________ SSN _____________________________

Group Policy Number___________________________________ Insurance # ______________________________

*Name of Secondary Insured* _________________________ Their DOB ______________ Employer ________________

Insurance Company ________________________________________ SSN _____________________________

Group Policy Number___________________________________ Insurance # ______________________________

Are you or any of your family seeing another therapist; Their Name ?__________________________________________

Doctor Name and Number ________________________________ Emergency Contact Person ____________________________

**Name of Parent or custodian**___________________________________________ Relationship____________________
Contact information_______________________________________________________________________________
Spiritual Beliefs and Practices_______________________________________________________________________
Hobbies, Interests & Activities______________________________________________________________________
Who may we thank for your referral?_________________________________________________________________

## 2. Presenting Problems

Describe the problem(s) or circumstances that brought your child here today:

*Please Check any of the Symptoms that your child is having:*

- ☐ Depression
- ☐ Extreme Sadness
- ☐ Trouble Concentrating
- ☐ Memory problems
- ☐ Change in Eating habits
- ☐ Feeling extreme happiness
- ☐ Trouble performing in job
- ☐ Lack of enjoyment of usual activities
- ☐ Self-Esteem Problem
- ☐ Perfectionism
- ☐ Obsessions or compulsions
- ☐ Feeling fearful
- ☐ Physical complaints of pain
- ☐ Problems with anger
- ☐ Bed wetting
- ☐ Running Away
- ☐ Substance Use
- ☐ Has hurt or cut on self
- ☐ Harm to other children
- ☐ Skipping school
- ☐ Suspended or expelled from school
- ☐ No sexual interest
- ☐ Thoughts about hurting yourself or others
- ☐ Feeling Hopeless
- ☐ Feeling tearful
- ☐ Change in sleeping habits
- ☐ Lack of energy
- ☐ Weight changes
- ☐ Change in sexual interest or function
- ☐ Problems getting along with family or friends
- ☐ Feeling Stressed
- ☐ Easily irritated
- ☐ Feeling guilty
- ☐ Feeling nervous
- ☐ Sudden feelings of Panic
- ☐ Muscle tension
- ☐ Acting violently
- ☐ Thumb sucking
- ☐ Isolation or withdrawal
- ☐ Fire-setting
- ☐ Harm to animals
- ☐ School work has deteriorated
- ☐ Doesn't mind parents, or ignores teachers
- ☐ Sexually promiscuous
- ☐ Unable to fall asleep or stay asleep
- ☐ Thoughts about killing yourself or others

Are there any agencies involved with you or your child(ren)?

Are there any recent traumas?

What were the traumatic event your child experienced during their life?

**3. Has your child ever been in Counseling before?** Yes ☐ No ☐

*If you have been in counseling before, please describe it below. Start with the most recent time first.*

When was the counseling? Date(s):
Counselor's Name:
Explain what happened:

Was therapy effective?
What got in the way of it being most effective?

## 4. Medical Information

Who is their doctor?
What are they seeing a doctor for?

What medications are they taking?

Are there any allergies?

Medical Conditions:

## 5. Substance Use History

| | | | | | | |
|---|---|---|---|---|---|---|
| Do they use/have you used tobacco in any form | Current | ☐ | Past | ☐ | No | ☐ |
| Do they use/have you used alcohol | Current | ☐ | Past | ☐ | No | ☐ |
| Do they use/have you used caffeine in any form | Current | ☐ | Past | ☐ | No | ☐ |
| Do they use/have you used recreational drugs | Current | ☐ | Past | ☐ | No | ☐ |

To what extent do substances affect their/your daily life______________________________

Use of any other substances not listed______________________________

Which ones______________________________

When did you last use any of these substances______________________________

Do you currently attend AA, NA, SA, ALANON or any other addiction program______________

Are you in a recovery program now or have you ever participated in one (please list when and where and the results) ______________________________

Have you ever been in trouble legally, with family, work or church due to substances______________

## 6. Developmental History

Were there any problems with the pregnancy or delivery of this child?______________________

Were / are there any problems with eating, sleeping or crying spells?______________________

Did the child have any problems, difficulties or delays in walking, talking or toilet training?

________________________________________________________________________________

Who took care of the child when they were young?______________________________________

With whom does the child feel safest?________________________________________________

Who scares or threatens the child?__________________________________________________

Have there been any family changes? ________________________________________________

Is there a history in the family of mental health or psychiatric problems?___________________

Is there a history or current use by family members of substances?________________________

What are the unstable factors in your family? __________________________________________

Please describe the child's relationship with each parent:

Please describe the child's relationship with siblings:

Please describe their temperament:

Who makes the rules and enforces the discipline at home? ________________________________

How is discipline enforced?

To what extent has the child been exposed in the home to any of the following?:

divorce or separation
violence
aggression
fighting
yelling
drugs

new members in the household
alcohol
death
physical abuse
sexual abuse
moving

## 7. School History

At what age did the child start school? _______

Were there any problems when the child started school?

What problems have emerged during school years?

What are the grades the child is receiving?

Are these grades acceptable to the parent and/or child?________

Describe any changes in the child's school performance:

How does the child get along with their teachers?

How does the child get along with his friends or peers at school?

What are the child's favorite subject or school activities?

What subjects or activities does the child have problems with at school?

## 8. Activities

What activities does the child engage in regularly?

What activities does the child engage in that are a source of conflict?

What activities does the child engage in the are supported and encouraged?

What activities is the child required by parents to participate in?

What activities is the child interested in participating in but hasn't been able to?

**Biological and Step Parents:**

Mother's Name ______________________________ Telephone: ____________________
Address _________________________________________________________________
City___________________________ Zip _______________ DOB __________
Employer _______________________________________________________________

Mother's Partner ______________________________ Telephone: ____________________
Address _________________________________________________________________
City_______________________ Zip _______________ DOB ________________
Employer _______________________________________________________________

Father's Name ______________________________ Telephone: ____________________
Address _________________________________________________________________
City________________________ Zip _______________ DOB _____________
Employer _______________________________________________________________

Father's Partner ______________________________ Telephone: ____________________
Address _________________________________________________________________
City___________________________ Zip _______________ DOB ____________
Employer _______________________________________________________________

**Previous Parents:**

❑ Mother's partner ❑ Father's Partner
Name ______________________________ Telephone: ____________________
Address _________________________________________________________________
City_______________________ Zip _______________ DOB _______________
Employer _______________________________________________________________

❑ Mother's partner ❑ Father's Partner
Name ______________________________ Telephone: ____________________
Address _________________________________________________________________
City_____________________ Zip _______________ DOB ________________
Employer _______________________________________________________________

❑ Mother's partner ❑ Father's Partner
Name ______________________________ Telephone: ____________________
Address _________________________________________________________________
City_______________________ Zip _______________ DOB _______________
Employer _______________________________________________________________

# Provider Policy on Insurance and Billing Practices

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

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

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

3. Insurance contracts change over time affecting deductible, co-insurance and co-pays, with these changes come alterations in your fees due to the therapist, please be an informed consumer of your insurance plan, knowing about these changes and recognize that the therapist is not responsible for the changes in your insurance payments and your increased or decreased fees for therapy services.

4. Reports for insurance companies, disability insurance and work related reports are billed at the current hourly rate per 50 minute hour. I encourage clients to make an appointment so we can write the report together.

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

6. Your insurance may or may not cover the cost of your office visits, tests, or certain procedure codes. Non-covered and out-of-network services are the responsibility of you, the insured.

7. If you have an insurance plan in which your therapist does not participate or is out-of-network, as a courtesy this office will nonetheless file the claim on your behalf; **HOWEVER**, payment is usually at a lower percentage than for an in-network provider and you may need to pay for the therapy session in full at the time of service depending on the insurance policy.

8. We, as your provider, are a participant with numerous insurance companies, but not all. While you will be provided with the best information available, **it is your responsibility to check with your insurance company *prior to the visit to verify coverage and benefits*.**

9. It is *your responsibility* to ensure that any required **Pre-Authorizations** are in place and made available to your provider prior to the visit.

10. You are required to pay any deductible, co-insurance or co-pay *at the time of the visit*. If you are unsure of the amount, the full session fee will be charged. You may pay by check or cash, at this time we do not accept credit cards or medical credit cards.

11. A service charge of $25 is assessed for all checks returned by your bank for non-sufficient funds or written on a closed account. Over-payments are sometimes held over for a future visit if you are continuing to see us. If you think a refund is due, please contact the billing office.

12. If the billing department is working on a disputed claim on your behalf, you will be financially responsible for the full fee until the dispute is settled. It can sometimes take a lengthy period of time to resolve some disputes with insurance companies.

13. The billing department is pleased to assist you with insurance questions that relate to how a claim was filed and provide additional information the insurance carrier might need to process the claim. Specific coverage issues, however, can only be addressed between the insurance company and the subscriber of the policy. You may need to make calls directly to your insurance company to resolve payment issues or gain the information you are seeking.

14. The billing department will process some secondary insurance claims. However, any unpaid balances 60 days after the primary insurance has paid will become your responsibility. Secondary insurance claims are filed as a courtesy to you, but are ultimately your responsibility.

15. It is your responsibility to provide us with current, correct insurance information and to bring your current card to each visit. You will be financially responsible for any services received wherein this office has been provided with incorrect or out-dated insurance information.

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

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

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

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

20. Finance charges and late fees will be placed against accounts that are 30 days past due and on a monthly basis until the balance is paid in full.

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

________________________________________ __________________

Signature Print Name Date

________________________________________ __________________

Signature Print Name Date

# Authorization to Use and Disclose Protected Health Information

I authorize ________________________________________________________________ to use or disclose to and from Upper Circle Inc., or its duly authorized representatives, all of the following information:

Kind of Information:

❑ Social ❑ Psychological ❑ Psychiatric ❑ Mental Health
❑ Financial ❑ Employment ❑ Educational or School ❑ Medical
❑ PSI - Presentence Investigations ❑ Workers Comp ❑ Probation/Parole Records
❑ Health ❑ Supervision Conditions ❑ Criminal
❑ Legal (court, police, polygraph, etc) ❑ Child Welfare ❑Other__________________

This release is for the purpose of case planning, evaluation and treatment or _______________________

I understand and agree that this authorization will be valid and in effect from________________________
and expires ___________________ or the end of supervision/treatment. I understand that after that date or event, no more of this information can be used or disclosed to the person or organization unless I sign a new Authorization like this one.

I understand that I can revoke or cancel this authorization at any time by giving written notice delivered by certified mail to all parties including Upper Circle, Inc. If I do this it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional listed above, nor will it affect my eligibility for benefits.
I understand that I may inspect and have a copy of the health information described in this form.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I am completing this form to allow the use and sharing of protected health information about:

_______________________________________________________________ ____________________
Signature of client or her personal representative Date

_______________________________________________________________ _________________________
Printed name of client or personal representative Relationship to the client

___________________________________________________________________________________________
Description of personal representative's authority

I have discussed the issues with the above client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

___________________________________ ____ Beth Doyle, M.A., LPC _____ ______________________
Signature of professional Printed name of professional Date

Upper Circle Inc
1300 Boone Rd SE
Salem, OR 97306

Beth Doyle M.A., LPC
503.391.1300

# Professional Disclosure Statement

Philosophy and Approach: My theoretical foundation is humanistic and existential therapy, with cognitive-emotive-behavioral therapy and holistic energy therapy. My philosophy in treatment is that most of our present difficulties have roots in traumas from our past. When we find the root cause of the trauma, unlock the blocked energy, then dissolve and release the difficulty, then true healing can occur. We each have the capacity, wisdom, and compassion to heal our deepest traumas and to achieve our true heart's desire. We may be guided and helped by others, however, the most powerful healing occurs when we access our own deepest truth and wisdom.

Most therapy sessions focus on your self-talk, expression of self statements verbally and non-verbally, including meta-language; self-awareness, choice, problem solving, and setting goals for the present and future; focusing on responsibility, meaning of life, your strengths, limitations, self-concept, acceptance, and change. A part of our work together is on identifying & understanding the "themes" which shape and guide your experiences in life.

I will challenge you in a caring and empathetic manner to look at yourself and seek alternative options and strategies for creating and responding to your life. My goal is to assist you to alter themes or patterns which no longer work for you in order for you to create and live a more fulfilling life.

Formal Education and Training: I hold a Masters Degree in Counseling and Educational Psychology from the University of Missouri-Columbia. Major course interests were group therapy and holistic/wellness approaches. I completed the 18 month National Training Laboratory program for group therapists and organizational development specialists. I have specialized in the treatment of sexual abuse, addictions, trauma, sexuality, stress-related conditions and violence. I am licensed to conduct the Abel Assessment of Sexual Interest Screening and HeartMath.

As a Licensee of the Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics. To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession. I regularly attend training and workshops to continue to update my skills and knowledge, I participate in organizations that increase my skills and support the work I conduct. I may substitute professional supervision for part of this requirement. I continue to participate in ongoing clinical supervision, which I will be happy to explain.

Fees: My fee is $126.00 per 50 minute therapy session and $60 per group therapy session; report, testimony or consultation is billed at the hourly rate. Initial appointment is $225.00. Cash discounts are given for both individual and group therapy. Clinical Supervision is $125 per 50 minute session. Reports

for court are billed separately at $200 per hour fee and must be paid in advance. A $1500 Retainer for court appearances paid in advance. Unpaid balances are assessed a monthly finance charge and may be turned over to collections after 90 days. Books and treatment materials are sold individually at a separate fee from therapy fees, materials are sold for the use of client's and their families and no client is under any obligation to buy materials directly from the therapist, they are welcome to purchase materials from any store.

As a Client of an Oregon Licensee You Have the Following Rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
    1) Reporting suspected child abuse;
    2) Reporting imminent danger to client or others;
    3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
    4) Providing information concerning licensee case consultation or supervision;
    5) Defending claims brought by client against licensee;
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

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

_______________________________________________

Client Name Printed and Signature Date

_______________________________________________

Client Name Printed and Signature Date

_______________________________________________

Beth Doyle, LPC Signature Date

Upper Circle Inc 1300 Boone Rd SE
503.391.1300 Salem, OR 97306

# UCI Office Policy Statement

### Appointments and Cancellations

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

### Length of Treatment

Individual therapy usually involves regularly scheduled weekly or bi-weekly sessions. The duration of treatment varies depending on the nature of the treatment and the individual client needs.

### Description of Services

I provide psychotherapy services to clients age 5 - 95 years of age. These services include initial assessment, individual, group, couple, and family therapy. A variety of therapies addressing mind, body, spirit and emotion are available to provide relief

### Telephone Calls, Texts, or Emails

You can reach me by phone when I am available, otherwise you will reach voice mail. There is no charge for ***brief phone calls***. Prolonged or frequent calls will be billed at the usual rate and quarter hour increments, at the rate of $45. I do not accept text messages. Emails to schedule appointments are an acceptable manner of contacting me and to share information, Email is not a proper method for us to discuss important personal issues.

### Emergencies

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

**Fees and Payments**
My fee is $126 for a 45-50 minute session, $189 for a 60-85 minute session and $225 for the initial appointment. I ask that you pay in full at each session. Your office visits may be partially covered by mental health provisions in your health insurance policy. *It is your responsibility to verify coverage by your insurer*. If I am a provider in your health care insurance, you are only responsibility for the deductible, co-insurance and co-pay, as well as the initial session at the $225 rate. If I am in-network with your insurance you will receive a statement that you can provide to your insurer to obtain reimbursement and will need to pay the full fee at each session.

**Methods of Payment**

**Private payment:** Full payment on the day of services allows us to avoid clerical costs for paperwork, billing and postage. Insurance co-payments, co-insurance and deductibles are due the day of service. A $20 clerical fee will be added if we have to bill you for these fees.

**Insurance:** As a courtesy insurance billing will be submitted without a charge to your primary insurance. Secondary billing may be submitted to a select number of insurance companies, please verify with us if your company is one of those and be very certain which company is primary. Any errors in submitting to insurance based on your determination of primary and secondary insurance will be your financial responsibility. Any insurer not paying within 90 days of submission of the bill will be treated as past due and you will be informed and asked to contact your insurance company accordingly. Please understand that **insurance is your coverage**, not ours, and we cannot guarantee any payments from your company or any financial liabilities. After 90 days we reserve the right to send your bill to collections if no prior agreement has been made. *You will also be responsible for all legal and collection fees*.

**Confidentiality**

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

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

**With Children under 18**:
When I work with children I let them know that I may share specific information at my discretion with their parents/guardian/caregiver if there is a serious concern or danger of them being harmed by another. I like to meet with the child alone, without meeting with the parents at the same time before or after the session. Parents are welcome to meet with me after every three - four sessions with their child to discuss updates and changes and assess the progress of therapy.

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

**Ethical Guidelines**

It is my commitment to conduct a relationship with you abiding by the highest ethical and professional standards, as specified by American Counseling Association Code for therapists. Please be assured that I view the purpose of the therapist -client relationship to exist solely to enhance the client's welfare and the achievement of therapeutic goals.

Accordingly, boundaries, including physical and emotional, will be respected at all times. When we create treatment goals we will discuss the scope of our relationship. Please understand that I can only be your therapist. I cannot have other roles in your life such as friend, romantic partner or become a client of your work or services. Be assured that any contact you have with a therapist or physician should be free of sexual contact, dating, sexual pressure and violations should be reported.

**Access to Information**
You have every right to be fully informed about your treatment. I urge you to ask any questions.

# Informed Consent

The first session is used for gathering information and discussing any questions you may have regarding the policy and procedures. In this initial session I will want to know as much as possible about the specific problems you need help with in addition to the forms you filled out. I need all of this information to develop a complete understanding of how I may help you.

We will discuss your goals, a plan, the anticipated benefits and risks, and projected prognosis and outcome. Since therapy is a process, it is not always possible to predict just exactly how long your particular problem will take to resolve. Please be sure to discuss these matters with me so I can let you know what treatment methods may be used in your specific case.

During the course of therapy it is common for issues to arise that create discomfort. Clients new to therapy are often surprised when unexpected feelings or memories emerge which may be confusing or uninvited. Problems may temporarily worsen before they get better. In therapy, major life decisions are sometimes made, including calling into question some of your beliefs and values. You may recall unpleasant memories, or feelings that may bother you at home, or work.

Your emotional experience may seem too intense to deal with at this time; you may not accept or forgive yourself; family secrets may be told and therapy may alter your relationships or lead to life changing decisions. This may or may not be the process you experience during your healing. These are but some of the "risks" that the psychotherapeutic process may generate. If questions or concerns

come up for you at any time during the counseling process, I encourage you to discuss them with me immediately.

Please be sure to ask me any questions you may have about any of the treatment methods we may be using. It is my intention to have a very open and honest therapeutic relationship, which requires that you be informed about where we are starting from and where we are going at each step in the process. Please make me aware of your spiritual beliefs so that our work can include your beliefs.

Please sign below to show that you have read and understand this *Informed Consent Statement*.

" I consent to participate in therapy and may voluntarily withdraw from therapy at any time. I will give a minimum of 24 hour notification for any appointments I must cancel due to conflicts or illness. I understand that if I do not I will be liable for costs for the appointment. I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits directly to the provider. I also agree to pay for all services received at time rendered unless payment options have been mutually agreed upon in writing."

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

__________________________________________________ ____________________
Signature Printed Name Date

______________________________________________________________________
Beth Doyle, LPC Michael Hubbard, BS, QMHA Date