

Date _____

Face Sheet
Referral and Case Assignment
Child Form

Co-Pay _____
Deductible _____
Diagnosis _____
GAF _____

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 Employer _____ 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

Name of Primary Insured _____ Their DOB _____ Employer _____

Insurance Company _____ ID # or SSN _____

Group Policy Number _____ Authorization # _____

Name of Secondary Insured _____ Their DOB _____ Employer _____

Insurance Company _____ ID # or SSN _____

Group Policy Number _____ Authorization # _____

If you or any of your family seeing another therapist; 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? _____

Consent to Treatment: I consent to participate in evaluation and treatment and understand that I may refuse services at any time. I authorize the release of any medical or other information necessary to process this claim. I 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.

Signed _____ Case Assigned to: _____
Responsible Party Date Supervisor Date

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:

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

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

5. Substance Use History

Do they use/have you used tobacco in any form	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do they use/have you used alcohol	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do they use/have you used caffeine in any form	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do they use/have you used recreational drugs	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
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 or 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 that 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?

Treatment Philosophy

Welcome to therapy. The following pages answer some frequently asked questions regarding therapy. Please read this information carefully and let us know if there is any part you do not understand.

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 can generate. If questions or concerns come up for you at any time during the counseling process, we encourage you to discuss them with us immediately.

The first session is used for gathering information and discussing any questions you may have regarding the policy and procedures. In this initial session we will want to know as much as possible about the specific problems you need help with. This is in addition to the information you have already provided us from the printed forms filled out by you. We need all of this information to develop a complete understanding of how we may help you. We will then share with you a proposed treatment plan, anticipated benefits and risks, as well as, 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 us so we can let you know what treatment methods may be used in your specific case.

Treatment methods may include but are not limited to the following: Neuro-Linguistic Programming (NLP); cognitive and solution-focused therapy; Energetic Healing; process-oriented psychotherapy; Ericksonian hypnosis; guided imagery; role play; drama therapy; sound, color or movement therapy; meditation or breath work; integration of spiritual beliefs; past life regressions; HeartMath; psychodynamic therapy which involves discussions of family of origin connections to present day problems; couple or relationship counseling; Applied Kinesiology, play therapy (using toys, sand, art etc) and family therapy which may include mediation.

Please be sure to ask us any questions you may have about any of the treatment methods we may be using. It is our 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 us aware of your spiritual beliefs so that our work can include your beliefs.

Policies and Procedures

Hours

We may be reached between 9:00 am to 6:00 pm Monday through Friday. Often, we are with clients and may not return your call immediately. We check messages during the day and will make every effort to return your call within a day. If we cannot reach you that same day, please call again. If you are having an emergency you may always call the **Mental Health Crisis Center** at **503-585-4949** for immediate assistance.

Fees

The fee for a standard 50-minute hour appointment is \$126.00 for individual therapy. Depending on the different therapy needs of each client, longer appointments may be necessary and you will be billed at 10 minute increments for the additional time. The fee for group therapy is \$45-\$60.00 for a 90-120 minute session. The initial assessment appointment is billed at \$150 - \$250 depending on the purpose of the initial assessment appointment. The cash payment discount for clients is \$90.00 for individual and \$45.00 for group.

Payment Policy

You are expected to pay your fee in full at the time of each visit, including co-pay. Should insurance not pay the full payment of the fees, you are expected to pay the entire remaining amount.

Cancellation Policy

If you need to reschedule or cancel an appointment, please let us know as soon as possible. Others are waiting for appointments. If we do not have a **24-hour notice of cancellation**, you will be charged the normal hourly appointment fee. This fee must be paid prior to your next appointment.

Confidentially

We abide by the laws and ethical principles that govern privilege and confidentiality. We will not disclose to anyone anything you tell me, nor even the fact that we have seen you without your written permission by way of a signed release of information form. There are a few exceptions to these standards:

- It is legally required of us that we act so as to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
- We are legally required to report cases of on-going child, elder or disabled abuse.
- We may have to release clinical information about you to an official on request.
- We may have to release your records when ordered to do so by a Court.
- On occasion, we consult with colleagues about their work. If your case were ever discussed it would be confidential and without your name or identifying information.

Consent for Treatment

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 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, which includes co-pays at the time of all appointments.

I give full consent for my child to participate in therapy with UCI and the entire staff of UCI. I will provide a written withdrawal of my consent for this treatment or therapy should I need to withdraw this consent at any time, which may result in legal consequences for my child and my family. There will be additional costs for testing that will be the obligation of the parents as well. I understand that my child is involved in therapy to help with a problem that has legal components and this may require staff to notify the authorities if their behavior is in violation of any of the conditions of a release agreement from court, probation or parole in order to hold them accountable and keep the community safe.

Client Signature

Date

Printed Name of Parent or Guardian

Date

Signature of Parent or Guardian

Date

HIPPA

Consent to Use and Disclose Your Health Information

This form is an agreement between you the client, _____ and Upper Circle, Inc.

When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here

_____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls *Protected Health Information* (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment for you. We may also share this information with others who provide treatment for you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The **Notice of Privacy Practices** explains in more detail your rights and how we can use and share your information. Please read and sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information. This may change our **Notice of Privacy Practices**. If we do change it, you may obtain a copy by calling us at 503-391-1300.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. Your request must be in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, although we may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative's authority

Date of NPP _____

Copy given to client/parent/personal representative

Upper Circle Inc 1300 Boone Rd SE, Salem OR 97306 503-391-1300 beth@uppercircle.com

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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Social | <input type="checkbox"/> Psychological | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Employment | <input type="checkbox"/> Educational or School | <input type="checkbox"/> Medical |
| <input type="checkbox"/> PSI-Presence Investigations | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Probation/Parole Records | <input type="checkbox"/> Health |
| <input type="checkbox"/> Supervision Conditions | <input type="checkbox"/> Criminal | <input type="checkbox"/> Legal (court, police, polygraph, etc) | |
| <input type="checkbox"/> Child Welfare | <input type="checkbox"/> 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 prior to 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 re-disclosed 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

Signature of professional Beth Doyle, M.A., LPC
Printed name of professional Date

Upper Circle Inc.
Beth Doyle, M.A., LPC
1300 Boone Rd SE, Salem, OR 97306
503.391.1300

Upper Circle Inc.
Beth Doyle, LPC
Michael Hubbard, B.S.
1300 Boone Rd SE
Salem, OR 97306
503.391.1300

1. Please describe the sexual problems your child has had, including the beginning of the problem, how extensive it became, how it came to your attention and their response to your involvement.
2. What does your child and family need most from this treatment program to help the family heal and become more functional?
3. As the parent or guardian in this situation, are there additional problems, challenges, complications or difficulties which you would like to share?