

**Child/Adolescent New Patient Intake Form (online fillable)**

**This is the intake paper work for Empowering Choices Counseling & Consultation. We understand that this is a long packet and that some of our questions are in-depth, and we understand they may, at times, ask for personal information, but it is intended to be an all-inclusive look at you as a person. Our intent is to collect as much information as we can about you in-order-to provide the best counseling services we can for you. If there are questions that you do not feel comfortable answering or would rather talk with your counselor about, please mark “Will talk to my counselor about”. Please return the paper work to your counselor on your initial session.**

**Name:**

|  |  |  |
| --- | --- | --- |
| Today’s Date:  |  | Date of Birth:  |
| Age:  | Gender:  | Street Address:  |
| City:  | State:  | Zip Code:  |
| Phone (Home):  |  | (Cell):  |
| May we leave messages for you?  | Home: Yes [ ]  No [ ]  | On Cell: Yes [ ]  No [ ]  |
| Preferred Contact E-Mail Address:  |  |  |
| Emergency Contact Name:  |  | Relationship:  |
| Emergency Contact Phone Number:  |  |  |
| How did you hear about us?  |  |  |

Name:

Can we mail correspondence to this address? Please Initial \_\_\_\_\_\_\_\_ [ ]  Yes [ ]  No

Home Ph: Is it alright to contact and leave message? Please Initial \_\_\_\_\_\_\_ [ ]  Yes [ ]  No

Work Ph: Is it alright to contact and leave message? Please Initial \_\_\_\_\_\_\_ [ ]  Yes [ ]  No

Cell Ph: Is it alright to contact and leave message? Please Initial \_\_\_\_\_\_\_ [ ]  Yes [ ]  No

E-Mail: Is it alright to contact by e-mail? Please Initial \_\_\_\_\_\_\_ [ ] Yes [ ]  No

*Family Relationships*

|  |
| --- |
| **Parents of the child/adolescent Amount of Custody if parents are divorced/separated** |
| **Father’s name:**  |  |
| **Mother’s name:**  |  |

**Who else lives with the client or is in the child’s weekly life (step parents, parents significant others, siblings, step siblings, grandparents, etc.)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Sex** | **Relationship** | **Additional Information** |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |
| 1.
 |  | [ ]  M [ ]  F |  |  |

|  |
| --- |
| Parent/child Relationship |
| Describe parenting your child/adolescent (e.g. challenging, easy):  |
| Wat do you find mots challenging in parenting your child/adolescent?:  |
| What kind of discipline works best with your child/adolescent?:  |
| What types of snacks does your child/adolescent like best?:  |

*History of mental health problems/diagnosis/treatment?*

|  |  |  |
| --- | --- | --- |
| *Diagnosis* | *Date/Age* | *Who did the diagnosis?*  |
| 1.
 |   |   |
| 1.
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| 1.
 |   |   |
| 1.
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|  |
| --- |
| Does anyone in the family have mental illness?:  |

*Empowering Choices Rates for Services, Policies & Procedures*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Service** | **Initial Visit Cost** | **Cost per Session** | **Number of Sessions** | **Other Services Cost** |
| **Community Counseling and Other Services** |  |  |  |  |
| Mental Health Assessment | $500 for Assessment |  | 1-3 sessions; may require additional records |  |
| Individual therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| ABA Therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| Family Therapy | $150 per hour/or sliding scale | $150 per hour/or sliding scale | Varies |  |
| Subpoenaed | $150 per hourSee Section below on court related issues and costs |  |  |  |
| Filling a document with the court | $100 |  |  |  |
| Group Therapy |  | $50 per hour | Groups normally run for a certain number of sessions |  |
| Life Coaching |  | $150 per hour | Varies |  |
| Work shops |  | Varied |  |  |
| Seminars |  | Varied |  | Regular Rate: $150 per hour for a group of 6 and under; $25 per person for a group of 7 or more.Nonprofit Rate: $100 per hour for a group of 6 and under; $15 per person for a group of 7 or more. |
| Consultation | $150 per hour/or sliding scale | $150 per hour/or sliding scale |  |  |
| NSF Check fee – Returned Checks | $30 per check |  |  |  |
| Phone calls |  |  |  | $25 per quarter hour |
| Letters/Reports (including pet letters) |  |  |  | $50 per page |
| Case Management | $150 per hour/or sliding scale |  |  |  |
| Consultation | $150 per hour/or sliding scale |  |  |  |
| Functional Assessment | $400-800 |  | Cost depends on time required to perform the assessment |  |
| School Consultation | Regular determined session fee | Regular determined session fee |  |  |
| Behavioral Planning | $85 PER HOUR |  | Varies |  |
| Behavioral Consultant | $85  |  | Varies |  |
| Copies of paperwork where applicable |  |  |  | .15 per page |

*The following statement expresses the current policies and procedures of this office. Please read it carefully and if you have any questions, ask your counselor for additional information and/or clarifications.*

# **Your health record contains personal information about you.  This information may identify you as it relates to your past, present or future physical and/or mental health condition(s) and related healthcare services.  This information is commonly referred to as Protected Health Information (PHI). Please understand, that any information we obtain or receive is only to assist our client in their growth and healing through the counseling process. This Notice of Privacy Practices describes how Empowering Choices Counseling and Consultation (ECCC) may use and disclose your PHI in accordance with state and federal law which includes the Health Insurance Portability and Accountability Act (HIPAA) regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.**

# **Our Obligations:**

# **ECCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. ECCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practice will be effective for all PHI that we maintain at that time. ECCC will provide you with a copy of the revised Notice of Privacy by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**

**Uses and Disclosure. ECCC may use and disclose protected health information without your consent in the following ways:**

 **Child Abuse or Neglect**

**Judicial and Administrative Proceedings**

 **Deceased Patients (with your prior signed consent)**

 **Abuse of and elderly or vulnerable adult**

 **Medical Emergencies**

 **To those you give consent too. Such as: friends and family also involved in your treatment.**

 **Law Enforcement (but only absolutely necessary information to the emergency)**

 **Health Oversight Agencies**

 **Public Health (preventing, treating, or controlling diseases)**

 **Public Safety**

 **Verbal Permission (once you have given it and to be followed by a signed release)**

 **Other members of our clinic team for consultation**

# **Professional Ethics and Accountability:** Empowering Choices Counseling and Consultation is a community of clinicians with a mission to provide compassionate and competent counseling services to children, adolescents, individuals, couples, and families. We are a group of professionals, most of which are preliscensed professionals, who practice according to the state board Code of Ethics. We encourage you to ask any further questions concerning our academic preparation, counselor training, professional credentials, theoretical orientations, case consultation, clinical supervision, or continuing education.

# **Child/Adolescent Agreement:** Similar to adults the involvement ofchildren and adolescents in therapy can be very beneficial to their overall development and healing. At times, our counselors may see the child/adolescent with parents or other family members and at other times, the counselor may view it best to see the child/adolescent alone. Due to the State Laws of Oregon, at the age of 14, it is up to the adolescent as to the involvement or information shared from sessions. This is not our policy but State laws which we as counselors have to follow. We do view partnering with parents as very important to therapy in any way we can.

**Treatment Risks and Alternatives:** Please be informed that there are risks involved in the counseling process. For example, some people experience an increase in stress, especially during the early stages of treatment. In some cases, a discussion of long-standing unresolved issues can seem to aggravate rather than alleviate a problem. These are natural occurrences of which you need to be aware. While we cannot guarantee the success of our outcomes, we nonetheless intend and attempt to provide you with the highest possible quality of care. If we determine we cannot provide treatment to meet your personal or particular needs, your counselor will inform you at the earliest opportunity and assist you in finding more appropriate services.

In addition to providing direct services, Empowering Choices Counseling and Consultation offers clinical training, experience, and supervision to post-graduate residents pursuing their professional credentials. Occasionally, these counselors will require recordings of their clinical work with clients to serve their educational needs. Accordingly, your counselor may ask your permission to record a session. Please allow your personal discretion to inform your consent. If you feel hesitant to give permission, speak with your counselor about your reluctance, or simply say “I would rather not.” Recordings are subject to our strict policy of confidentiality, are used exclusively to assist supervisors in helping counselors to develop their clinical skills and are destroyed immediately following their use in supervision.

**Legal Issues and Proceedings:** Our mission includes helping children, adolescents, individuals, couples, and families resolve their psychological, spiritual and relationship conflicts through the counseling process; rather, than providing them advocacy, evaluation or testimony in the judicial system (see legal preceding below). If you need a forensic assessment or a clinician who will testify in court, we will attempt to assist you in finding a provider who offers those services.

**Legal Proceedings: As clinicians, we understand that we may be called into court to testify at times. When we are called to testify, we are bound by ethics to answer things honestly. This does not mean that your clinician’s testimony will be solely in your favor. In many ways our hands are “tied” to answering the specific questions of the prosecution and defense. We are not allowed to freely advocate for our clients as we would and could do in other situations such as: with doctor, schools, other professionals, etc. We can only testify to the facts of a case and not to our professional opinion. Due to these specific limitations, as a general rule, we discourage you from having your therapist subpoenaed into court. If and when we are subpoenaed, we do charge for the time we have to move other clients or block out times within our schedule too travel too and appear in court (See our rate of pay chart above). In addition to our general rate, clients may be responsible for all attorney fees and costs incurred by the therapist as a result of the legal action.**

**Office Hours:** Office hours are by appointment only. Appointments are forty-five (50) minute sessions and begin promptly at the appointed time. Each clinician primary keeps control of their own appointments and availability.

**Initial Sessions:** Your first appointment will be a fifty (50) minute session with one of our counselors. The counselor will review the information you shared when you called for your appointment, listen to your concerns and assess your needs, answer any of your questions, and plan with you how to proceed. You may decide mutually to work together, be referred to another clinician at Empowering Choices Counseling and Consultation or be referred to another person or agency in the community for appropriate assistance.

**Fees**: The standard fee for service at Empowering Choices Counseling and Consultation is $150.00 per session. If you need an adjusted fee based on your ability to pay, please ask your counselor for a copy of the Fee Adjustment Scale which is our sliding scale.

**Payment Policy:** Our policy is to receive payment in full at each session unless you make arrangements with your individual counselor. Please make checks payable to “ECCC” (i.e., Empowering Choices Counseling and Consultation).

**Insurance. ECCC is currently credentialed as an: In-Network-Provider with several insurance companies such as: Regence Blue Cross/ Blue Shield, Moda, Providence, and Oregon Health Plan (OHP). As we are working to continually be credentialed into other insurance companies, this list may continually grow. Check our website under “Insurances”.** Although our clinic may not be set up directly with other insurance companies, a large number of insurance companies will work with us as what is referred to as: **Out of Network Providers** on several different levels. On our website, under “payments” we explain how to talk to your insurance company to see if they will allow us to bill them for our services. Some insurance plans do reimbursements or allow you to use health savings plans. Please check with your insurance company prior to your appointment. We will be happy to do what we can in talking with your insurance company; however, you are responsible for keeping current with payments.

**Cancellation Policy:** Our policy is to charge a “$40” fee for all cancelations and missed sessions that are under 24 hours except in the case of occasional emergences. We feel that in under 24 hours, the “$40” will cover the clinicians struggle to fill their time slot. Our company feels that a cancelation over 24 hours gives the clinician a fair amount of time to fill the time slot on their own which helps us keep the lights on.

**Telephone Calls:** See table at the beginning of this paperwork or on the website under “payments”**.**

**Emergency Procedures:** Empowering Choices Counseling and Consultation is not a crisis response facility. **In the event of an emergency—defined here as an imminent danger to yourself, others or both—please call 9-1-1 for immediate assistance.**

**Support Services:** All functions concerning billing and payment, insurance reimbursement, case documentation, and other support services are provided with the same concern for professionalism and quality. In order to protect your confidentiality, a written authorization will be required for the release of information. A service fee may be charged for duplication, summarization, and other document preparation. Many of our prices are listed on the table at the beginning of this paperwork or on our website under **“Payments”**. Please direct any questions about any other services you do not see listed to your counselor. At this time, ECCC does not provide general case management, medication management, and or housing; however, our counselors do have access to other community resources and/or agencies which do provide those services.

**Consent to Treatment:** I have read the above information about which I have had the opportunity to ask questions. I understand the limits of confidentiality and the risks associated with counseling. If there are children involved in counseling, I hereby consent to their treatment and affirm I am the legal guardian with the authority to consent to their treatment. I agree to the payment and billing policies outlined above and accept full responsibility for any and all fees charged for counseling sessions, cancellations, or missed appointments. I consent to participate in counseling and understand that I may decline services at any time. I am aware that my counselor may consult periodically on client issues with other clinicians at Empowering Choices Counseling and Consultation, with clinical supervisors, or both. My signature below indicates that I have read, understand, and agree to accept the policies outlined on both sides of this document, and have received a copy of these policies for further reference.

[ ]  I agree to pay the standard fee of $150. **OR** [ ]  I need an adjusted fee based on my ability to pay.

[ ]  I have received a copy of Empowering Choices Counseling & Consultation for Protecting Client Privacy (HIPAA).

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Counselor Signature: |  | Date: |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Empowering Choices Counseling & Consultation Authorization for Insurance Billing*

Counselor: Client:

Please check with your insurance company (there are tips on our web site) prior to receiving services to answer the following questions:

 [ ]  Deductible Amount-How much of your deductible have you met for the current year?: [ ]  Co-Pay Amount:

[ ]  Does your insurance require pre-authorization?:

[ ]  Anniversary date of Coverage:

[ ]  Copy of insurance card has been provided:

***A copy of the insurance card will be required at the time of initial visit***

 **(Fill out the following ONLY if copy of card was NOT provided)**

**Primary Insurance**: ID#: Group#:

Subscriber (Name on policy): DOB:

Employer:

**Secondary Insurance**: ID#: Group#:

Subscriber (Name on policy): DOB:

Employer:

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Empowering Choices Counseling & Consultation directly for services rendered according to my mental health coverage. I authorize Empowering Choices Counseling & Consultation to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor’s referral if required. I understand that I am financially responsible for services performed, whether or not, paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. I understand I am responsible for a $40 cancelation fee per session canceled without a 24 hour notice.

Signature of client or responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Questions about your child/adolescent*

**In order for us to provide the most complete care to you as our clients, please complete this form. If you are not sure about any of the questions, or feel uncomfortable answering them, please feel you can leave them blank. Feel free to speak with your counselor about any areas of concern you have.**

Please describe the problem that has led you to seek our services at this time.

|  |
| --- |
| What are the current concerns? List them in order of importance. |
| 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.  |

|  |
| --- |
| What are the strengths of your child/adolescent? |
| 1.
2.
3.
4.
5.
 |

|  |
| --- |
| What are your child/adolescent interests?: |
| 1.
2.
3.
4.
5.
 |

*Developmental History*

|  |
| --- |
| Prenatal and Delivery History |
| How was the mother’s overall health during pregnancy with this patient? [ ]  Good [ ]  Fair [ ]  Poor [ ]  Don’t know |
| How was the mother’s overall health during delivery with this patient? [ ]  Good [ ]  Fair [ ]  Poor [ ]  Don’t know |
| Did the mother experience any medical problems or complications during pregnancy? [ ]  Yes [ ]  NoIf yes, please specify: How old were the parents when this patient was born? Mother Father  |
| What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?[ ]  Alcohol: Describe amount and frequency. [ ]  Tobacco: Describe amount and frequency. [ ]  Street Drugs: Describe what drugs, amount, and frequency.  |
| Was this child/adolescent born: [ ]  less than 30 weeks gestation [ ]  30-35 weeks [ ]  36-40 weeks [ ]  over 40 weeksWas delivery: [ ]  Normal [ ]  Breech [ ]  Caesarian [ ]  Forceps/vacuum assisted [ ]  Induced What was the child/adolescent’s birth weight? Were there indications of fetal distress during labor/birth? [ ]  Yes [ ]  NoIf yes, please specify [ ]  Yes [ ]  No |
| Toddler Period |
| As an infant/toddler, how did this child/adolescent behave with other people?[ ]  More social than average [ ]  Average sociability [ ]  Actively avoided socializing [ ]  More shy than averageAs an infant/toddler, how insistent was this child/adolescent when he or she wanted something?[ ]  Very insistent [ ]  Somewhat insistent [ ]  Average [ ]  PassiveAs an infant/toddler, how active was this child/adolescent?[ ]  Very insistent [ ]  Active [ ]  Average [ ]  Less active [ ]  Very activeHow would you describe this child’s play as an infant/toddler? (Check all that apply)[ ]  Loud [ ]  Interested in playing with others [ ]  Imaginative/Make believe[ ]  Quite [ ]  Played alone [ ]  Repetitive [ ]  Rigid, concrete  |
|  Developmental Milestones |
| Have you or anyone else ever had concerns about this child/adolescent’s development? [ ]  Yes [ ]  NoIf yes, please specify At what age (in months) did this child/adolescent:Sit up? Crawl? Walk? At what age (in months) did this child/adolescent speak single words (other than “Mama” or Dada”)? At what age (in months) did this child/adolescent begin stringing two or more words together? Has your child experienced any of the following medical conditions during his/her lifetime? |

*Medical Information*

|  |
| --- |
| Has your child experienced any of the following medical conditions during his/her lifetime?[ ]  Allergies [ ]  Surgery [ ]  Serious Accident [ ]  Head Injury[ ]  Chronic Pain [ ]  Asthma [ ]  Headaches [ ]  Stomach Aches[ ]  Dizziness/fainting [ ]  Meingitis [ ]  Seizures [ ]  Vision Problems[ ]  High Fevers [ ]  Diabetes [ ]  Hearing Problems [ ]  Miscarriage[ ]  Sextually Transmitted Disease [ ]  Abortion [ ]  Sleep Disorder[ ]  OtherPlease list any CURRENT health concerns:  |

|  |
| --- |
| Current prescriptions medications: [ ]  None |
| Medication | Dosage | Date First Prescribed | Prescribed By |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Name of primary care physician:  |

|  |
| --- |
| Previous Mental Health Treatment |
| Yes | No | Type of treatment | When? | Provider/Program | Reason for Treatment |
|   |   | Outpatient Counseling |   |   |   |
|   |   | Medication (Mental Health) |   |   |   |
|   |   | Psychiatric Hospitalization |   |   |   |
|   |   | Drug/Alcohol Treatment |   |   |   |
|   |   | Self-help/Support Groups |   |   |   |
| [ ]  Yes [ ]  No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: [ ]  Yes [ ]  No Has your child ever had thought, made statements, or attempted to hurt someone else?If yes, please describe: [ ]  Yes [ ]  No Has your child ever restricted their eating or eaten in a way that made you uncomfortable?If yes, please describe: [ ]  Yes [ ]  No Has your child recently been physically hurt or threatened by someone else?If yes, please describe: [ ]  Yes [ ]  No Has your child ever had thoughts, made statements, or attempted to hurt him/herself?If yes, please describe: [ ]  Yes [ ]  No Has your child ever had thoughts, made statements, or attempted to hurt someone else?If yes, please describe: [ ]  Yes [ ]  No Has your child ever restricted their eating or eaten in a way that made you uncomfortable?If yes, please describe: [ ]  Yes [ ]  No Has your child recently been physically hurt or threatened by someone else?If yes, please describe:  |

|  |
| --- |
| Psychiatric/Psychological History |
| **Is your child currently being seen by a counselor?** [ ]  **Yes** [ ]  **No**If yes, name of current counselor: Length of Treatment:  |
| **Is your child currently being seen by a psychiatrist?** [ ]  **Yes** [ ]  **No**If yes, name of current psychiatrist: Length of Treatment:  |
| **Has your child ever been diagnosed with a mental health, emotional, or psychological condition?**[ ]  **Yes** [ ]  **No** **If yes, what diagnosis was your child giver?:**  **When?:**  **By whom?:**  |

*Information about your child/adolescent*

|  |
| --- |
| Education |
| **Is your child/adolescent currently enrolled in school?** [ ]  **Yes** [ ]  **No Name of school:**  |
| **What grade is your child currently in (if summer, was grade is your child going into)?:**  |
| **How would you describe your child’s attendance (currently)?** [ ]  **Attending regularly** [ ]  **Home-schooled** [ ]  **Some truancy** [ ]  **Alternative school** [ ]  **Expelled** [ ]  **Dropped Out** [ ]  **GED program** |
| **How would you describe your child/adolescence grades in school?:**  |
| **How would you describe your child/adolescence attitude towards school/education?:**  |
| **Disciplinary or behavioral issues at school?** [ ]  **Yes** [ ]  **No If yes, describe:**  |
| Please check if your child has any of the following |
| [ ]  Special Education Accommodation or a 504? Please describe:  |
| [ ]  An Individualized education Plan (IEP)? Please describe:  |
| [ ]  Diagnosed Learning Disability? Please describe:  |
| [ ]  Receiving Special Services at school? Please describe:  |

*Interpersonal/Social/Cultural Information*

|  |
| --- |
| Please describe your child’s social support network (check all that apply):[ ]  Family [ ]  Neighbors [ ]  Friends [ ]  Students [ ]  Coworkers [ ]  Support Group[ ]  Community Group [ ]  Religious/Spiritual Center (which one?) |
| To which cultural group (s) does your child/adolescent belong?:  |
| If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:  |
| How important are spiritual matters/values to you? [ ]  Not at all [ ]  Little [ ]  Somewhat [ ]  Very much |
|  Would you like spiritual/religious beliefs to be incorporated into your child’s counseling? [ ]  Yes [ ]  No |

|  |
| --- |
| Substance Use: |
| Does your child/adolescent drink?: [ ]  **Yes** [ ]  **No** If so, how often: If so, how much in one setting?:  |
| Does your child/adolescent use substances?: [ ]  **Yes** [ ]  **No** If so, how often: Please list substances your child/adolescent has used:  |

Professional Disclosure Statement

Minette Bennett, MA, Registered LPC Intern

Empowering Choices Counseling & Consultation

147 Commercial St NE Suite #15

Salem, OR 97301

Supervisor: Bob Powell, MMFT, LMFT, ClinSup

Philosophy & Approach

In my role as a Christian Counselor, I work to provide a safe and mutually respectful environment where couples and individuals can explore and question their world. Whenever possible and with the client’s permission, I incorporate Biblical Truth into the counseling and healing process. Using a holistic approach, I consider the various spheres of life, i.e., physical, spiritual, relational, and emotional, helping the client become aware of and examine faulty thought and behavior patterns that occur because of past experiences. New ways of thinking and relating are then explored. I believe people are basically trustworthy, resourceful, capable of self-understanding, and able to make the changes they desire. Additionally, I believe that happiness and success are related to social adeptness, that is, our ability to connect and contribute. Maintaining a healthy place in family and society fulfills basic needs of security, acceptance, and worthiness.

Formal Education & Training

A graduate of Corban University with a Master of Arts in Counseling, I am an intern registered with the Oregon Board of Licensed Professional Counselors & Therapists working to become a Licensed Professional Counselor. I interned at the Salem Free Counseling Clinic and have additional prior training and experience as a peer counselor at both Capitol Hill Pregnancy Center in Washington, DC and at Hope Pregnancy Clinic in Salem, Oregon.

Major coursework included but was not limited to Counseling Theory, Human Developmental Theories, Child Therapy, Family Therapy, Attachment Theory, Crisis and Trauma Counseling, Psychopathology, Pharmacology, Group Counseling, Ethics, Research Methods, and Addiction Counseling.

Code of Ethics

Since licensure with the Oregon Board of Licensed Professional Counselors and Therapists is my goal, I adhere to their code of ethics as well as the code of ethics issued by the American Counseling Association of which I am a member.

Confidentiality

It is my goal to create a counseling relationship that provides tangible benefit to the client. To do so requires the establishment and maintenance of trust. Confidentiality must therefore be the cornerstone of the counseling relationship. All information disclosed in the course of counseling, including status as a client, is kept confidential. In instances of suspected child or elder abuse, convincing threats of homicide or suicide, or the likely spread of a deadly, contagious disease, the State of Oregon mandates that confidentiality be breached.

Benefits and Risks of Therapy

While counseling is proven to be beneficial, there are some risks to consider. Some clients may experience uncomfortable feelings and may, for a time, feel worse as they begin to work on sensitive areas of their lives or recall unpleasant memories. Usually these feelings do not last long but they can affect the client’s life outside the counseling office. Sometimes individuals in the client’s life may have a negative view of counseling which can create distance in their relationship. Any doubts or concerns the client has should be discussed prior to therapy and, if possible, be alleviated in order to minimize the potential risks and maximize the benefits of counseling. The client has the right to accept or refuse part or all therapeutic treatment.

Client Bill of Rights

A licensee makes available as part of the disclosure statement a bill of rights of clients, including a statement that consumers of counseling or therapy services offered by Oregon licensees have the right:

1. To expect that a licensee has met the minimal qualifications of training and experience required by state law:

2. To examine public records maintained by the Board and to have the Board

confirm credentials of a licensee;

3. To obtain a copy of the Code of Ethics;

4. To report complaints to the Board;

5. To be informed of the cost of professional services before receiving the services;

6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:

A. Reporting suspected child abuse.

B. Reporting imminent danger to client or others.

C. Reporting information required in court proceedings or by client’s

insurance company, or other relevant agencies.

D. Providing information concerning licensee case consultation or supervision.

E. Defending claims brought by client against licensee.

7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Oregon Board of Licensed Professional Counselors and Therapists

3218 Pringle Road SE Suite 120

Salem, OR 97302-6312

Telephone: (503) 378-5499

Fee Schedule

The standard fee for counseling services is $100 per 45 to 50 minute session with a sliding fee scale available upon request.

Appointments Missed or Cancelled

There is no charge for appointments cancelled or rescheduled more than 24 hours in advance. However, except for emergencies, your regular fee may be charged for failure to cancel in advance.

Please sign and date. A copy will be given to you for your records.

I read and understand this document and I agree to its terms.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_