Anne Emmett LCSW

516 SE Morrison, Suite 500

Portland, OR 97214

503-238-2405

CLIENT POLICIES AND CONSENT TO TREATMENT

Welcome to my psychotherapy practice! Here is some information about my practice that I ask you to read and sign that you have reviewed this information. Thank you.

Length and frequency of psychotherapy sessions: Psychotherapy typically involves regular sessions, usually 45 minutes in length. The initial session is 60 minutes. Duration and frequency of sessions will be mutually determined and may vary depending on the nature of your problem and your individual needs.

Confidentiality: Information shared with me will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality cannot be assured in life-threatening situations involving yourself or others, in situations involving a child or senior at risk of harm or if your records are subpoenaed by a court. I routinely review my work with colleagues and seek consultation as needed. In those circumstances I disguise identifying information and use a pseudonym. I have made arrangements with a trusted colleague to access files and notify clients in the event that I were to become unexpectedly incapacitated. I will make arrangements for coverage of my practice during any planned absence.

Fees: Initial appointment fee for a 60 minute session is $165, and $125 for subsequent 45 minute sessions.

Fees and co-pays are expected to be paid at the start of each session. If you plan to use insurance please be aware of what your coverage is prior to meeting with me. This would include your deductible and whether that has been met and if you have a co-pay. You will be responsible to pay full fee for any session that you miss unless you give me at least 24 hour notice. Please be aware that insurance carriers will not cover cancellation fees.

If you request that your insurance be billed by me be aware that your carrier will be requesting information from me in order to provide payment. You are responsible for your bill even though you may have insurance. Phone calls over 10 minutes will be billed as a professional service, as will letters and reports related to client care. Insurance typically does not cover these expenses and you may be billed for them at my pro-rated

fee. I reserve the option to use a collection service in the event of an outstanding, unpaid bill.

Legal Issues: If you are anticipating involvement in a court action I advise that you discuss the matter with your attorney prior to disclosing information to me that could be damaging to your case. By signing this form, you agree to not involve me in legal/court proceedings or attempt to obtain records of treatment for legal/court proceedings when couples or family therapy has not resolved disputes.

Phone/text/email and emergency contact: For routine matters please contact my office #503-238-2405. For urgent matters I can be reached on my cell# 503-753-3017. I am usually able to return calls within 24 hours. If you cannot reach me directly and it is an emergency please call 911 or go to the nearest emergency room. Multnomah County Mental Health Crisis Line is 503-988-4888. You can text or email me for brief logistical/informational matters but know that neither is a confidential venue and that neither should be used to reach me in an urgent/emergent situation.

Social media contact: I do not accept friend or contact requests from former or current clients on social networking sites. Please do not message me from these sites as this is not a reliable way to reach me and also is not confidential.

Physician/Health Care provider contact: Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. It is often helpful for me to communicate with your primary care doctor and/or other health providers and I would need your written permission to do so.

Freedom to withdraw: You have the right to end therapy at any time. If you wish, I will give you the names of other qualified psychotherapists.

Informed consent: I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I agree to enter into a professional psychotherapy relationship with Anne Emmett LCSW.

Signature: _____

Date: _____

Revised: 9/17

INTAKE INFORMATION SHEET

Anne Emmett LCSW
516 SE Morrison, Suite 500
Portland, Oregon 97214
Phone: 503-238-2405

NAME:_____

DATE OF BIRTH:_____

PREFERRED PRONOUNS:_____

ADDRESS:_____

CITY/STATE/ZIPCODE:

_____

_____

PHONE: _____

May a message be left on this phone? YES / NO

EMAIL: _____

EMERGENCY CONTACT: Name, relationship to you and contact information:

_____

CURRENT MEDICAL CONDITIONS:

_____

PRIMARY HEALTH PROVIDER NAME AND CONTACT INFORMATION:

_____

_____

ADJUNCT HEALTH PROVIDERS/COUNSELORS YOU ARE WORKING WITH:

_____

_____

CURRENT PRESCRIBED AND OTHER MEDICATIONS & SUPPLEMENTS:

_____

ALLERGIES: _____

PRIOR PSYCHOTHERAPY:

_____

_____

HOSPITALIZATIONS/RESIDENTIAL TREATMENT PROGRAM:

_____

_____

Legal Issues:_____

REFERRED BY: _____

Briefly state what brings you to seek psychotherapy?

_____

_____

IF YOU PLAN TO USE INSURANCE:

Health Insurance: _____
Address and Phone of Insurance Company:

_____

_____

Name of Policy Holder, their date of birth and employer (if different from you).

_____

Policy# _____
Group# _____
ID # _____
What is your deductible and have you met it? What is your co-pay?

_____

INSURANCE RELEASE AND AUTHORIZATION:

Your signature below indicates your consent to disclose to your insurance company information sufficient to process your claim and authorize insurance payment to Anne Emmett LCSW.

SIGNATURE: _____

DATE: _____

Revised 9/17

AUTHORIZATION & CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Anne Emmett LCSW

516 SE Morrison, Suite 500

Portland, Oregon 97214

Phone: 503-238-2405

I authorize Anne Emmett LCSW to: (initial all that apply)

_____Verbally or electronically exchange information to:

_____Receive and or send a copy of my health information to:

To/From:_____

I authorize this information to be used for: (initial all that apply)

_____continuation of mental health care

_____coordination with medical/health providers

_____legal issues (specify)

_____completion of evaluation

_____other (specify)

I authorize the exchange of the following information: (initial all that apply)

_____Mental health session notes

_____Mental health treatment summary

_____Billing records

_____Coordination of care via phone call/electronic record

_____Alcohol and drug information

_____Genetic information

_____HIV information

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy Rule If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time and that if revoked this form is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. Any information that had been exchanged prior to a revocation cannot be retrieved. To revoke this authorization, please send a written statement to Anne Emmett LCSW.

Unless revoked, this authorization will expire in:

_____one year

_____other/specify

_____upon termination of mental health treatment

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

Signature of client or client's legal representative: _____

_____

Description of representative's authority: _____

_____

Date: _____

Significant information: Information used or disclosed under this authorization may be subject to redisclosure by others without your permission. In some instances federal and state law may protect your information from being shared if it is HIV/AIDS, genetic information or alcohol/drug related.

To the recipients of protected health information: The information disclosed to you by this authorization is protected by state law (ORS 179.5015,192.525) and Federal regulations (42 CFR Part 2.45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of drug and alcohol treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised 9/2017

Anne Emmett LCSW

516 SE Morrison, Suite 500

Portland, Oregon 97214

503-238-2405

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The 1996 federal law, the Health Insurance Portability and Accountability Act (HIPAA) requires that I give you this notice.

Privacy: My commitment is to your privacy. Your protected health information (PHI) is shared by you in the course of psychotherapy sessions. PHI includes information about you that may identify you and that relates to your past, present or future physical and/or mental health and related health care services. I must ethically and legally keep this information confidential.

How I use and disclose your PHI with your consent*:* Your PHI is used to provide you with treatment, to arrange payment and for health care operations. I have a written contract with any third party (such as billing services) that requires your PHI be kept private. I will ask you to sign a consent form after you read this that will allow me to use your information in this manner. If you do not consent and sign the form I am unable to treat you.

Disclosing your PHI without your consent*:* The following are situations where I am legally or ethically obligated to disclose your information: When required by law, when there is an immediate danger to the health and safety of a person or the public, when PHI is needed to identify you if you have died or determine the cause of your death and for worker's compensation or other programs that provide benefits to you for work-related injuries or illness.

Your rights regarding your PHI: Uses and disclosures not specifically permitted by law will be made only with your written authorization, which may be revoked at any time.

You have the right to access, inspect and copy your PHI. I may restrict your access only when there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

Right to amend: If you feel that the PHI I have is inaccurate or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an accounting of disclosures: You have a right to request an accounting of the disclosures I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12 month period.

Right to request restrictions: You have a right to request a restriction on the use or disclosure of your PHI for treatment, payment or health care operations. I am not required to agree with your request.

Right to request confidential communication: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

You have a right to a copy of this notice.

Complaints:

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing to me: Anne Emmett LCSW, 516 SE Morrison St, Suite 500, Portland, Oregon 97214. Fax # 1-888-974-3958

You can also contact the Secretary of Health and Human Services in Washington D.C. Complaints must be in writing and will not change the health care that I provide to you. Please sign the form to acknowledge that you have read this notice:

Signature:_____

Printed Name:_____Date:_____

Rev: 9/17