Katherine Calvert, LCSW
4207 SE Woodstock Blvd. #185
Portland, OR 97206
Phone: 503-705-2194
Fax: 971-865-5191

PROFESSIONAL SERVICES CONTRACT

INFORMATION AND CONSENT TO TREATMENT

Please read the following carefully and sign on the last page. If there are any items contained within that you would like to discuss, please bring them to the attention of the counselor.

Beginning service date: ____________________

FEES: The standard service charge is $263.00 for an initial session, assessment, and a 90-minute couples/family session. All subsequent session charges are: $150.00 for a 45-minute session for individuals; $175.00 for a 60-minute session for individuals. Class sessions are $55.00 per class for 30 weeks for a total cost of $1,650.00. Insurance companies can be billed for the cost of the classes. Reimbursement may vary based on the individual's policy.

Telephone sessions, insurance reports and third party consultations will be billed at the standard rate. Telephone consultations of fewer than fifteen minutes are generally at no cost unless there is a need for frequent calls. Returned check fee is $20. Fee schedules for travel to locations outside of the office are available upon request.

PAYMENT POLICY: Payment is due in full at the time of each session. If we have agreed to bill your insurance company, co-payment is due at the time of service.
Please understand that if your insurance company should for any reason decline your claim, the full responsibility of the amount owed will become that of the client.

CANCELLATIONS: Must be made at least 24 hours in advance by calling and leaving a message on the voicemail at (503) 705-2194. **Individual appointments cancelled with less than 24 hour notice will be charged in full to the client. Clients will be charged full Group fee for all Missed Group sessions.** Please note that insurance companies will not reimburse for missed appointments or group (class) sessions.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the social worker and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS: I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) or one 90-minute session for a couple, per week at a time we agree on, although some sessions may be longer or more or less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES: My hourly fee is $150.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of more than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceeding.

PROFESSIONAL CONSULTATION: To enhance the services we provide, we participate in supervision. Our supervisors are bound by the rules of confidentiality and to ensure privacy client identities are never disclosed. If you have concerns about the review of your case with a consultant, please share your concerns with your counselor.

EMERGENCIES: You may leave a message on our office voicemail at (503) 705-2194, 24 hours a day. Monday through Friday calls will be returned during regular business hours as quickly as possible. On weekends, calls may not be returned. In emergencies that threaten life or property call 911 for assistance. In the event of a mental health emergency after hours or any time you cannot reach your therapist, you should call your local crisis line or go directly to a hospital emergency room.

CONFIDENTIALITY: The information that you share in therapy is kept in confidence as protected by both federal and state laws. This confidentiality applies to the therapists work with children, adolescents and adults. If it is necessary to disclose information during the course of therapy, or to consult with a third party, a written release signed by the client will be obtained prior to the disclosure.

Under certain circumstances the therapist is mandated by law to break confidentiality:

- **If subpoenaed to testify in court, information may be given without your permission**
- **When statements are made about suicidal or homicidal intentions**
- **Statements indicating that you or someone you know have committed or intend to commit acts of child or elder abuse.**
- **Information that would assist in a medical emergency.**

I have read the above statement and understand my rights and responsibilities. I understand that there can be no absolute guarantee of cure in the practice of therapy. I agree to comply with all of the policies and to meet my financial obligations. I understand my rights to confidentiality as well the limitations. I may receive a copy of this form if I request it.

Client's printed name: ______________________________

Client's signature: ______________________________ Date: ____/____/____

Partner's name: ______________________________

Address: ______________________________
Street Address

____
City State Zip

Phone Numbers: H: ______________________ May we leave a message?________

W: ______________________May we leave a message?________

Emergency Contact Person (only to be used in an emergency, not merely to contact you):

Name: ______________________________

Phone: ______________________________

EMERGENCY RESOURCES

Crisis lines:

Crisis lines:

Multnomah County: (503) 988-4888
Washington County: (503) 291-9111
Clackamas County: (503) 655-8585
Clark County (Washington): (360) 696-9560
Kaiser Permanente members: (503)331-6425

Some hospital resources with psychiatric services through the emergency department*:

Unity Center for Behavioral Health
1225 NE 2nd Ave, Portland, OR 97232
(503) 944-8000

Providence Portland Medical Center
4805 NE Glisan St., Portland, OR 97213
(503) 215-1111

Providence St. Vincent Medical Center
9205 SW Barnes Rd, Portland, OR 97225
(503) 216-1234

Kaiser Sunnyside 24-hour Mental Health Emergency Services
10180 SE Sunnyside Rd, Clackamas, OR 97015
(503) 331- 6425

Randall Children's Center (Children and Adolescents under 18 y/o)
2801 N Gantenbein Ave, Portland, OR 97227
(503) 276-6500

*** In the event of any potentially life-threatening medical emergency, or if you do not believe you can safely get to one of the facilities above, please go to the emergency room of any hospital facility near you.**

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CONTACT MANAGEMENT FORM

How did you hear about Katherine Calvert?

____
____
____

It is always our goal to safeguard your confidentiality. Please indicate below how we may contact you by providing the information requested and circling Yes or No:

Telephone

Home Phone:____________________

- May we leave a message on a voicemail system/answering machine? Yes No
- May we leave a message with whomever answers the phone? Yes No

Cell Phone:____________________

- May we leave a message on a voicemail system/answering machine? Yes No

Work Phone:____________________

- May we leave a message on a voicemail system/answering machine? Yes No
- May we leave a message with the receptionist/secretary? Yes No

If you are seeing us with your partner and there is an accounting or appointment question/issue, may we speak with either of you? Yes No

If No was selected, with whom may we speak concerning accounting or appointment issues?

Mail by US Postal Service

Home Address (including city, state, zip):

____
____

Mailing Address (if different than home):

____
____

- May we send you sealed envelopes of bills/statements/registrations, etc. that have the return address of Katherine Calvert? Yes No

Email

Email Address:____________________

- May your therapist correspond with you via email (even to return your email requires your permission. Please be aware that email might not be confidential)? Yes No

If more than one person is receiving services, we require a signature from both parties.

____
Client's Printed Name

______________________________________ ____________________
Client's Signature (or parent/guardian's), Date
indicating agreement to all of the statements above.

Therapist: ____________________________

____
Client's Printed Name

______________________________________ ____________________
Client's Signature (or parent/guardian's), Date
indicating agreement to all of the statements above.

Therapist: ____________________________

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INSURANCE INFORMATION FORM

- If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, I need the information requested below. I will explain any part of this form that you do not understand.
- Your co-pay or fee is due at the time of service. If your insurance company does not pay in a timely manner, you will be responsible for the bill.

A. Patient's Name: ____________________
Patient's DOB: ____________________
Address: ____________________
Home Phone: __________ Work Phone: __________

B. Name of Insured: ____________________
Relationship to Patient: ____________________
DOB of Insured: ____________________
Insurance Company Name: ____________________
Mailing Address to Submit Claims: ____________________
____
Phone Number for Verification: ____________________
Insured's ID Number: __________ Group Number: __________
Employer: ____________________

C. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

D. I understand that I am responsible for all charges, regardless of insurance coverage.

E. Assignment of benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

____
Client's Printed Name

____________________ __________
Client's Signature (or parent/guardian's), indicating agreement to all of the statements above. Date

Therapist: ____________________ __________
Date

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ADULT CHECKLIST OF CONCERNS

Name: ______________________________ Date: ______________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems (also, see bottom of page)
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits

- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Over sensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns. . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, over-sensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Because some health problems or drug treatments can cause mood interferences, we must ask you to list any medical concerns you are being treated for at this time. This includes allergies. What, if any, drugs are you taking and who is your provider?

____

____

____

____

Any other concerns or issues:

- ☐ ____________________________________
- ☐ ____________________________________

Please look back over the concerns you have checked off, choose the one that you most want help with and list it here: ________________________________

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are 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 Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

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As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

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threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at ______________________:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for

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accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at ____________________ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

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