Amy Berg, Ph.D., LMFT ◆ 4605 NE Fremont St, Suite 210F ◆ Portland OR 97213 ◆ 503.998.3415

INFORMED CONSENT FOR TREATMENT AND POLICIES

Welcome! Below is information that you may find helpful about my services.

Appointments

Typical office hours are Monday, Tuesday, Thursday, and Friday from 9:00 am through 3:00 pm. Since I don't answer the telephone during sessions, it is best to leave me a voicemail message. I'll return your call within 24 hours on business days. When calling to schedule an appointment, be sure to leave several preferred dates and times on your voicemail. If circumstances prevent you from arriving on time, please understand that I must follow my regular schedule.

Cancellations

A 24-hour advance notice MUST be given for cancelled appointments. This will enable me to use the session time for other clients. In the event that you need to cancel or reschedule an appointment, please give me as much advance notice as possible so that I may offer the time to another client. If you cancel with less than 24-hour notice, you will be billed a $75 fee. Exceptions to this rule are made for family emergencies, illness, or inclement weather.

Fees

It is customary to pay for professional services at the beginning of the scheduled appointment. Payment may be made through cash, check, or credit card.

My fee schedule is: $175 per initial intake session
$125 per 50-minute individual session
$135 per 50-minute couple or family session

Telephone calls longer than 15 minutes may be charged at a pro-rated amount per minute increments.

Guarantee on Account

All accounts must be guaranteed with an active credit card. Your signature will be kept on file, and your credit card will be charged either at your request or with a 30-day notification of any outstanding service balances for items such as co-pays, deductibles, and cancellations with less than 24-hour notice. There is a $25 service charge for NSF or returned checks. Regardless of your insurance status or authorization, you are ultimately responsible for the balance on your account for all professional services provided.

Insurance

If you have health insurance, it will usually provide some coverage for mental health treatment. I am happy to work with any insurance company that will work with me. Nonetheless, it is a ***really*** good idea for you to double-check your coverage with your insurance company. Mental health coverage is often contracted separately from the rest of your medical benefits and may have a deductible, limitations, exclusions, and/or higher co-pays. Benefits may also change from year to year. It is your responsibility to notify me of any changes in plan coverage.

Emergencies

If you are having an emergency, please do one of the following options as best suits the circumstances:

- Call Multnomah County Mental Health Crisis Line: 503.988.4888
- Go immediately to the nearest emergency room
- Call 911

Confidentiality and Data Privacy

Confidentiality of information and records is strictly maintained. Except in the situations described below, no one other than you can access your information without a signed release of information from you authorizing me to communicate with a person or agency.

Some Limits of Confidentiality Based on Law:

- **Child or Elder Abuse:** I am required by Oregon law to report instances of abuse or neglect of a child or vulnerable adult.
- **Suicide or Violence:** I am required to disclose information without your consent if you are at substantial risk for harming yourself or someone else.
- **Non-custodial Parents:** When the client is a minor, by law non-custodial parents can gain access to their adolescent's records.
- **Court Order:** In some cases, a court will order the release of your records or your record may be subpoenaed. I do all that I can to maintain the confidentiality of your records in these instances, but must comply with the specifics of a court order.
- **Other Circumstances:** There are additional circumstances specified in statute in which health care information must be released without the client's consent although these are rare. If you have questions, you may consult the Oregon Health Licensing Agency at 503.378.8667 or www.oregon.gov/OHLA/

Client Endorsement

My signature indicates that I have read, understood, and consented to these policies.

Signature: _____ Date:_____ Revised 3/10

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ACCOUNT INFORMATION

Insurance Information

Client Name: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber's Information:

Name: _____ Social Security #: _____ DOB: _____

Address: _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Billing Address: _____

ID Number: _____ Group / Policy Number: _____

Insurance Release

I understand that Amy Berg, Ph.D., LMFT may be required to furnish information about me to the insurance company indicated above in order to receive payment for services provided, and I authorize her to do so.

Signature: _____ Date: _____

Pre-Authorized Guarantee on Account

I hereby authorize Amy Berg, Ph.D., LMFT to keep my signature on file and to charge my account for the balances of customary charges for services provided to me and/or my family. I understand that this authorization will remain in effect until Amy Berg, Ph.D., LMFT has received written notification from me of its termination in such a time and manner that affords her a reasonable opportunity to act on it. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for all professional services provided. I certify that this information is correct to the best of my knowledge and that I will notify you of any changes.

☐ Visa ☐ MasterCard Cardholder's Name (as it appears on the card): _____

Address where statement is mailed: _____

Credit Card Number: _____ Expiration Date: _____ CCV:_____ (3 digit code on back of card)

Signature: _____ Date: _____

Revised 4/10

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ADULT INFORMATION FORM

Name: _____ Date: _____
Address: _____ Gender: ☐ M ☐ F Age: ___
City: _____ State: _____ Zip: _____ Date of Birth: _____

Referred by?_____

CONTACT TELEPHONE NUMBERS

PHONE NUMBERS	OK to leave messages? Yes	No	Primary contact number?
Home: ( ) _____	☐	☐	☐
Work: ( ) _____	☐	☐	☐
Cell: ( ) _____	☐	☐	☐

MARITAL STATUS

☐ Single
☐ Living as Married (_____ years)
☐ Married (_____ years)
☐ Separated (_____ years)
☐ Divorced (____ years)
☐ Widowed (_____ years)

EMERGENCY CONTACT INFORMATION

Name: _____
Phone: ( ) _____ Relationship to you: _____

PRIMARY CARE PHYSICIAN

Current Physician: _____
Physician Address: _____
Physician Phone Number: ( ) _____
Physician Fax Number: ( ) _____

CURRENT SYMPTOMS AND CONCERNS

☐ Sadness/depression
☐ Wide mood swings
☐ Seasonal mood changes
☐ Loss of pleasure/interest
☐ Fatigue
☐ Lack of motivation
☐ Withdrawal from people
☐ Crying spells
☐ Loneliness
☐ Low self-worth
☐ Guilt/shame
☐ Hopelessness
☐ Self-harm behaviors
☐ Suicidal thoughts
☐ Past suicide attempt(s)
☐ Anxiety/worry
☐ Panic attacks
☐ Racing thoughts
☐ Social discomfort
☐ Obsessive thoughts
☐ Compulsive behavior
☐ Excessive energy
☐ Suspicion/paranoia
☐ Flashbacks
☐ Hearing voices
☐ Visual hallucinations
☐ Distractibility
☐ Hyperactivity
☐ Impulsivity
☐ Work/school problems
☐ Relationship problems
☐ Aggression/fights
☐ Frequent arguments
☐ Irritability/anger
☐ Sexual problems
☐ Problems with pornography
☐ Computer addiction
☐ Gambling problems
☐ Parenting problems
☐ Eating problems
☐ Sleep problems
☐ Memory problems
☐ Abuse/physical violence
☐ Alcohol/drug use
☐ Other: _____

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FAMILY HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Spouse or partner			
Children			

☐ Parents married or living together
☐ Parents temporarily separated
☐ Parents divorced
☐ Mother remarried: # of times _____
☐ Father remarried: # of times _____

Has anyone in your family had a serious mental health issue? _____
_____
_____
_____
_____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

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			

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Alcohol								
Marijuana								
Cocaine / Crack								
Heroin / Opiates								
Methamphetamines								
Pain Killers								
Other:								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

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MEDICAL INFORMATION

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies ☐ Headaches ☐ Chronic pain ☐ Miscarriage
☐ Asthma ☐ Head injury ☐ Sleep disorder ☐ Abortion
☐ Dizziness / fainting ☐ Seizures ☐ Surgery ☐ Sexually transmitted disease
☐ Stomachaches ☐ Diabetes ☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center

To which cultural or ethnic group do you belong? _____

☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

MISCELLANEOUS INFORMATION

Employment

Employer: _____
Position: _____
Length of time in this position: _____

Stress level of this position:
☐ Low
☐ Medium
☐ High

☐ Stay at home parent
☐ Currently unemployed
☐ Disability or social security benefits

Education

☐ Yes ☐ No Are you currently attending college classes?
What is your highest level of educational achievement? _____

Military Service

☐ Yes ☐ No Have you ever been or are you currently serving in the military? Branch? _____

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? _____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings?