# Tracey Beagle LPC, PC

## Statement of Understanding and Consent for Treatment

Psychotherapy is not like a medical doctor visit; 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 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.

In couples therapy, if you and your partner decide to have some individual sessions, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish to be kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

I am generally available by appointment only, Tuesday through Friday. You may call and leave a confidential message at any time and I will return your call as soon as possible, sometimes before 8 AM or after 8 PM. My policy for after-hours coverage is to leave a message and I will return your call the next business day. If you are in need of urgent or emergency services after hours, contact your local social services crisis line (Washington County: 503-291-9111) or dial 911.

Please understand that information obtained from you is confidential under Oregon law. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received
2. When there is a reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/neglect of a child, elderly person, disabled person, or any animal is occurring or has occurred.
4. Information necessary for billing purposes, justification for treatment, and resolution of a complaint.

Your initial beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time.

_____ I understand and have reviewed statement of financial responsibilities.

_____ I have received a professional disclosure statement.

_____ I have received a copy of HIPPA's Notice of Privacy Practices.

_____ I understand that any records sent to or retrieved from other professionals will be marked and directed as "NO FURTHER DISCLOSURE" to protect your privacy

Your signature indicates that you understand this "Statement of Understanding and Consent for Treatment" and agree to the above. I hereby give Tracey Beagle, LPC consent to provide my treatment.

| _____ | _____ | _____ |
|---|---|---|
| **Print Name** | **Client Signature** | **Date** |

***Tracey Beagle, LPC PC***

## Statement of Understanding and Consent for Electronic Communication

I utilize various methods of communication to maintain contact with clients. Please understand this office is portable and thus phone contact with me will be on a cellular phone through a secure router in this office. There are various methods of contact with me including phone and email. I utilize text messaging in very limited circumstances and only for scheduling or basic information purposes.

Please be aware that electronic communication via telephone or email may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy. The type of information transmitted via email should be used for scheduling or other incidental issues only. Contacts to discuss all other issues should be made preferably in person or via phone if arises.

As a general rule, I do not have contact with clients outside of the office that is unrelated to mental health treatment. This rule applies to various internet messaging sites, social networking sites, and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

_____ I understand the risks associated with utilizing any electronic methods of communication and agree to do so at my own risk.

_____ I understand email contacts will be for scheduling and incidental purposes. All other forms of communication will be made preferably in person or via phone if emergency arises.

_____ _____ _____

Print Name Client signature Date

# Tracey Beagle, LPC

## 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. Please review it carefully.** You have the right to get a copy of your paper or electronic medical record, correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, get a list of those with whom we've shared your information, get a copy of this privacy notice, choose someone to act for you, and file a complaint if you believe your privacy rights have been violated. You have some choices in the way that we use and share information as we tell family and friends about your condition, provide mental health care, and market our services and sell your information. We may use and share your information as we treat you, run our organization, bill for your services, help with public health and safety issues, do research, comply with the law, address workers' compensation, law enforcement, and other government requests, and respond to lawsuits and legal actions. You can get a paper copy of your medical record. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html .We can share health information about you for certain situations such as reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in response to a subpoena. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**Client Signature:** _____ **Date:** _____

# Statement of Financial Responsibility and Authorization to Bill Insurance

**Fees**: The fee for professional services is $200 for the initial intake session and $175 for each individual session after initial intake session. Payment and insurance copays are due in full by cash, check, or credit card at the beginning of each session. You are responsible for these bills including any portion not covered or reimbursed by your insurance company. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

**Cancellation Policy**: Please call (no email or text) in advance to change or cancel an appointment to allow that time for another person. You are able to leave a message 24 hours a day. If you do not show for an appointment and do not call to cancel within 24 hours of the session, you will be billed $65. Health insurance does not cover this fee.

**Payment Policy and Agreement**: In the event that my account has not been paid within 90 days, or I miss an appointment without canceling at least 24 hours in advance, I authorize Tracey Beagle, LPC to charge the following account for services according to the financial policies and payment agreement above. At which time, the account will be charged any unpaid balance.

_____

Type of Card:
Visa Mastercard Amex Debit

Account Number:_____Expiration Date:_____
Card Holder Name:_____Security Code:_____
Address:_____Billing Zip Code:_____
Telephone:_____Email for receipt:_____
Signature:_____

Insurance Company: _____ Member ID Number: _____
Group Number: _____ Customer Service Phone Number: _____
Primary Subscriber (if not myself): _____ DOB of Subscriber: _____
Address of Subscriber: _____ Subscriber's Employer: _____

Covered Under Secondary Insurance? Yes No Name of Plan: _____

I have read this Statement of Financial Responsibility. I understand that I am responsible for my bill, payable to Tracey Beagle, LPC.

_____ _____ _____

Print Name Client Signature Date

# Tracey Beagle LPC, PC

## Professional Disclosure Statement

**Philosophy & Approach:** I utilize an eclectic approach, combining aspects of cognitive-behavioral, developmental, and humanistic aspects in counseling. I incorporate a variety of treatment modalities to fit the needs and learning styles of the client.

**Education & Training:** I hold a Masters Degree in Counseling Education from Portland State University.

**License Information:** As a Licensed Professional Counselor (LPC) of the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT), I will abide by its Code of Ethics. Additionally, I am required to complete and document 40 hours of Continuing Education (CE) every two years, focusing on increasing knowledge and/or skills in areas such as theory and techniques of counseling/therapy, and professional ethics.

**Client Bill of Rights:** The following client rights have been established by the Oregon State Board of Licensed Professional Counselors and Therapists [OAR 833-60-0001(4)(h)]. 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; and
    e) Defending claims brought by the client against the 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.

You may contact the Oregon Board of Professional Counselors and Therapists at the following address and phone number: 3218 Pringle Road SE, Suite 250, Salem, OR 97302-6312, 503.378.5499

**Print Name** _____ **Client Signature** _____ **Date** _____

# ADULT CONTACT INFORMATION FORM

Date Completed: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

## Contact Telephone Numbers

| | | Message OK? |
|---|---|---|
| Home Phone | (  ) _____ | ☐ Yes ☐ No |
| Work Phone | (  ) _____ | ☐ Yes ☐ No |
| Cell Phone | (  ) _____ | ☐ Yes ☐ No |

Email (if you wish to communicate by email) _____

## Emergency Contact Information

Partner's Name (if applicable) _____

May I contact your partner if I am unable to reach you? ☐ Yes ☐ No If yes, please provide phone numbers:

Work Phone (  ) _____

Cell Phone (  ) _____

Alternate Emergency Contact: _____

Home Phone (  ) _____

Work Phone (  ) _____

Cell Phone (  ) _____

Relationship to you: _____

## Primary Care Physician Information

Current Physician _____

Physician Address _____

Physician Phone (  ) _____ Physician Fax (  ) _____

# Adult Intake Form

Name: _____ Date: _____

## PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:_____

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following

- ☐ Yes ☐ No Have you ever felt the need to bet more and more money?
- ☐ Yes ☐ No Have you ever had to lie to people important to you about how much you gambled?

| Therapist Notes: |
| --- |
| |
| |
| |
| |
| |
| |
| |
| |
| |

## FAMILY AND DEVELOPMENTAL HISTORY

| Relationship | Name | Age | Quality of Relationship |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Stepmother | | | |
| Stepfather | | | |
| Siblings | | | |
| | | | |
| | | | |
| | | | |
| Spouse/partner | | | |
| Children | | | |
| | | | |
| | | | |
| | | | |

| Family Mental Health Problems | Who? |
|---|---|
| Hyperactivity | |
| Sexually Abused | |
| Depression | |
| Manic Depression | |
| Suicide | |
| Anxiety | |
| Panic Attacks | |
| Obsessive-Compulsive | |
| Anger/Abusive | |
| Schizophrenia | |
| Eating Disorder | |
| Alcohol Abuse | |
| Drug Abuse | |

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

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

| Therapist Notes: |
|---|
| |
| |
| |
| |
| |
| |
| |
| Init: ____ |

## 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 | | | |

| Therapist Notes: |
|---|
| |
| Init: ____ |

Name: _____

## SUBSTANCE USE HISTORY

| Substance Type | Current Use (last 6 months) | | | | Past Use | | | |
|---|---|---|---|---|---|---|---|---|
| | Y | N | Frequency | Amount | Y | N | Frequency | Amount |
| Tobacco | | | | | | | | |
| Caffeine | | | | | | | | |
| Alcohol | | | | | | | | |
| Marijuana | | | | | | | | |
| Cocaine/crack | | | | | | | | |
| Ecstasy | | | | | | | | |
| Heroin | | | | | | | | |
| Inhalants | | | | | | | | |
| Methamphetamines | | | | | | | | |
| Pain Killers | | | | | | | | |
| PCP/LSD | | | | | | | | |
| Steroids | | | | | | | | |
| Tranquilizers | | | | | | | | |

☐ 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: _____

| Therapist Notes: |
|---|
| |
| |
| Init: ____ |

## MEDICAL INFORMATION

Date of last physical exam: _____

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

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Asthma | ☐ Headaches | ☐ Stomach aches |
| ☐ Chronic pain | ☐ Surgery | ☐ Serious accident | ☐ Head injury |
| ☐ Dizziness/fainting | ☐ Meningitis | ☐ Seizures | ☐ Vision problems |
| ☐ High fevers | ☐ Diabetes | ☐ Hearing problems | ☐ Miscarriage |
| ☐ Sexually transmitted disease | ☐ Abortion | ☐ Sleep disorder | ☐ Other: _____ |

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

| Medication | Dosage | Date First Prescribed | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

| Therapist Notes: |
|---|
| |
| |
| Init: ____ |

Name: _____

## 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 (which one? _____)

To which cultural or ethnic group do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ 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.):_____
_____

| Therapist Notes: |
|---|
| |
| |
| Init: ____ |

## MISCELLANEOUS INFORMATION

**Employment**

Employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Stress level of this position: ☐ Low ☐ Medium ☐ High
Other jobs you have held: _____

**Education**

☐ Yes ☐ No Are you currently attending school?

☐ High School Graduate? Or ☐ GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

**Military Service**

☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____
☐ Yes ☐ No Were you in combat?

**Legal**

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain_____
_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____

| Therapist Notes: |
|---|
| |
| |
| Init: ____ |