Katrina I. Gould, MSW, LCSW
*Therapist for Adults * Couples * Groups*
*8125 S.E. Pine St. * Portland, OR 97214*
503-702-0877

Please fill out all applicable information
One form for each client. Thank you.

Date: ____________________

Name: ____

Prefered Pronoun: ___ She/Her ___ He/His ___ They/Their ___ Other ___________

Address: ____

City: ______________________________________ Zip: _________________

Cell Phone: ________________________ Email: ____________________________

Birthdate: _______________________ Age: _______

Employer: __________________________ Job Title: __________________________

Is your cell phone your prefered place for me to leave a message for you? ____________

Emergency Contact: ______________________________________

Relationship: ____

Cell Phone: ________________________

How did you hear about me? ___________________________________

If you were referred by someone, may I contact them to thank them for the referral (yes or no)?_____________

Cancellations:

If you need to cancel an appointment, you can cancel up to **24 hours** before your scheduled appointment without being charged for it.

By signing below, I acknowledge that **I am responsible for all charges that are not covered by insurance**, as well as for **charges for any session not cancelled within 24 hours**. I have also read the **Notice of Privacy Practices**.

Signature: _______________________________________ Date: _______________

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Client Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize **Katrina I. Gould, MSW, LCSW**, to use and/ or disclose certain protected health information about me to the party or parties listed below.

This authorization permits Katrina I. Gould, LCSW, to use or disclose to Quality Medical Billing Services (QMBS) the following individually identifiable health information required for the processing of your insurance claim which may include pertinent healthcare information as requested by your insurance company. Client confidentiality will be maintained to the fullest extent of the law.

This authorization will expire one year following termination of services.

When my information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **Katrina I. Gould, LCSW** has acted in reliance upon this authorization. My written revocation must be submitted to **Katrina I. Gould, LCSW**.

____ ____________________
Signature of client or legal guardian Date

____
Printed name of client or legal guardian

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Insurance
Insurance is a contract between you and your insurance company. I file claims as a courtesy to my clients. I do not accept responsibility for collecting your claims or negotiating a settlement on a disputed claim. I cannot render services on the assumption that charges will be paid by the insurance company. You are ultimately responsible for all services rendered. Your co-payment is due in full at the time of service unless negotiate otherwise.

Billing
My preferred way to handle payment is at the time of a session. However, I am open to billing clients with the following understanding: I bill clients when I am able to make the time to do it. This means that a client might get a bill at the end of the month one month and then not another for a couple of months.

Payment:
I charge $105.00 per session. Sessions are 50 minutes in length. The remaining 10 minutes of the hour (or more) are spent writing notes so that I can provide you with a high level of continuity of care. I prefer to be paid at the beginning of each session unless we have negotiated some other arrangement. I have a limited number of lower fee slots available to clients who qualify for them.

Cancellations:
If you need to cancel an appointment, you can cancel up to **24 hours** before your scheduled appointment without being charged for it.

Notice of Privacy Practices:
All communications between clients and myself are confidential - with some specific exceptions - and will not be disclosed to anyone without your written authorization.

These exceptions include: • The client discloses their intent or plan to harm themselves or another • The client discloses information that suggests an concern about child abuse, elder abuse, or dependent adult abuse. • In legal situations, when court-ordered by a judge, I am required to disclose information to comply with the law • Your case may be discussed in the context of clinical consultation in this event, no identifying information about your case is used.

Privacy and Technology:
I monitor my email on a regular basis, with the exception of weekends and holidays, and will make every effort to return your email as soon as possible. I am happy to communicate by email, text or phone. Again, to the extent that I have control over my email and phone accounts, those communications are confidential. However, I ask that clients understand technology and its confidentiality is still evolving and there may be circumstances I cannot anticipate that impact these communications. For that reason, I ask that clients consider the nature of what they send me through email, text, etc.

Quality Medical Billing

Phone 503-253-1653**Fax 503-253-0457

www.qmbs-medical-billing-service.com

Email: cholmes105@aol.com

Insurance Verification Form Date:

Type:

( ) Primary ( ) Secondary ( ) Supplemental ( ) MVA ( ) WC In Network? Y N

Patient ________________________________ ID# ____________________ DOB ____________

Insured ______________________________ ID# ___________ DOB ________

Address __________________________City, State, Zip ______________________________

Cell Phone: ________________ Other Phone: _____________________________ Group #

_________________________________ Group Name ____________________________

Insurance_______________________________________

Address _______________________________________

City __________________________________ State ________________ Zip________________

Phone #: ___________________________________ Fax #: _______________________________

Email/ Web Address ___________________________________

____

Circle one:

ND Acupuncture Chiropractic MT Mental Health

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Today's date ____________________________

Instructions Please each fill out one copy of this form and bring it to your first appointment. Be prepared to discuss any parts of the form that were particularly difficult to fill out, were particularly thought-provoking, or that struck you in some way.

Your Information:

Name ____ Age __________

Street Address ____

City ____ Zip code _____________

Cell: _____________________ Email: ____

Profession: ____

Length of time you and your partner have been together: ______________________________

Number of previous significant relationships & length of time they lasted: ________________

____

Partner/ spouse's name & age

____

How would you describe your sexual orientation? Heterosexual, Gay, Queer, Lesbian, Bisexual, etc.____ Current gender identity? Female, Male, Crossdresser, Transsexual, In transition, etc.

____

Are you sexually active at this time?

Are you satisfied with your sexual life?

Is spirituality important to you?

What is your spiritual or religious orientation or affiliation (if any)?

Family of Origin Information

Mother's Name Age Deceased?

City & State where mother lives

Mother's Profession

Mother's Health

Mother's Nationality Mother's Religion

Father's Name Age Deceased?

City & State where father lives

Father's Profession

Father's Health

Father's Nationality Father's Religion

Your Siblings: Include yourself in order of oldest first

1) Name ________________________________ Gender ________ Age ________

2) Name ________________________________ Gender ________ Age ________

3) Name ________________________________ Gender ________ Age ________

4) Name ________________________________ Gender ________ Age ________

Please write three words to describe the person(s) who raised you (biological, step, adopted,

grandparent, or other)

Mother / Other	Father / Other
Mother / Other	Father / Other
Mother / Other	Father / Other

Your children's names and ages

1) ______________________________ 2) ___________________________

3) ______________________________ 4) _____________________________

Please describe your current issues or problems in your primary relationship

When your partner/ spouse is stressed and exhibiting their worst behavior, describe how they act; what they do; what they look like

Names and telephone #'s of other therapist(s) you are currently seeing:

Names and telephone #'s of other therapist(s) you have seen in the past:

I may want to talk with them if it will help us work more effectively. By signing below, you are giving me permission to contact your therapist(s)

____

(your signature)

Health Care Checklist

You:

Anxious ____ Depressed ____ Substance &/or Alcohol Abuse ____ If yes, which substance(s) ______________________

You, continued:

Anger ____ Workaholic ____ Food Addiction ___ Sex Addiction ___

Spending/ Gambling ___

Physical Health (describe)

If Applicable, Your Partner/ Spouse:

Anxious ____ Depressed ____ Substance &/or Alcohol Abuse ____ If yes, which substance(s) ______________________

Anger ____ Workaholic ____ Food Addiction ___ Sex Addiction ___

Spending/ Gambling ___

Physical Health (describe)

If Applicable, Your Child or Children:

Anxious ____ Depressed ____ Substance &/or Alcohol Abuse ____ If yes, which substance(s) ______________________

Anger ____ Workaholic ____ Food Addiction ___ Sex Addiction ___

Spending/ Gambling ___

Physical Health (describe)

<u>Desired Outcome</u> – write a complete summary

In your own words, describe what you hope to accomplish during couples therapy. Please tell me your goals for your relationship. Also write down what you think the relationship would be like if the problem(s)/ issue(s) described above were solved. If you feel at all stuck, try phrasing your summary as a series of wishes, for example, "I wish my partner would learn to control his/ her temper," "I wish I could stop avoiding conflict," etc. Please be frank. It's very important that I understand the results you are seeking.

Client Name: ___________________________

Substance Use History

Alcohol Use

Do you use/ have you used alcohol? ____Current ____Past ____No

Alcohol Frequency ____Never ____Less than once a month ____1-4 times per month ____2-3 times per week ____ Daily

Usual Alcohol Consumption ____Never ____1-2 drinks per sitting ____ 3-4 drinks per sitting ____5 or more drinks per sitting

Intoxication Frequency ____Never ____Less than once a month ____1-4 drinks per month ____2-3 times per week ____Daily

Please check all alcohol related problems that apply:

Interpersonal Problems _____ Binges _____ Job Problems _____

Medical Complications _____ Arrests _____ Blackouts _____

Concern Over Drinking _____ Hangovers _____ Changes in Tolerance _____

Inability to Stop After 1st Drink _____Physical Withdrawal _____Assaults _____

Sleep Disturbances _____ Pass Outs _____ Seizures _____

Marijuana Use

Do you use/ have you used marijuana? ____Current ____Past ____No

Marijuana Frequency ___Never ___Less than once a month ___1-4 times per month ___ 2-3 times per week ___Daily

Frequency to Impairment ____Never ____Less than once a month ____ 1-4 times per month ____ 2-3 times per week ___ Daily

Please check all alcohol related problems that apply:

Interpersonal Problems _____ Binges _____ Job Problems _____

Medical Complications _____ Arrests _____ Blackouts _____

Concern Over Smoking _____ "Hangovers" _____ Changes in Tolerance _____

Inability to Stop with just one hit ____ Physical Withdrawal ____ Assaults _____

Sleep Disturbances _____ Pass Outs _____ Mental Health Impacts _____

Other Substance Use

Please check all other substances you have used in the past 6 months:

None ____
Inhalants ____
Prescription drugs ____
Cocaine ____

Sedatives ____
Opiates ____
Stimulants ____
Hallucinogens ____

Caffeine: ____ cups a day
Tobacco: ____ cigarettes a day

History of Substance Abuse Treatment

Stopped on own ____
Attended in-patient ____
Attended community-based program ____

Attended AA/ other 12-step program ____
Attended out-patient ____
None ____

Please Describe: