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: ____

Address: ____

City: _____________________________ Zip: _____________

Cell Phone: ____________________ Other Phone: _____________________

Email: ________________ Birthdate: ________ Age: ____

Employer: ___________ Job Title:___________________

May I leave a message for you at home (yes or no)? _____________ At work? _____________

Emergency Contact: ____

Relationship: ______________________________

Cell Phone: __________________ Other 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 received a copy of 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

This 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 $155.00 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.

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QMBS Phone 503-253-1653**Fax 503-253-0457
Quality Medical Billing 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 ____

<u>Instructions</u> 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.

<u>Your Information:</u>

Name ____Age

_____________Street Address ____

City ____Zip code _____________

Home Phone: __________________________________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

____

____

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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 _________________________________ Sex ___________Age _________
2) Name _________________________________ Sex ___________Age _________
3) Name _________________________________ Sex ___________Age _________
4) Name _________________________________ Sex ___________Age _________

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

Mother _______________________ Father

Mother _______________________________Father

Mother Father

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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)

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Health Care Checklist

You:

Substance &/or Alcohol Abuse ___ Anxious ___ ___Depressed ___ ___________

______Anger ___ Workaholic ___ Food Addiction ___ Sex Addiction ___ ___

______Spending/ Gambling ___ ____

Poor Physical Health (describe) ____

____

Your Partner/ Spouse:

Substance &/or Alcohol Abuse ___ Anxious ___ ___Depressed ___ ___________

______Anger ___ Workaholic ___ Food Addiction ___ Sex Addiction ___ ___

______Spending/ Gambling ___ ____

Poor Physical Health (describe) ____

____

Your Child or Children:

Substance &/or Alcohol Abuse ___ Anxious ___ ___Depressed ___ ___________

______Anger ___ Workaholic ___ Food Addiction ___ Sex Addiction ___ ___

______Spending/ Gambling ___ ____

Poor Physical Health (describe) ____

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____

Desired Outcome – 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.

____

____

____

____

____

____

____

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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 _____

Other Substance Use

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

None Prescription drugs Hallucinogens
Inhalants ___________Marijuana Sedatives
Cocaine _______Opiates Stimulants
Caffeine: ____ cups a day Tobacco: ____ cigarettes a day

History of Substance Abuse Treatment

Stopped on own Attended in-patient Attended out-patient
Attended community-based program Attended AA/ other 12-step program None

Please Describe: ____

____

____