Katrina I. Gould, MSW, LCSW

Therapist for Adults * Couples * Groups
8125 SE Pine St. * Portland, OR 97215
503-702-0877

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

Date: _____

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Birthdate: _____ Age: _____

Employer: _____ Job Title: _____

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

Emergency Contact: _____

Relationship: _____

Home Phone: _____ Work 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 Relationship to client

_____ _____

Printed name of client or legal guardian Date

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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 _____

Home Phone: _____ Cell Phone: _____

Group # _____ Group Name _____

Insurance _____ Claim # _____

Address _____

City _____ State _____ Zip _____

Phone #: _____ Fax #: _____

Email/ Web Address _____

Circle one:

ND Acupuncture Chiropractic MT Mental Health

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Today's date _____

Client Information and History

I have tried to provide adequate space for you to answer the questions but feel free to use the back if needed.

Name _____ DOB/ Age _____

Street Address _____ Zip code _____

City _____ Email _____

Cell Phone _____ Other phone _____

Are you (circle): single married coupled with significant other

separated divorced widowed

Please list the people you live with at the moment _____

_____

Why have you sought therapy at this time? _____

_____

_____

_____

What would you most like to sort out in our work together? _____

_____

_____

_____

Have you seen a therapist before? ___ Yes ___ No

If so, at what time was the therapy and who did you see?

What were your reasons for seeking therapy, and what was the experience like? _____

_____

In what areas of your life do you feel successful? _____

_____

_____

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What are sources of pleasure in your life? _____

_____

_____

Work and Education History

Current occupation: _____

How would you describe your level of satisfaction with your work? _____

_____

Medical History

How is your health at this time? _____

_____

Doctor's name _____

Have you seen your doctor this year? _____ What for? _____

_____

What medications are you currently on? _____

_____

Please list any surgeries or major illnesses you have had; indicate your age at the time.

_____

What allergies to do you have? _____

Health Care Checklist

You: Substance &/or

Anxious _____ Depressed _____ Alcohol Abuse _____

You, continued:

Anger _____ Workaholic _____ Food Addiction _____

Spending/ Gambling _____ Sex Addiction _____

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If Applicable, Your Partner/ Spouse:

Anxious _____ Depressed _____

Substance &/or Alcohol Abuse _____ Anger _____

Workaholic _____ Food Addiction _____

Spending/ Gambling _____ Sex Addiction _____

Physical Health (describe) _____

_____

If Applicable, Your Child or Children:

Anxious _____ Depressed _____

Substance &/or Alcohol Abuse _____ Anger _____

Workaholic _____ Food Addiction _____

Spending/ Gambling _____

_____ Sex

Addiction _____

_____Physical

Health (describe by name if you have more than one child) _____

_____

The family you grew up in

Mother/ Stepmother/ Foster mother (circle one)

Name _____ Age _____ Health status _____

Deceased (at what age and of what cause) _____

Primary occupation _____

What was her personality like? How did she treat you as a child, and how does she treat you now? _____

_____

Did she abuse any substances or have any mental or emotional disorders? _____

_____

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Father/ Stepfather/ Foster father (circle one)

Name _____ Age _____ Health status _____

Deceased (at what age and of what cause) _____

Primary occupation _____

What was his personality like? How did he treat you as a child, and how does he treat you now? _____

_____

Did he abuse any substances or have any mental or emotional disorders? _____

If you were not brought up by your parents, explain that situation here: _____

_____

_____

Siblings in order of birth

Name	Age now	How is your relationship with each at this time?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe what the atmosphere at home was like as you were growing up: _____

_____

_____

Describe ethnic and religious identification of your family: _____

_____

Current family:

Significant other/ Spouse (circle one)

Name _____ Age _____ How long together? _____

Describe your relationship _____

_____

_____

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Child: Biological/ Non-biological (circle one)

Name _____ Age _____

Describe your relationship _____

_____

_____

Other significant person

Name _____ Age _____

Describe your relationship _____

_____

_____

Do you have supportive friends? Describe _____

_____

Miscellaneous:

What are the important interests, projects, and/ or passions in your life? _____

_____

_____

Are there any financial issues that affect your mental health? Explain. _____

_____

Are there any legal issues that affect your mental health? Explain. _____

_____

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)? _____

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What do you consider your inner strengths and resources? _____

Please use the remaining space to tell me anything else you'd like me to know about you.

Desired Outcome

Describe what you hope to accomplish during therapy. How do you think your life would be different if the issues that are problematic for you were resolved?

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

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

History of Substance Abuse Treatment

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

Please Describe: