Introduction Letter

Bari Isaacson L.P.C.
845 SE Mosher St. mail: PO Box 594
Roseburg, OR 97470
Ph: (541) 492-7222 Fax:(541) 492-7221

Thank you for making a first appointment with me.

In making the best use of our therapy time it is helpful to have the enclosed information filled out and brought to your first session. If you've any questions, we can cover them when we meet. Depending on whether you downloaded forms from my website (www.bari-isaacson.com), there may be additional forms I will need with your signature.

I look forward to meeting you at _____ on _____.

> ***I do not make reminder phone calls.***
> ***Payment is due at the time of session.***

Please call me at 541-492-7222 or email: bisaacson@riousa.com if you are unable to keep this appointment or have other questions. I check my messages on a regular basis.

My office is on the corner of SE Mosher and Jackson Streets in downtown Roseburg (see map). It is accessible by Trans-Link bus system.
There is free off-street parking that is handicapped accessible to my main floor office. The parking lot behind the building requires you to use stairs to the main floor or you can walk around to the front entrance. Signs will direct you to my waiting area.

OFFICE POLICIES

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Appointments:

- Appointments are scheduled by calling **541-492-7222.** Please leave your name and a phone number with area code where I may reach you and a detailed message. I check my messages regularly and will return your call as soon as possible. You may call 24 hours a day to leave messages (including cancellations) on my voice mail system.
- **Late Cancellations and Missed Appointments:** *To avoid a $40.00 fee, cancellations or other changes must be made at least 24 hours prior to our scheduled appointment. This charge is the responsibility of the client and cannot be billed to insurance. Additional scheduling may not occur until this fee is paid in full.*

Insurance:

- There is no additional charge to bill your primary insurance company for your claim. By agreeing to bill your insurance, I am providing a service to you. *If your insurance does not pay or pays less than you expect, you are still required to pay your bill in full.* You are responsible for all charges not reimbursed by insurance.
- *You are expected to pay the insurance co-payment and deductible if applicable at the time of service.*
- I will not schedule a return appointment if you are behind two or more payments (for example two or more co-payments).
- Your portion of the account must be paid in full within 30 days.
  Bari Isaacson L.P.C. reserves the right to charge a fee of $5.00 per month on any balance overdue by 60 days.

Emergencies:

- ***In the case of a life-threatening situation or an after hours emergency, dial 9ll or go to the nearest emergency room. Emergency room personnel will typically attempt to contact your providers if you tell them who your counselor is.***

- ***My Voice Mail system allows for messages and provides you with my after hours emergency contact number(s).***

Fees:

- You will be charged for additional services such as reports, letters, filling out of forms and copies of records. A fee may be charged for phone consultations.
- Direct questions or concerns regarding business/financial matters to my office by calling 541-492-7222 or write to: bisaacson@riousa.com
- Forensic (legal) Testimony: In the event you require testimony or involvement in legal/court proceedings, you will be charged the prevailing rate for forensic (legal) testimony. I cannot provide both treatment and evaluation. I will be unable to disclose

any information pertaining to other family members or parties involved in treatment without their specific consent for disclosure.

Confidentiality and It's Limits:

At the first session you will be asked to sign an **"Acknowledgement and Consent to Treatment"** form. This allows me to set up your account and release the *minimum information* necessary to seek payment for our services.

The only way I will share clinical treatment information about you (written and/or electronic record*) is if you first sign an authorization for the release that specifies who is to receive the information and what is to be shared. There are, however ***exceptions to confidentiality:***

. It is legally required of me to act so as to prevent physical harm to yourself or others when there is 'clear and imminent' danger of that happening;

.I am legally required to and will report cases of abuse involving children, elders and the disabled;

.I may have to release your records when ordered to do so by a court of law. However, I will attempt to discuss this with you beforehand and request a written authorization for the release from you; and

.on occasion, clinicians ethically must consult with colleagues about their work. If your case were ever discussed, it would be done confidentially and with only the minimum necessary information for the consultation.

I expect my work to be helpful to you, but no counselor can ethically guarantee success. Counseling has both benefits and risks.

My approach to treatment is practical and problem centered with an emphasis on the client's present situation. At any time you may request a copy from me of my "Professional Disclosure Statement" that is on record with the Oregon Board of Licensed Professional Counselors and Therapists.

*for further information: www.hhs.gov/ocr/privacy/hipaa or a written copy is posted in office

9/2013

INTAKE & BILLING INFORMATION

Name_____ Date of Initial Appointment ____/____/____

Partner/Spouse or Parent Name if applicable_____

Mailing Address_____City & Zip_____

COMMUNICATION:
Telephone(s) home_____ cell_____ work_____
Email_____ to be used for non-urgent messages only

OTHER INFORMATION:
Gender circle M F Age____ Birth Date ___/___/____ Marital Status_____
Education highest grade_____ Partner highest grade _____
Occupation self _____ Partner _____
Client's Employer_____ Partner _____
Emergency Contact name & phone number _____
How did you hear about me?_____

BILLING INFORMATION: Cash ____ ***Insurance _____ *see below*** EAP _____

1. **Primary Insurance**

Name of Insured _____Insured Date of Birth ____/____/____
Name of Insurance Company _____
Insurance Identification Number _____
Relationship of Client to Insured Person self___ partner/spouse___ child____

2. **Secondary Insurance**

Name of Insured_____Insured Date of Birth ____/____/____
Name of Insurance Company_____
Insurance Identification Number_____
Relationship of Client to Insured Person self___ partner/spouse___ child___

*****PLEASE BRING YOUR INSURANCE CARD TO FIRST SESSION*****

Note: I do *not* make reminder calls for appointments

Office Use: co-pay/session fee $_____ Cash___ Check____ Credit /type_____

9/2011 doc.

Client Rights

(OAR 309-39-540)

Clients served by *Bari Isaacson L.P.C.* have the right:

a) To expect that their counselor has met the minimal qualifications of training and experience required by state law;

b) To examine public records maintained by the Board which contain the credentials of a licensee;

c) To obtain a copy of the Code of Ethics;

d) To report complaints to the appropriate Board;

e) To be informed of the cost of professional services before receiving the services;

f) To privacy as defined by rule and law;

g) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;

h) To refuse treatment unless mandated by a court; and

i) To be treated with dignity and respect.

9/2011

Medical History Questionnaire

Bari Isaacson, L.P.C.

Client's Name: _____Date of Birth: ____/_____/_____

This information will help me to help you; however if you are uncomfortable answering any of the questions, please feel free to leave them blank and we will discuss them in the first session.

All information is confidential

PROBLEM CHECKLIST: Check ( ) every item you have had.
Circle ( ) those problems which you consider serious and still trouble you.

__ Alcohol Abuse
__ Allergies food or environmental
List_____
__ Anger/Agitation
__Appetite change
__Anxiety
__Attention/Concentration difficulties
__Blood Pressure
__Decision making problems
__Depression
__Diabetes
__Divorce or separation
__Drug Use
__Eating disorder type_____
__Euphoric (high) mood swings
__Family Problems
__Fatigue/ low energy
__Financial problems
__Gambling
__Grief
__Guilt
__Hallucinations/hearing voices
__Headaches chronic
__Head Injury
__Heart Problems
__Hepatitis
__HIV
__Hypoglycemia
__Irritability
__IV drug use
__Memory problems
__Mood swings
__Obsessions
__Panic
__Phobias type_____
__Recent weight change
__Rituals (counting/checking)
__Sexual problems
__Self harm/mutilation
__Social isolation
__Sleep disturbance/nightmares
__Stomach problems
__Suicidal feelings
__Suicidal attempts
__Thyroid problems
__Trauma survivor
physical/emotional/sexual
__Ulcers
__Worry chronic

Other_____

Family & Interpersonal History

List others living in the home:

Name	Age	Relationship to Client

Overall Rating

Rate your **physical health** on a scale of 1 to 10 (1=very poor health, 10= excellent health) _____
Rate your current **psychological distress** (1=very low, 10=extreme distress) _____

Medical Information

Medical Care Provider (Physician or Other) _____
If you are under medical care at this time, explain the reason_____

List **any medication**(s) you are presently taking, prescribed or otherwise:

	Medicine	Dosage	Prescribed by	Reason for Taking
1.				
2.				
3.				
4.				
5.				

Surgeries/Injuries/Major Illnesses	Your Age or Year Occurred
1.	
2.	
3.	
4.	

Nutrition: Good___ Fair___ Poor____ **Appetite**: Good___ Fair____ Poor____

Sleep Pattern (check all that apply)

No Problem__ Problems falling asleep__ Early wakening__ Frequent wakening__
Non-restful___ Too much sleep___ Too little sleep___ Disturbing dreams___

Women Only: (check all that apply)
Pregnant or unsure___ Breast-Feeding___ Birth Control Method_____
If Premenstrual problems rate by circling: mild moderate severe
If Menopausal symptoms, rate by circling: mild moderate severe

Counseling/Treatment History

If you have you ever seen a psychologist, psychiatrist, social worker or counselor, fill out below

	When	Who	Problem	Date(s)/ Length of Treatment
1.				
2.				
3.				
4.				

If any member of your immediate/birth family has mental health problems, list:

	Who	Problem Area(s)
1.		
2.		
3.		
4.		

Were you ever assessed as having any of the following:
__Dyslexia __IEP (Individualized Education Plan) __504 Plan ___Remedial Classes

Legal Involvment

Have you ever been arrested, accused or convicted of a crime?
If Yes, describe:

Are you currently involved in the legal/court system? If so, why?

Have you legal representation? Who?

Education Highest grade completed for self_____ partner _____
Special training for self_____ partner_____

Employment Occupation for self_____Employer_____

Occupation for partner_____ Employer_____

Substance Use **no alcohol past 6 months___ no street drugs past 6 months___**
Type of use: Beer__ Wine___ Mixed drinks___ Coolers___ Straight Drinks___
How often do you drink_____ How much when you drink_____
Last time you drank to excess/were drunk?_____
Has your spouse or family every been concerned about your drinking/drug use? _____
Have you ever been cited or arrested for driving under the influence? _____ When_____
Have you ever been in Diversion or a treatment program for alcohol or drug use
When?_____ Where?_____

At what age(s) have you used street drugs_____ never_____
Type of drug(s) when using:

Personal Habits If you smoke cigarettes, how much_____For how long_____
If you chew tobacco, how much_____ For how long_____
If you use caffeinated beverages on a daily/regular basis,
Type_____ How much_____
Type_____ How much_____

Life Experiences
If you have served in the military, which branch_____
Combat?_____ Dates of service_____
Where stationed_____ Type of discharge_____

Have you ever been pushed, slapped, choked, bruised in a relationship? _____
If yes, has this happened within the past 3 months? _____

Has anyone ever touched, fondled or in any other way been sexually inappropriate with you? ___

If you have experienced a traumatic life threatening injury or event, describe briefly
_____
_____
_____

Current Problem – ***Describe briefly why you are seeking counseling***
_____
_____
_____
_____

Acknowledgement and Consent to Treatment

Summary of Privacy Practices - Bari Isaacson, LPC

My commitment to you:

I recognize the importance of maintaining your privacy and confidentiality. My release of information about you *whether in written or electronic record format* * is guided by the following principals:

. I release *only the minimum* information necessary for a given purpose (an example is to process your insurance claim or set up billing records).

. I release *only the minimum* information necessary to other health care providers to make decisions and coordinate your care and treatment (an example is to consult with a primary or other medical/mental health specialist)

. I will share or release to you or any treatment provider (with your authorization) any and all records necessary to provide for your care and treatment.

. You may request that some or all of your protected health information not be used or disclosed. I am not required by law to agree with such requests especially if the information is necessary for effective treatment or would result in the appearance of fraudulent activity.

I or We have been given a copy of the Office Policies

1. I/We understand 'Confidentiality and It's Limits'
2. I/We agree to not involve Bari Isaacson LPC in legal or court issues unless specifically agreed upon at the start of treatment
3. I/We consent to allow Bari Isaacson LPC (my billing representative) to release protected health information necessary for processing my insurance claim
4. I/We consent to the release of clinical record information to the insurance company for the purpose of utilization review and quality assurance review
5. I/We have read and agree to the directions and guidelines in the "Office Policies"
6. I/We agree to make all co-payments and pay balances on unreimbursed insurance billings (for example deductibles and uncovered services)
7. I/We agree to cancel 24 hours prior to a scheduled session and to pay late fees for any session cancelled with less than 24 hours notice.
8. Phone consultations, letters to attorneys, agencies or other entities will be billed at $15 per quarter hour with a $15 minimum.

Attention Parents & Custodians of Minors

Under Oregon law, both parents are entitled to a minor child's records. This means that all statements made by either parent could be included in a child's record and accessible to both parents whether written or electronic.

I/We give free consent for this treatment.

_____ Date___ /_____/_____

_____ Date___/_____/_____

*Uses and disclosures of Electronic Health Record (EHR) information is available at: www.hhs.gov/ocr/privacy/hipaa or posted at my office.