

**Catherine Beckett, LCSW, PhD**  
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Hello!

Welcome. I look forward to meeting you, and to working together. My foremost concern is that your counseling needs and goals are met. This letter outlines office policies and other issues related to beginning counseling, and is meant to allow us to begin our important conversations more quickly. Please read through this letter, sign where indicated, and bring it to your first session. Should you have any questions about the contents prior to signing, please feel free to call me, or to ask when you come in.

### **Confidentiality**

Our sessions are completely private and confidential, with the following exceptions: 1) my legal obligation to report abuse of children or elders; 2) a subpoena requiring release of records to the court; 3) a serious threat of harm to yourself or another; 4) a medical emergency; and 5.) information required by insurance companies to receive benefits.

I may consult with clinical colleagues regarding your care; however, your name and identity will be carefully protected. I will communicate with your other care providers only when you have signed a Release of Information authorizing this communication, and will then disclose only the specific information you have authorized.

Please ask if you have any questions about confidentiality. My priority is to provide you with a trustworthy relationship and to protect your privacy to the fullest possible extent.

### **Guiding Principles**

There is no “one-size-fits-all” approach to therapy; my intent is to work collaboratively with you to determine what approach will be the best fit for you. I do believe strongly in not only addressing problems, but also recognizing and building on strengths; I also believe that while examining the influence of the past can be helpful, good counseling also builds strategies for moving forward. If at any time you feel that the approach or treatment is not helpful or needs to be redirected, please say so. I will ask for ongoing verbal and written feedback in order to track how counseling is working for you and to make adjustments to the work we are doing together.

Although counseling is generally a very safe way to address your concerns, there are some risks associated with it. Some people experience an increase in stress at first. Some problems may get worse before they get better; discussing long-standing unresolved conflicts or unhappiness can be uncomfortable in the initial stages of treatment.

It is always advisable to check with your doctor when beginning any form of therapy, to ensure that none of your concerns are related to a medical problem. If you feel it would be helpful for me to communicate with your Primary Care Physician or other professionals treating you, I will be glad to do so with your written permission.

I share my office suite with other therapists, all of whom I hold in high regard. While we do provide each other with professional support, we are all independent practitioners; we do not assume liability for each other’s practices.

### **Availability**

I am available by phone during normal business hours, Monday through Friday. I will return all voice messages within 24 hours. If you feel you have an emergency situation, call 911 or the Multnomah County Crisis Line (503.988.4888), or go to the nearest emergency room.

**Legal Issues**

In order to protect confidentiality and the treatment relationship, it is my policy never to participate in any legal proceedings involving current or former clients. This means that I will not testify in cases of divorce, custody, workman’s compensation, competency, or any other legal actions. By signing this form, you are agreeing not to involve me in legal/court proceedings, or to attempt to obtain records of treatment for legal/court proceedings.

**Insurance**

At this time, the only insurance companies I bill directly are Lifewise, PacificSource and Kaiser (if referred and authorized by Kaiser). Should you wish to use another insurance to cover the cost of treatment, it is your responsibility to provide payment and then seek reimbursement. I will be happy to provide the documentation you need to submit to your insurer.

**Fees**

All fees, including co-pays, are due at the time of service. Payment may be made by cash, check, or credit card. Credit cards will be charged an additional \$1.00 per transaction to cover the rising costs of providing this service.

- *Self-pay individual session: \$170*
- *Self-pay couple or family session: \$180*
- *Individual sessions billed to insurance: \$190 (Couple/family session: \$200)*
- *Initial assessment visit billed to insurance: \$220*

In special situations, exceptions to the fee policy and rates may be negotiated. Please let me know if you have circumstances that create a hardship.

Our appointments are scheduled for a 50-minute block of time; this time is reserved exclusively for you. **A minimum of 48 hours notice is required to cancel or reschedule.** Other people may want an appointment if you cancel, but I do need at least this much advance notice to offer the time to someone else. There will be a charge of one half of the session fee for the first incident of a late cancel; the full fee will apply for any late cancels thereafter.

All balances on account are your responsibility regardless of insurance coverage. Interest will be charged on any balance after 90 days. NSF or returned checks incur a \$35 fee. I assess and may revise fees, based on community rates, once per year. I will discuss any rate changes with you at least two months in advance.

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**Consent to Treatment**

**I hereby consent to treatment for myself and/or my minor child by Catherine Beckett, LCSW, PhD. I have reviewed the contents of this document and agree to comply with all of its provisions. I understand I am financially responsible for all charges involved in these services, and I have had an opportunity to ask questions about billing, fees, office policies and my rights to privacy.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Catherine Beckett, LCSW, PhD**  
**Intake Information**

Name \_\_\_\_\_ Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ E-Mail \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_ OK to contact to coordinate care? Y \_\_\_ N \_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Pronouns \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
(Please clearly mark the number you would prefer to have me use to contact you.)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Current medications or supplements \_\_\_\_\_

\_\_\_\_\_ Allergies \_\_\_\_\_

Do you have any current or ongoing concerns about your physical health? \_\_\_\_\_

\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

***Insurance information below is only required if you will be using your insurance to cover counseling.***

Name of Insured \_\_\_\_\_ SSN# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber # / I.D. # \_\_\_\_\_ Group# \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION  
AND ASSIGNMENT OF INSURANCE BENEFITS**

- I hereby authorize the provider to furnish my insurance company with all information requested concerning claims arising from this treatment.
- I acknowledge that I am responsible for all charges not covered by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

What are the issue(s) that brought you here today? \_\_\_\_\_

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What goals do you have for this counseling work? \_\_\_\_\_

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Rate any of the symptoms you are experiencing: **1 = MILD 2 = MODERATE 3 = SEVERE**

- |   |  |
|---|--|
| <input type="checkbox"/> Feeling depressed                  | <input type="checkbox"/> Tearfulness/crying                  |
| <input type="checkbox"/> Feelings of hopelessness           | <input type="checkbox"/> Sleep changes or problems           |
| <input type="checkbox"/> Trouble concentrating/focusing     | <input type="checkbox"/> Lack of energy                      |
| <input type="checkbox"/> Short-term memory problems         | <input type="checkbox"/> Weight gain or loss                 |
| <input type="checkbox"/> Long-term memory problems          | <input type="checkbox"/> Behavior problems                   |
| <input type="checkbox"/> Change in appetite/eating habits   | <input type="checkbox"/> Change in sexual desire or function |
| <input type="checkbox"/> Trouble making decisions           | <input type="checkbox"/> Problems with family                |
| <input type="checkbox"/> Trouble performing job             | <input type="checkbox"/> Problems with friends               |
| <input type="checkbox"/> Social isolation or withdrawal     | <input type="checkbox"/> Feeling stressed or overwhelmed     |
| <input type="checkbox"/> Self-esteem issues                 | <input type="checkbox"/> Easily irritated                    |
| <input type="checkbox"/> Perfectionism                      | <input type="checkbox"/> Feeling guilty                      |
| <input type="checkbox"/> Obsessive thoughts                 | <input type="checkbox"/> Feeling nervous or anxious          |
| <input type="checkbox"/> Compulsive behaviors               | <input type="checkbox"/> Intense feelings of panic           |
| <input type="checkbox"/> Sudden or intense mood swings      | <input type="checkbox"/> Muscle tension/body stress          |
| <input type="checkbox"/> Issues with physical pain          | <input type="checkbox"/> Hostility                           |
| <input type="checkbox"/> Problems with anger                | <input type="checkbox"/> Substance use change or concerns    |
| <input type="checkbox"/> Intense sadness                    | <input type="checkbox"/> Self-harming behaviors              |
| <input type="checkbox"/> Thoughts of hurting self or others | <input type="checkbox"/> Other concerns about safety         |

Other symptoms? Please list: \_\_\_\_\_

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Catherine Beckett, LCSW, PhD  
(503) 319-8998

## 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.

### My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I also am required by law to keep your information private. These laws are complicated, but I must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, I can't cover all possible situations, so please feel free to bring up any specific questions or concerns.

I will use the information about your health that I get from you or from others mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities, which are called, in the law, health care **operations**. Along with this NPP, I will ask you to sign a **Treatment Consent Form** to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes, I will discuss this with you and ask you to sign a Release of Information form to allow this.

I will do all I can to keep your health information private, but there are some times when the law requires me to use or share it. For example:

1. If there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't arise very often. They are described in the longer version of the NPP; I will be happy to provide you with a copy of this document upon request.

### Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can obtain a copy of these records, but I may need to charge you for this service, as the materials may need to be reviewed with you in person.
4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (this is called amending) to your health information. You will need to make this request in writing, and to include the reasons you want to have the changes made.
5. You have the right to a copy of this notice. If I change this NPP I will post the new version in my waiting area.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me directly and/or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please let me know.

The effective date of this notice is 2001.

Also, you may have other rights which are granted to you by the laws of our state, and these may be the same or different from the rights described above. I will be happy to answer questions about these situations with you now or as they arise.

***By signing below, I acknowledge that I have received a copy, or have been offered and declined a copy, of this Notice of Privacy Practices.***

Signature \_\_\_\_\_

Date \_\_\_\_\_