Catherine Beckett, LCSW, PhD
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Hello and 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 provide payment for covered services.

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 if you have signed a Release of Information form authorizing this communication, and will then disclose only the specific information you have authorized.

Please ask if you have any questions about confidentiality. My intent 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; I will work collaboratively with you to identify goals and determine what approach might be the best fit for you. I 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 what we are doing is not helpful or needs to be redirected, please say so. I will ask for ongoing feedback in order to track how counseling is working for you and to guide 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 symptoms or problems may get worse before they get better; attending to 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 might be related to a medical problem. If at any point you would like me to communicate with your primary care doctor or other professionals treating you, I will be glad to do so (with your written permission).

I share my office location with other therapists. While we do sometimes provide each other with professional support, we are all independent practitioners; we do not assume liability for each other's practices.

Service Options and Availability

At this time, I offer sessions both in person and via telehealth (Zoom). Though masking is no longer required in health care offices, I am always happy to mask in person if this is your preference; just let me know. If you are scheduled for an in-person appointment and are experiencing any symptoms of illness, please inform me and we can discuss options and determine the best way to proceed.

I am available by phone or email during normal business hours, Monday through Friday, and will return 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 both confidentiality and our treatment relationship, it is my policy not 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 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. Should you need an assessment for a court proceeding, I am happy to help you find a practitioner who can provide these services.

Insurance

At this time, the only insurance companies I bill directly are Lifewise and Pacific Source. Should you wish to use another insurance to cover the cost of treatment, it is your responsibility to provide payment in full and then seek reimbursement from your insurance company. I will be happy to provide the documentation that your insurer will need from me.

Fees

All fees, including co-pays, are due at the time of service. Payment may be made by cash, check, Venmo or PayPal.

- *Individual sessions, standard (billable) rate: $210 (Couple/family session: $220)*
- *Initial assessment visit, standard (billable) rate: $240*
- *Individual session with self-pay discount: $190*
- *Couple or family session with self-pay discount: $200*

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. Except in cases of illness or emergency, **a minimum of 48 hours notice is required to cancel or reschedule.** Someone else may want to take an appointment spot if you cancel, but I do need at least this much advance notice to offer the time to someone else.

All balances on account are your responsibility regardless of insurance coverage. Interest may be charged on any balance after 90 days. NSF or returned checks incur a $40 fee. I assess and may revise fees, based on community rates, once per year. I will discuss any changes with you at least two months in advance.

* * * * *

Consent to Treatment

I hereby consent to treatment for myself by Catherine Beckett, LCSW, PhD. I have reviewed the contents of this document and agree to comply with all of its provisions. I understand that 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 Name (Printed)

_____
Client Signature

_____
Date

Catherine Beckett, LCSW, PhD
Intake Information

Name_____ Street Address_____

City, State, Zip _____E-Mail _____

Date of Birth_____ Age_____ Pronouns _____

Best phone number to use to contact you _____

Referred by_____ Primary Care Doctor_____

Doctor's Phone Number _____OK to contact to coordinate care? Y___ N___

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? _____
_____
_____
_____

What goals do you have for this counseling work? _____
_____
_____
_____

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

___ Feeling depressed

___ Feelings of hopelessness

___ Trouble concentrating/focusing

___ Short-term memory problems

___ Long-term memory problems

___ Change in appetite/eating habits

___ Trouble making decisions

___ Trouble performing job

___ Social isolation or withdrawal

___ Self-esteem issues

___ Perfectionism

___ Obsessive thoughts

___ Compulsive behaviors

___ Sudden or intense mood swings

___ Issues with physical pain

___ Problems with anger

___ Intense sadness

___ Thoughts of hurting self or others

___ Tearfulness/crying

___ Sleep changes or problems

___ Lack of energy

___ Weight gain or loss

___ Behavior problems

___ Change in sexual desire or function

___ Problems with family

___ Problems with friends

___ Feeling stressed or overwhelmed

___ Easily irritated

___ Feeling guilty

___ Feeling nervous or anxious

___ Intense feelings of panic

___ Muscle tension/body stress

___ Hostility

___ Substance use change or concerns

___ Self-harming behaviors

___ Other concerns about safety

Other symptoms? Please list: _____
_____

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 _____