The DBT Clinic
2104 SE Morrison St.
Portland, OR 97214

Office: 971-285-6545
Fax: 503-764-9483

Client-Therapist Agreement/Informed Consent

The DBT Clinic and its staff consider working with you a privilege and we are grateful for your trust. In an effort to avoid misunderstandings, our policies for conducting counseling services are outlined below. **Please read the following policies carefully.** If anything is not clear, or if you'd like an explanation, feel free to ask. **If you agree to these policies, please sign below.**

- **Payment is due at time of service,** unless other arrangements are made. If your therapist is in-network with your insurance company, we'll collect your deductible and copay, and bill to your insurance company. **If costs are incurred in pursuit of collection of money owed by a client, the client is responsible for those costs. Clients are responsible for tracking benefits, authorizations and eligibility. If you do not know this information at time of intake, your therapist must take time out of the intake session to determine eligibility benefits before preceding.** If your therapist is out-of-network, they will discuss the specifics of your coverage with you at or prior to the time of intake. **Please have your out-of-network benefits information on hand.**
- **Fees:** Unless other arrangements are made, The DBT Clinic fees are as follows: Individual Therapy-$180-$250.00; Group Therapy-$55.00/hr; Family Therapy-$180-$250; Court Testimony-$200/hr, including travel time (client responsibility); Training and Consultation-$180/hr, including travel time.
- **Cancellation Policy:** Your appointment is reserved specifically for you. If you are unable to keep your scheduled appointment, **please give at least 24-hours notice**, **excluding weekends.** Without this prior notice, **you will be charged the full amount the insurance company would pay for the session.** If your therapist is able to fill this time with another client, you will not be not be assessed a fee.
  In the case of group therapy, even with 24-hr advanced notice of cancellation, a $20.00 fee is applied as a spot is reserved for the ongoing group until or unless the client withdraws, is terminated or graduates.
- **Crisis**: If you are in a crisis (defined as having difficulty resisting suicidal urges, self-harm or substance abuse) between sessions, you are encouraged to call the Crisis Line in your community (Mult. Co. 503-988-4888; WA Co. 503-291-9111; Clack. Co. 503 655-8401; Clark Co. 360-737-1399), call 911 or go to an Emergency Room. **Do not hurt yourself!**
- **Confidentiality**: Communications between you and your therapist are privileged and private. However, there are limits to confidentiality. These limits include the following: If you intend to harm yourself or others and have reasonable means and intent to act on those urges, **we are required by law to do what we can to keep you and others safe**. We do our best to cooperate with you in this process, however we will contact emergency services if we believe there is an imminent risk to life or limb. We are also mandated reporters and by law must report any abuse of children, the elderly and persons with disabilities. If we receive a subpoena by a court, we may be compelled to release records and/or testify. You can waive privilege by signing a **release of information,** which allows us to communicate to specified persons or agencies as noted on the release. In the case of family therapy, the all parties being treated have privilege. In as much, all parties have to sign releases of information in order to send records to other parties. If you're using insurance to pay for services, you must agree to allow us to communicate such information as is necessary to secure authorization and payment for treatment. For a more detailed list of protections and limits to your Personal Health Information, please refer to the HIPPA Act, a copy offered at intake and available at any time upon request.

If you agree to the terms outlined above, please note with your signature below:

Client(s) signature(s):

_____ Date: _____

_____ Date: _____

Printed Name(s):

_____

_____

The DBT Clinic, PC

Client-Therapist Agreement/Informed Consent
(Client Copy)

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If you agree to the terms outlined above, please note with your signature below:

Client(s) signature(s):

_____ Date: _____

_____ Date: _____

Printed Name(s):

_____

_____

AGREEMENT TO TREAT

I, _____agree to enter counseling treatment with The DBT Clinic, PC with the following understandings:

1. I understand that although there is empirical evidence for the effectiveness of psychotherapy, this evidence is not presented as a guarantee either direct or implicit of the effectiveness of this treatment. I understand that things may feel worse before they get better and that this is natural part of the therapeutic process.

2. I understand each individual must independently evaluate and use his or her own judgment in choosing among treatments and therapists available.

3. I understand there are other therapist and treatments available to me.

By signing my name below, I understand and accept all terms of this agreement.

_____ _____

Client Signature Date

_____ _____

Therapist signature Date

Informed Consent Addendum:Policies Regarding Electronic Communications

Client confidentiality is protected by law. Communications via e-mail and text messaging can be intercepted at a number of junctures. Therefore, **The DBT Clinic, PC will not communicate any clinical information via text messaging or e-mails.** It is permissible to use these methods of communication to cancel or change appointments. Clients are discouraged from sharing personal information in this manner. If you have personal/clinical concerns you'd like to discuss, it's advised you leave a voicemail message. If you prefer to email or text, it's advised to state you would like me to call you to discuss a concern, but please don't go into specifics of what your concern is.

Client's signature below indicates the client has been informed of this policy:

_____ _____

Client Signature Date

Client Intake Questionnaire (Adults)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Legal Name _____ Date _____

Preferred Name _____ Pronouns _____

Gender Identity _____ Ethnicity/Cultural Identity _____

Home Phone _____ Cell Phone _____

Home Address _____

City _____ State_____ Zip Code _____

Date of Birth _____ Age _____ Marital Status _____

Job title _____ Employer _____

Email Address _____

Can I leave a message? ○ No ○ Yes
May I identify myself and my profession? ○ No ○ Yes

Emergency Contact Information:

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Do you authorize this person to discuss care or treatment with the office in the case of an emergency? ○ No ○ Yes
Can I leave a message? ○ *No* ○ *Yes*
May I identify myself and my profession? ○ *No* ○ *Yes*

Do we have an ROI (Release of Information) on file for you from previous mental or physical health professionals? ○ No ○ Yes

If no, please fill out the online ROI on our website (www.thedbtclinicportland.com/forms) and bring this in with this packet. **This is highly encouraged for coordination of care.**

The DBT Clinic, PC

Mental Health Information Sheet

Describe your current concerns, issues, or symptoms that you hope to resolve:

_____
_____
_____
_____

How long have these symptoms been occuring? When did they first occur?

_____
_____
_____

Have you *ever* had thoughts of harming yourself in any way (including self-injury and suicide)?
○ No ○ Yes If yes, when was the last time you felt that way? _____

Have you *ever* had thoughts of harming others in any way? ○ No ○ Yes
If yes, when was the last time you felt that way? _____

Have you ever attempted suicide? ○ No ○ Yes If yes, when and what method did you use?

_____

Have you ever self-injured? ○ No ○ Yes If yes, when was the last time and what method did you use? _____

Have you ever been psychiatrically hospitalized? If so, when, where and why? _____
_____
_____

Have you had previous counseling? What did you enjoy and dislike about your sessions?

_____
_____

What is your goal for therapy? How will you know when therapy is done?

_____
_____
_____

Please list any other information you think would be helpful for treatment:

_____
_____
_____
_____
_____

Please list the other mental health therapists you have seen, when and how long below:

_____
_____

The DBT Clinic, PC

Depression Screener (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you marked any of the above questions anything other than 'Not at all' how difficult have they made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult

Anxiety Screener (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you marked any of the above questions anything other than 'Not at all' how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somew hat Difficult	Very Diffic ult	Extremel y Difficult

The DBT Clinic, PC

General Health Information

Primary Care Practitioner: _____ Date of last visit: _____

Clinic Name: _____ Phone Number: _____

Dentist Name/Clinic: _____ Date of last visit: _____

General medical illnesses that I have or had (for example: cancer, arthritis, heart, thyroid, neurological diseases, or other illnesses such as migraines, chronic fatigue syndrome, etc.).

_____

_____

General medical illnesses that run in my family (such as diabetes, heart disease and others).

_____

_____

Prescriptions or over-the-counter medications that I take regularly (**Include reason and dosage**).

_____

_____

_____

_____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

1. How often do you drink alcohol per week?	Not at all	A couple days	More than half the days	Nearly every day
2. How often do you have more than one drink per day?	Not at all	A couple days	More than half the days	Nearly every day
3. How often do you have more than three drinks in a day?	Not at all	A couple days	More than half the days	Nearly every day
4. How often do you engage in recreational drug use per week?	Not at all	A couple days	More than half the days	Nearly every day
5. If you have used recreational drugs in the past, how often did you use per week?	Not at all	A couple days	More than half the days	Nearly every day

Specify what substance(s) you have used, for how long and when you stopped?

_____

_____

Payment Information

Please indicate how you intend to pay for treatment:
Cash: _____ Check: _____ Credit Card: _____ Insurance: _____ Third-Party: _____

Please indicate how you intend to pay for copay (if applicable and different from above):
Cash: _____ Check: _____ Credit Card: _____ Insurance: _____ Third-Party: _____

If a third-party will be paying for your treatment (copay or late fees apply), please provide the following information:
Name of the person paying for your therapy: _____

Your Relationship to this person: _____

Phone Number for this person: _____

Email for this person: _____

If a third party is paying, please have the third-party fill out and sign the form below.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ HSA or FSA Card
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
CVV:
Cardholder Billing Address:

I, _____ (Credit card holder from above), authorize The DBT Clinic, PC to charge my credit card above for agreed upon purchases on _____'s (Client being seen at The DBT Clinic, PC) account. Including, but not limited to: copay for any therapy service provided, late cancel, no show, deductible, full session charges, any outstanding balances, etc.). I understand that my information will be saved on file for future transactions on the client's account.

Credit Card Holder Signature _____ Date _____

Credit Card Holder Printed Name _____

Client Signature _____ Date _____

Client Printed Name _____

Insurance Information

(If you don't know your deductible and copay or coinsurance, please call your insurance company for this information BEFORE your appointment)

Primary Insurance Company: _____

Identification ID# _____ Gp # _____

Deductible $_____ Deductible met? ○ No ○ Yes How much is left? _____

Co-pay or Co-insurance: _____ Out-of-Pocket Max: _____

Preauthorization required? ○ No ○ Yes Auth. # _____

Subscriber Information Relationship to client ○ Self ○ Spouse ○ Parent ○ Other

Name _____ DOB _____

Address _____City _____ State _____ Zip _____

Phone _____ Insured's employer _____

Secondary Insurance Company (if applicable): _____

Identification ID# _____ Gp # _____

Subscriber Information Relationship to client ○ Self ○ Spouse ○ Parent ○ Other

Name _____ DOB _____

Insurance Notes:

_____

_____

The DBT Clinic, PC and its contracted billing service have my permission to bill my insurance company. I authorize The DBT Clinic, PC and it's contracted billing service to release any information necessary to process claims and secure authorization for treatment. I further authorize my insurance benefits be paid directly to The DBT Clinic, PC.

Signature: _____ **Date**: _____