DBT of Southern Oregon
Ph: (541) 621-0303 Fax:541-779-3260

INSURANCE RELEASE FORM

Client Name: **Date:**

Insurance Information		For Secondary Insurance	
Policy Holder's ID/SS#		Policy Holder's ID/SS#	
Ins Co. Name		Ins. Co. Name	
Policy Holder's Name		Policy Holder's Name	
Relationship to client		Relationship to client	
Policy Holder's Address		Policy Holder's Address	
Policy/Group #		Policy/Group #	
Policy Holder's DOB		Policy Holder's DOB	
Male _____ Female _____		Male _____Female _____	
Employer		Employer	

Deductible $_____ Has it been met? Yes ☐ No ☐ Co-payment $_____
Person responsible for deductible and co-payments: _____
Address of responsible party:

_____
Street City State Zip

Does your insurance company authorize these visits? Yes ☐ No ☐
Authorization number _____ Number of visits ____

Referred by:_____

Nearest relative or friend I can contact in case of emergency:

_____
Name Relationship Phone

IF YOU WOULD LIKE ME TO BILL YOUR INSURANCE COMPANY FOR YOU, PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

Fees for service are $160.00 per 50 minute session with group rates posted. I understand that I am ultimately responsible for these fees, and agree to pay any balance not covered or disallowed by my insurance. I further understand and agree that I will be charged $40.00 for a missed session that I do not cancel within 24 hours and $80.00 for any session I do not call to cancel and do not attend. I hereby authorize the release of any personal information necessary to process my insurance claim, including my diagnosis. I understand that may become a permanent part of my insurance records. I authorize payments directly to Claudia Stevens, LCSW. I received a copy of the professional disclosure statement at my initial session ____.

RESPONSIBLE PARTY SIGNATURE_____
Date

THERAPIST SIGNATURE _____
Date

DBT of Southern Oregon
Ph: (541) 621-0303 Fax:541-779-3260

Client Rights And Responsibilities

Client Name:	**Date:**

Confidentiality Everything we discuss in session will be held confidential with the following exceptions:

1. I am required by law to report suspected child or elder abuse
2. I will breach confidentiality if I feel you are in imminent danger of harming yourself or someone else.
3. I may need to make reports to other agencies with your consent.
4. I may need to consult with my supervisor or colleagues about your case (your name will be withheld).
5. I may need to present information from your records in court if a claim is filed against me, by you.
6. I will need to release a limited amount of information about you to your insurance company in order to process claims. This may include diagnosis and treatment plan, and this information may become a permanent part of your insurance records.
7. You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court or your past due status is reported to a credit reporting agency, the fact that you received treatment at my office may become a matter of public record.

Client Rights As a client of an Oregon licensee you have the following rights:

1. To expect that your therapist has met the minimum qualifications of training and experience required by state law.
2. To examine public records maintained by the Oregon State Board of Clinical Social Workers, 3218 Pringle Rd. SE Suite 240, Salem, Oregon 97302 and to have the board confirm your therapist's credentials.
3. To obtain a copy of the code of ethics.
4. To report complaints to the board.
5. To be informed of the costs of services prior to receiving services.
6. To be free from discrimination on the basis of race, religion, gender or any other protected category while you are receiving services.
7. To review your records.
8. To not be exploited by your therapist for their own personal benefit or advantage.
9. To be assured privacy and confidentiality with the previously mentioned exceptions.

Client Responsibilities:

1. To keep all scheduled appointments and to contact me at least 24 hours in advance to cancel or reschedule.
2. To attend all sessions alcohol and drug free.
3. To make all your payments completely and on time and notify me of changes to your insurance promptly.
4. To be active in the treatment process.

Permission to treat: I acknowledge that it is my choice to participate in therapy and I realize that the outcome of therapy depends upon my personal investment in the treatment process. If I decide to terminate treatment I will discuss termination before ending treatment.

HIPPA NOTICE : I have been offered a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy guidelines. I have read this and understand how my private health information will be used.

Before you sign below, please ask any questions you may have of this document. Your signature acknowledges agreement and understanding of this contract.

CLIENT SIGNATURE_____ **Date**

PARENT SIGNATURE_____ **Date**

THERAPIST SIGNATURE _____

DBT of Southern Oregon
Ph: (541) 621-0303 Fax:541-779-3260

CLIENT INFORMATION

Today's Date: _____

Client Name_____ Date of Birth_____

Mailing Address_____
Street City Zip
Physical Address_____
Street City Zip
Home Phone_____ OK to leave message?____ Work Phone_____
OK to leave message?____ Cell Phone_____ OK to leave message?____

Employer _____ Occupation_____

Emergency contact _____ Connection to You _____
Their Cell Phone_____ Home Phone _____

Please describe the specific concerns you'd like to address in our work together:
_____
_____

What are your expectations of therapy and how do you hope it will help you?
_____
_____

Name and phone number of your primary care practitioner:
_____

Are you currently taking any prescribed medications? **Yes ___No ____**
Name Dose How Often Taken For What Reason
_____
_____
_____

Describe any physical problems you have been experiencing during the past 60 days:
_____
_____

Have you been in therapy before? Briefly describe your experience and include any psychiatric hospitalizations as well as alcohol and drug treatment:
_____
_____

Are you ***currently*** working with **any** other Therapists or mental health providers such as a psychiatrist?
Yes __No ___ If **yes**, please provide name(s) and phone number(s).
_____