DBT of Southern Oregon
Integrated Health Services, INC
Ph: (541) 621-0303 Fax:541-708-6557

CLIENT INFORMATION

Today's Date: _____

Client Name_____ Date of Birth_____ Age _____

Mailing Address_____
Street City Zip
Physical Address_____
Street City Zip
Cell Phone_____ Leave message? Y__ N__ Work Phone _____
Leave message? Y___ N___ Home Phone _____ Leave message Y___ N___
Employer _____ Preferred Pronouns: _____

Who lives in the Home: _____
_____

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

Are you currently taking any prescribed medications? **Yes C No C**

Name Dose How Often Taken For What Reason
_____
_____
_____

Name and phone number of your Primary Care Practitioner: Are they Prescribing above Meds? Y__ N___
_____

Check all symptoms that you have experienced in the last two months:

Isolating from others___
Sadness ___ extreme? ___
Trouble concentrating ___
Problems getting along with friends or family ___
Eating more__ Eating Less ___
Extreme mood swings ___
Trouble performing your job ___
Lack of enjoyment of usual activities ___
Low self esteem ___
Thoughts of death ___
Obsessions or compulsions ___
Feelings of anxiety ___ Panic ____
Feeling suicidal ____Past ____

Feeling hopeless___
Feeling tearful ___
Sleeping more ___ Sleeping less ___
Lack of energy ___
Weight gain __ Weight loss ___
Change in sexual interest or function ___
Overspending/buying impulsively ___
Impulsive risky behavior ___
Easily irritated ___
Feeling excessive guilt ___
Feeling more talkative/pressured speech ___
Racing thoughts ___
Cutting self ___

Are you at risk to be harmed by physical violence? Y___ N___
Are you at risk of harming others? Y___ N___

Do you use Alcohol? Y___ N___ How often?_____ How Much?_____
Do you use Drugs? Y___ N___ How often? _____How Much? _____

Check any of the following that apply to you:

Depression Job stress/performance issues

Check any of the following that apply to you:

___ Depression
___ Anxiety/Panic Attacks
___ Drug or Alcohol use/abuse
___ Marital/Relationship Issues
___ Physical/Emotional Abuse
___ Sexual Abuse/Harassment
___ Eating/Food Issues
___ Gambling
___ Parent/Child Issues
___ Job stress/performance issues
___ Trauma issues
___ Visual/auditory hallucinations
___ Caretaker for the Elderly/Disabled
___ Medical /Health Issues
___ Porn
___ Grief/Loss Issues
___ Legal Issues
___ Other _____

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

Have you been in therapy before? Y ___ N___ Counselors Name _____
Approximate Dates _____ For what issue?_____
Any Psychiatric Hospitalizations? Y ___ N___ Where? _____
Approximate Dates _____ For what issue? _____
Alcohol and Drug Treatment: Y ___ N____ Where? _____ Inpatient Y ___ N___
Approximate Dates_____

Are you ***currently*** working with **any** other Therapists or mental health providers such as a psychiatrist? **Yes C No C** If **yes**, please provide name(s) and phone number(s).
_____

Please describe the problems that brought you here today that you want to address in our work together:
_____
_____

What are your goals for therapy and how do you hope it will help you? How will you know it is helpful?
_____
_____

Despite living in _____ I am willing to travel to Medford Y___N___ or Ashland Y___N___

I understand that JCMH has a free crisis program which I can access by calling 541-774-8201. I also understand that completing these packets does not make me a client of DBT of Sothern Oregon and that I do not become a client until I with meet face to face a therapist about 4 times and am accepted into the full program.

Signature: _____ Date: _____

INSURANCE RELEASE FORM

Client Name: **Date:**

	Insurance Information		For Secondary Insurance
Insurance ID #		Insurance ID #	
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	
Group #		Group #	
Policy Holder's DOB		Policy Holder's DOB	
Male _____ Female _____		Male _____Female _____	
Employer		Employer	

Policy Holder's DOB		Policy Holder's DOB	
Male _____ Female _____		Male _____Female _____	
Employer		Employer	

Deductible $_____ Has it been met? Yes C No C 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 C No C

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:

I understand that I am ultimately responsible for fees based on the amounts determined by my health insurance, and I agree to pay any balance indicated by my insurance as my responsibility. I further understand and agree that I will be charged $40.00 for a missed Individual session that I do not cancel within 24 hours and $80.00 for any individual session I do not call to cancel and do not attend. Group sessions where I do not attend for any reason will result in a $25.00 charge. I hereby authorize the release of any personal information necessary to process my insurance claim, including my diagnosis. I understand the diagnosis may become a permanent part of my insurance records. I authorize payments directly to Integrated Health Services, INC.

RESPONSIBLE PARTY SIGNATURE_____

Date

DBT of SOUTHERN OREGON THERAPIST SIGNATURE _____

Date

Client Rights And Responsibilities

Client Name: **Date:**

Limits on Confidentiality

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. The clinical notes, which are the therapist's as an in independent contractor, are also the property of DBT of Southern Oregon and are maintained through an Electronic Health Record.
6. I may need to present information from your records in court if a claim is filed against me, by you.
7. 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.
8. 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 license holder 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.

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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.

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. I understand that any contact with the therapist will become part of my clinical record including texts.

Termination: All therapy will come to an end eventually. If the therapist decides to terminate treatment they will discuss this with you so you can be active in the termination process. If there is no contact for 45 days and there is no appointment scheduled, I understand that my case will be closed and that I am no longer a client.

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

DBT of SOUTHERN OREGON THERAPIST SIGNATURE _____

Date