Stephen Emerson, L.C.S.W.
7687 SW Leslie Street
Portland, Oregon 97223
(503) 208-2176

To economize on our time together, would you please supply the following information and read and sign the accompanying service contract:

Name_____ Date_____

Address_____ Home Phone_____

_____ Work Phone_____

Social Security # _____Birth Date_____Age_____

Drivers License # _____ State____ Education_____

Occupation_____ Employer_____

Name, address, and telephone of nearest relative not living with you:

_____

In case of emergency, the name, address and telephone number of a person I may call:

_____

Please list the members of your present household:

Name	Age	Relationship	Occupation

Please describe your reason for seeking help:

_____

_____

_____

_____

Circle your estimate of the severity of the issue: Mild Moderate Severe Very Severe

Who suggested you contact me or how did you learn about me?_____

Have you ever received psychiatric or psychological help of any kind before?_____

If you have, would you briefly explain?_____

_____

_____

_____

_____

Current marital status:_____Live with someone?____
Name of present spouse/partner: _____Years: _____
Education: _____ Occupation: _____

Past & present marriage/s (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):
_____
_____
_____

Children/step/grand (names, ages & brief statement on your relationship with the person):
1._____
2._____
3._____
4._____
5._____

Parents/step-parents (name, age, occupation, personality, how did s/he treat you, brief statement about the relationship):
Father:_____
_____
_____
Mother:_____
_____
_____
Step-parents_____
_____
_____

Siblings (name, age, brief statement about the relationship):
1._____
2._____
3._____
4._____
5._____

Medical doctor/s (name/phone): _____

How would you rate your physical health at this time?_____

Past/present medical care (major medical problems, surgeries, accidents, falls, illness):
_____
_____
_____

Specify medication you are presently taking and for what:
_____
_____

Past/present drug/alcohol use/abuse (AA, NA, treatments):

Suicidal thoughts, plan, attempt/s or violent behavior (describe: ages, reasons, circumstances, how, etc):

Friendships, community activities, spirituality (describe quality, frequency, activities, etc.):

Describe your childhood in general (relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

If parents divorced: Your age at the time: _____, Describe how it affected you at the time:

Family history of alcoholism, mental illness, or violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

Are you involved in any current or pending civil or criminal litigation, lawsuits, divorce or custody disputes? (if you answer yes, please explain):

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

PAYMENT INFORMATION

Who will be responsible for payments?_____

Address_____

Phone_____ Relationship to you_____

PERMISSION TO CONSULT

It may be helpful for me to discuss aspects of counseling with other clinicians for the purpose of consultation and/or supervision. Your confidentiality will be safeguarded, and relevant information will only be discussed with trained and qualified personnel who may be able to help me provide you with the best possible service. I am asking your permission to have this option.

I, _____ hereby give permission to my therapist to consult with qualified clinical personnel as the need arises. I understand that this permission is in effect from the date below until our work is complete, or until I withdraw my permission.

Signature _____ Date _____

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Professional Services Contract/Informed Consent for Treatment

Please place a check mark after each paragraph indicating you have read and understand it.

Appointments: Our appointments are your time to use as you wish**.** Those that are not utilized, or are canceled without sufficient notice, will be charged a fee of $40. "Sufficient notice" is at least 24 hours, and more is appreciated. Please note that third party payers will not reimburse for the charges of missed appointments. Messages can be left with my voice mail at 503 208-2176. ____

Confidentiality: Professional ethics, as well as state law require that I honor your right to privacy and the confidentiality of our work together. I will not provide information about you to others without your informed consent and written permission except as required by law. I must report clear and present danger to yourself or others and any form of abuse of children, elders, or the disabled, as well as infectious diseases. **Minors and parents**: clients under the age of 14 who are not yet emancipated and their parents should note that the law may allow parents to examine their child's records unless deemed harmful to the child. My policy is for clients ages 14-17 and their parents to contract about general information that can be shared with parents. Laws regarding court proceedings are included in HIPAA regulations. ____

Fees and Billing: Services are based on a fee-for-service contract. Please be prepared with cash or check, to pay for services at the time of appointment. In special circumstances payment may be delayed by arrangement, and interest will accrue at a rate of 1.5% per month. In the event that full payment for charges incurred is not made, you pay all costs of collection, court costs, and attorneys' fees. ____

Insurance Coverage: Your work with me may be covered by your health insurance. If so, you are responsible for any deductible and copay defined in your insurance contract at the time of service. I will bill your insurance in accordance with their policies and procedures. If your insurance does not pay in a timely manner, you are responsible for payment. Use of insurance will entail disclosure of your personal information such as diagnoses, symptoms, and progress. Laws regarding information given to insurance companies are included in the HIPAA regulations. ____

The Nature of Psychotherapy: Psychotherapy is a collaborative process of self discovery. It's intended to alleviate problems and distress, facilitate growth, bring about change, and foster healing. It can lead to improved relationships, increased happiness, and greater satisfaction with life. It can be enlightening and transformative. But you should know that the process is not always easy. You may find yourself having to discuss very personal information. The conversations can sometimes be difficult, embarrassing, and anxiety producing. As you learn more about yourself, you may encounter increased conflict with friends, co-workers, and family members. It's possible that you may, at times, become somewhat depressed, feel awkward or uncomfortable, or feel things more acutely. I believe that fully engaging in the process can be extremely beneficial and effective, but I cannot offer any promises about the results you will experience. Your outcome will depend on many things. Early in the process we will look together at what you would like to change, what we will do to change it, and how we will know you are succeeding. Based on these factors, we will create a treatment plan together. You will always be free to move at your own pace. I use an integrated approach to psychotherapy which means I draw from many different models according to what is called for by the issues you are dealing with, and what fits you. Mindfulness (especially Acceptance and Commitment Therapy or ACT) and depth psychology are my primary approaches. Dream work is often an important component of the work and I invite you to bring those in for exploration. I also make use of meditation, music, art, cognitive and behavioral therapy, and EMDR. ____

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me, Stephen Emerson, LCSW, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. ____

Emergency Coverage: I do not provide emergency coverage at this site. In case of emergency, you may leave a message with my voice mail at 503 208-2176, and I will return your call as soon as possible. I do not check messages after 6:30 p.m. on weekdays nor routinely on weekends. If you are unable to make contact with me personally, I recommend that you contact your family physician, local emergency room, or the crisis line at 503 291-9111 (Wash. Co.) or 503 988-4888 (Portland and Multnom. Co.). ____

Fee: For a 50-60 minute appointment: _____ Please make your check out to **Stephen Emerson, LCSW**. Please sign both this and the following copy. **Your signature indicates you agree to the terms of this contract and give your informed consent for treatment. ____**

Signature _____Therapist_____ Date _____

Your signature below indicates that you have received the Notice of Privacy Practices indicating my compliance with HIPAA rules. You may ask questions regarding these practices at any time.

Print Name _____ Signature _____

Date _____ Witness _____ **Therapist Copy**

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Print Name _____ Signature _____

Date _____ Witness _____ **Client Copy**