Legal Name (First Last)	Preferred Name (if different)	Date of Birth

Katie Jane Roeda, MSW, LCSW

Name: _____Date: _____

Referred by: Self/Other_____May I thank them? Yes / No

Primary Care Doctor _____ Clinic_____

Emergency Contact_____

What would you like the focus of your sessions to be?_____

_____

_____

Please provide the following information as applicable:

List dates of prior inpatient or outpatient mental health therapy and substance abuse recovery programs:

_____

_____

Medical Conditions:

_____

_____

Allergies: _____

Current medications and supplements: _____

_____

_____

Describe your history and current consumption of alcohol:_____

_____

Describe your recreational use of marijuana, prescription drugs, and other drugs (history and current):

_____

Describe past and present self-harm behavior and/or suicidal thoughts:

_____

Trauma History (e.g. injuries, accidents, abuse)--Please provide dates:_____

_____

Who do you currently live with?_____

Partner/spouse history_____

Rate current level of satisfaction with partner/spouse (1-10, 10 being most satisfactory)_____

Current School/Employment: _____

Family Mental Health and Substance Abuse History:

_____

_____

_____

Repetitive behaviors impairing functioning:

_____

Specific fears: _____

Sleep problems: _____

Sensory sensitivities:

_____

Appetite/Eating/Nutrition concerns:

_____

Outlets for physical activity/Exercise:

_____

Social support:

_____

Hobbies/Creative Interests: _____

_____

Strengths:

_____

_____

Legal history: _____

Military history: _____

Katie Jane Roeda, MSW, LCSW

Under federal law, I am required to provide this notice about how I protect your privacy and protect information about you. I am committed to providing you with quality health care and maintaining a relationship with you that is built on trust. This trust is based, in part, on my commitment to respect the privacy and confidentiality of your Protected Health Information (PHI). Protected Health Information refers to individually identifiable health information. PHI includes any identifiable health information received or created by me.

1. Uses and Disclosures for Treatment, Payment, and Practice Operation

I may use or disclose your Protected Health Information only to coordinate treatment, obtain supervision, arrange for insurance reimbursement, or as otherwise required by law. I may be required by law to give PHI to government agencies or courts of law. I will not use or disclose your PHI for any other purpose without your (or your representative's) written permission, except as described below. I take handwritten working notes during each session. I keep materials you bring or send me. Be aware that email is not a secure medium. My handwritten working notes are secured double-locked. I use a ONC-certified electronic health record system called Practice Fusion. My electronic files are 256-bit encrypted and password protected.

2. Uses and Disclosures Requiring Authorization

I may use or disclose confidential information for purposes of treatment, payment, and practice operations when your written informed consent is obtained. I may use or disclose PHI for purposes outside of treatment, payment, and practice operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances if I am asked for information for purposes outside of treatment, payment and practice operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing a report written at your request about your care during a private, group, joint, or family counseling session. Reports are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or reports) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

3. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause to believe that a child with whom I have had contact has been abused I may be required to report the abuse. Additionally, if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation, I may be compelled to turn over PHI. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

Mentally ill or Developmentally Disabled Adults: If I have reasonable cause to believe that a mentally ill or developmentally disabled adult, who receives services from a community program or facility has been abused, I may be required to report the abuse. Additionally, if I have reasonable cause to believe that any person with whom I come into contact has abused a mentally ill or developmentally disabled adult, I may be required to report the abuse. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

Other Abuse: I may have an ethical obligation to disclose your PHI to prevent harm to you or others.

Health Oversight: Courts may subpoena relevant records from me should I be the subject of a complaint.

Judicial or Administrative Proceedings: Your PHI may become subject to disclosure if any of the following occur:

• If you become involved in a lawsuit, and your mental or emotional condition is an element of your claim or

• A court orders your PHI to be released, or orders your mental evaluation.

• Serious Threat to Health or Safety: I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

• Worker's Compensation: If you file a worker's compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

4. Client Rights and My Duties

Client Rights: Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (For example, you may not want a family member to know that you are seeing me). Upon your request, I will contact you at a special number or address.

Right to Inspect and Copy - You have the right to inspect or obtain a copy of PHI for as long as this information is maintained. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me upon request.

My Duties: I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will post them. I will contact you in advance and mail you a copy if reasonably possible when information is requested from your file.

5. Social Networking and Internet Searches

I do not conduct web search on clients unless requested to do so by the client. If you have concerns or questions regarding this practice, please discuss it with me. I do not accept friend requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

6. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (503) 440-1548. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint by email to katiejroeda@medsecuremail.com. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services and/or the Oregon Board of Licensed Clinical Social Workers.

7. Effective Date Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain if the laws about privacy and security change. I will provide a revised notice if this notice changes.

Signature_____ Date_____

Last updated 1/20/2017

DISCLOSURE NOTICE
OFFICE PRACTICES: BILLING, CONFIDENTIALITY, PRIVACY, AND SECURITY
Katie Jane Roeda, MSW, LCSW

Please read this document I am giving to you that discloses important information. Please discuss any questions you have with me. Your signature at the bottom of this sheet signifies that you have read, understand, and agree to these policies.

CREDENTIALS: I am a Licensed Clinical Social Worker with a master's degree in social work. I have postmaster's training in neurobiology, trauma, attachment, dream work and collaborative problem-solving.

APPOINTMENTS: Office hours are 9am to 6pm, Monday through Thursday, 9am-5:30pm Friday. A therapy session is typically 45-60 minutes long. I do not conduct therapy by email or text. I can provide teletherapy using secure videoconferencing software called Breakthrough. An additional $6.00/session will be assessed for teletherapy services. You may telephone me at (503) 440-1548. I check voicemail every 24 hours.

EMERGENCIES: Phone 911 or a mental health crisis line if you have a mental health emergency.

FEES: The fee for psychotherapy is $120/45-minute session, $160/60-minute session. Your insurance company may have capitated my rate in which case the fee may be lower. The cost of report writing, testing, or consultations with other providers is the same rate per hour that is billed for a session. You are responsible for the full amount of your bill. Determining what your insurance company will reimburse may take more than one billing cycle because often the exact amount the insurance company will pay is not clear. You must pay your copay at the time of your visit with a credit card, check or cash. I have a 24-hours-notice cancellation policy. **If you cancel with less than 24 hours notice, you will be billed $30. Note that insurance companies do not reimburse for missed appointments.**

INSURANCE: The billing service of Today Integrative Health + Wellness will bill your insurance company monthly as a courtesy to you and will follow-up with your insurance company to assist with reimbursement for services. You are responsible for checking with your insurance company regarding your coverage and for tracking your coverage as therapy progresses. Keep in mind whether you are currently covered, whether your insurance company reimburses for out-of-network care, whether you have met your annual deductible, and the percent of reimbursement, if any. Determination of the exact amount of your copay can take one to three billing cycles depending on the insurance company. **Remember that you are responsible for the cost of therapy whether your insurance company pays or not.**

BILLING AND ACCOUNTING: The billing staff of Today Integrative Health + Wellness will bill your insurance company and track your account. Billing staff maintain the highest standards of professionalism and confidentiality of records. You may contact Today Integrative Health + Wellness at 503-746-5889 with any questions or problems regarding your account.

CONFIDENTIALITY AND THE RELEASE OF INFORMATION: Your participation in therapy and information about you is confidential. Images that you produce during therapy are confidential. As a matter of general policy, I do not release information of any kind about any client without explicit written permission in advance by the client. However, there are limits to confidentially. The law outlines some instances in which information about you may be released. Examples include abuse of a child, elder or disabled person; harm or danger to self or others; subpoena in the event a court asks for records; and waiver if you request a release of your confidential records or as required by law. As a professional, I do consult with my peers periodically about client issues. During consultation, client identity remains anonymous and protected. Remember that email and text message is not confidential. Emails and text messages become part of your file.

To speak confidentially, phone me at (503) 440-1548.

HIPAA NOTICE OF POLICIES AND PRACTICES: A federal law, the Health Insurance Portability and Accountability Act (HIPAA), and state law require that I protect the privacy of your information. The law requires that I give you a notice that describes how clinical information about you may be used and disclosed and how you may get access to this information. **I understand that cancellations or changes in appointments with less than 24-hours' notice will be billed to me.**

Printed name: _____

Signature: _____ Date_____