

Trinity Counseling Center

Adult Client Intake Form

Office use only: Therapist: _____ DX: _____

Welcome to the Trinity Counseling Center. The information asked for below is to help us understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence. Please note, all associates of TCC are independent contractors and TCC will only handle billing responsibilities.

How did you hear about us? (Check one)
Clergy persons, Social Service Agency, Family, Friend, Employer, Advertisement, School, Former Client of TCC, Physician or other
Please include specific name if appropriate.

Please specify religious background, preference or denomination:

Name: (Last) (First) (Middle)
Street Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: (if different) _____ City: _____ State: _____ Zip: _____
Telephone No.: Home: _____ Work: _____ EMail: _____
Mobile: _____ Other: _____ SS #: _____

Employer/School: _____ Occupation: _____

Education/Training: (Highest Level Obtained) _____ Sex: Male Female

Military Service Yes No Dates: _____ Did you serve in combat? Yes No

Birth Date: _____ Age: _____ Height: _____ Weight: _____

Sexual Orientation: Heterosexual Gay/Lesbian Bisexual Other: _____

Relationship Status: Married Never Married Widowed Single
Divorced Separated Living together as partners

If married, date of present marriage _____ Are there children living at home? Yes No

Names and ages of children: _____ Age: _____ Age: _____
Age: _____ Age: _____

Spouse's Partner's Name: _____ Age: _____

Previous marriages: (date, how ended) _____

Guardian/Parents: (if under 18) _____

Have you had previous therapy? Yes No Spiritual or Pastoral Counseling? Yes No

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When _____ With whom? _____

Are you presently seeing another therapist? Yes No

Your Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

When was your last medical exam? _____

Are you currently on medication? Yes No

If so, what medication? _____

Prescribed by: _____

Major surgeries or illnesses in past five years? Yes No

For what condition(s): _____

Other health related conditions: _____

What do you believe your physical condition is at the present time? (Check one) Poor Fair Average Good Excellent

What do you believe your emotional condition is at the present time? (Check one) Poor Fair Average Good Excellent

Which of the following describe or relate to the concerns which bring you here:

- | | | | |
|--|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Aging issues | <input type="checkbox"/> Suicidal feelings | Relationship with: | Loss of: |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Religious doubts | <input type="checkbox"/> Partner | <input type="checkbox"/> Self respect |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Parents | <input type="checkbox"/> Faith |
| <input type="checkbox"/> Frequent crying | <input type="checkbox"/> Finances | <input type="checkbox"/> Children | <input type="checkbox"/> Meaning |
| <input type="checkbox"/> Eating/Food | <input type="checkbox"/> Vocation/Career issues | <input type="checkbox"/> Others | <input type="checkbox"/> Love |
| <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Physical health | | Abuse Issues: |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Self esteem | | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Self doubt | <input type="checkbox"/> Poor appetite | | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Sleep disturbance | | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Hopelessness | | |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Weight Loss | | |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Mid-life issues | | |

State in your own words the concerns that bring you to therapy:

What do you hope to achieve in therapy (your goals/expectations)?

Insurance Form

DISCLAIMER: By providing your insurance information you acknowledge TCC will bill your policy on your behalf, and any benefits quoted by our office or your insurance company is not a guarantee of coverage. Benefits will be determined by your insurance policy per session billed, and any non-covered charges will be the responsibility of the client. Client is responsible to update TCC if there are any changes to the policy listed.

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: _____
2. Name of Primary Insured: _____ D.O.B.: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone No.: _____ Male: _____ Female: _____
3. Relationship of Client to Insured: _____
4. Primary Insured's Employer (if group policy): _____
5. Employee ID/Policy # of Primary Insured: _____ Group Number: _____
6. Check one of the following: Health Insurance EAP Worker's Comp Automobile Insurance
7. Insurance Company: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone No.: _____
8. Is there another health benefit plan or insurance company providing coverage? Yes No
If Yes, complete the following:
Name of Primary Insured: _____ D.O.B. _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone No.: _____ Male: _____ Female: _____
Other Insurance Plan Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone No.: _____
Other Insured's Employer: _____
Other Insured's Policy Number: _____ Group Number: _____

I hereby authorize Trinity Counseling Center, LLC and any clinical associates of the Center to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits.

I further authorize payment of medical benefits to Trinity Counseling Center, LLC for services provided.

Signed: _____
Client/Parent/Legal Guardian

Date: _____

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The Civil Rights Act of 1964 requires that the Trinity Counseling Center not deny services to any citizen on the grounds of race, color, sex, national origin, religion, or handicap.

As a client you have the right to:

- Prompt, confidential and respectful response by a trained professional.
- Know where you are in the treatment process including probable length of treatment.
- Obtain a copy of your treatment plan.
- Know fees and billing procedures at the clinic.
- Request a different therapist after discussing that request with your present therapist. You may meet with the Administrative Director if you are not in agreement with your therapist's decision.
- Know that your records will be kept in locked storage not to be shared with anyone not affiliated with the Center, without your written permission unless court ordered or where reporting of an extreme risk to life or child abuse is required by Oregon laws.
- Refuse treatment unless court ordered without losing the right to other appropriate treatment, if available. This includes the right to know what will happen if you do not accept treatment,
- Submit complaints about services to the Administrative Director.
- Have access to the information contained in your record. To review you record, make arrangements with your therapist.
- The right to privacy, with the exception to confidentiality of information obtained in the course of services that included the following:
 1. Reporting suspected child abuse
 2. Reporting imminent danger of client to self or others
 3. Reporting information required in court proceedings or by client's insurance company or other relevant agencies
 4. Licensee consultation or supervision
 5. Defense of claims brought by client against licensee
 6. Reporting disclosure by client of intent to commit a crime, which would result in the harm of others
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

As a client you have the responsibility to:

- Keep appointments or cancel at least 24 hours in advance.
- Take medications as prescribed
- Pay bills and inform therapist and receptionist of changes in financial status that would affect your fee or changes in address or telephone number.
- Be an active participant in your treatment planning.
- Review with your therapist how you are progressing in treatment.
- Not drop out of treatment without having an appointment with your therapist to discuss those plans.

I have read the above information and understand my rights and responsibilities. I seek and consent to therapeutic services of the Trinity Counseling Center.

(Client Signature)

(Client Signature)

(Date)

(Therapist Signature)

FEE AGREEMENT

Our standard counseling fees are listed below. These fees can be paid in a number of ways. Trinity Counseling Center accepts insurance reimbursements and payments from some Employee Assistance Programs. Clients with insurance coverage are expected to pay their co-pay or co-insurance payment to TCC prior to each counseling session, as well as all fees not covered because the insurance deductible amount has not been met. We accept Cash, Check and Credit Card Payments. **Payments are to be made payable to Trinity Counseling Center.**

CPT	Description	Fee
90791	Intake Session	\$ 320.00
90837	Psychotherapy Session (52 min+)	\$ 300.00
90834	Psychotherapy Session (45 min)	\$ 250.00
90832	Psychotherapy Session (30 min)	\$ 150.00
90847	Family Session w/client	\$ 300.00
90839	Crisis Session (up to 60 min)	\$ 320.00
90840	ADD ON: Add'l 30 min for Crisis	\$ +150.00
90785	ADD ON: Interactive/Play Therapy	\$ +30.00
96103	ADD ON: Computerized Testing	\$ +175.00
MISSED	Canceled/Missed Appt w/o prior notice	\$ 85.00

<i>Office Use</i>
Deductible: \$ _____
Coins % _____ / Copay \$ _____
Insurance UCR: \$ _____ (90791)
Insurance UCR: \$ _____ (_____)
Client Payment: \$ _____ /session
Balance to bill (if applicable): \$ _____
CASH Fee: \$ _____

Client Consent to Fee Agreement:

Initial

- _____ I have read the above information and agree to the listed fees.
- _____ I consent to being treated by the assigned counselor.
- _____ I agree to pay the contracted fee at the time of service.
- _____ I understand I will be responsible for paying missed sessions for which a 24-hour prior notice is not given, and my insurance company will not be billed*.
- _____ I am fully responsible for all fees assessed to my account.
- _____ If my insurance policy or another third-party coverage does not pay TCC for the services rendered, I am responsible for paying the full amount of the TCC fee (unless otherwise prohibited by insurance company regulations communicated to TCC as part of the authorization process).
- _____ I understand fees for counseling are to be paid in advance, before my session, unless other arrangements have been made.
- _____ Trinity Counseling Center has a legal right to utilize a collection service to collect payment if I fail to pay in full for services received, and to review services until such payment is made.
- _____ I have read and understood the conditions upon which my fee has been determined, and I agree to these conditions.

Client/Responsible Party

Client/Responsible Party

Date

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NOTICE OF FEES FOR COURT/LEGAL PROCEEDINGS

September 1, 2017

If a therapist receives a subpoena or court order, or is requested to appear for any court proceedings and/or prepare supporting documentation, those services are not included in client's therapy session fees and not billable to insurance for reimbursement. The following fee schedule will be implemented for all legal services beyond the scope of client/therapist out-patient office visits.

All state and professional psychotherapist-patient privilege will be followed without exception. It is in the best interest of most clients to NOT request their therapist to appear or provide documentation in a court matter. The therapist is not an expert witness, and will only provide the court or legal representative with their professional opinion based on the information presented during therapy. No opinion as to custody will be given by the therapist: they are not a child custody evaluator. Only information that has been released by the client will be provided unless information is compelled into testimony by legal action. Even though the client is responsible for the testimony related fees, it does not mean any testimony will be solely in their favor. If a therapist is seeing a couple separately or a minor, requesting testimony can adversely affect the current therapeutic relationship. Therefore, we strongly discourage any client or related party to request testimony or psychotherapy records.

**Subpoena or notice to meet attorney(s) is to be served during office hours and with 72 hours notice. If notice is not given in that time frame, an additional \$300 expedite fee will be applied.*

If a therapist is requested to participate in any legal proceedings, the following fees apply and will be assessed if therapist is scheduled for court on client behalf, and is not contingent upon any actual participation or testimony:

- Preparation Time (including submission of records) @ \$220/hr
- Phone Calls: \$220/hr
- Time required in giving testimony: \$250/hr
- Mileage: \$0.40/mile
- Time away from office due to depositions or testimony: \$220/hr
- All attorney fees and costs that are incurred by the therapist as a result of the legal action
- Filing documents with the court: \$100
- The minimum charge for a court appearance: \$1500 (via cashier's check)

A retainer of \$1500 is due at least 72 business hours before the scheduled court appearance.

The remainder of the costs will be billed after court appearance and will be due upon receipt.

If the therapist is subpoenaed and the case is reset with less than 72 business hours notice prior to the beginning of the day of the scheduled subpoena, trial, and/or the testimony is not given, then the client will be charged \$500 (in addition to original retainer of \$1500 for having to appear in court)

If therapist has to change vacation plans due to scheduled appearance, all fees will be assessed at 200% of stated fees.

Client Signature _____

Date _____

Therapist Signature _____

Date _____



Electronic Communication Consent Form

1. Risk of Using Email and Text Communication

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Emails and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and online services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Emails and texts can be used as evidence in court.
- Emails and texts should be assumed to be unencrypted and, therefore, it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the Use of Email and Text Communication

- Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The client/responsible party should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- Emails may be printed and filed into the client's medical record. Texts may be printed and filed as well
- Provider will not forward client's/responsible party's identifiable emails and/or texts without the client's/responsible party's written consent, except as authorized by law
- Clients/responsible parties should not use email or texts for communication of sensitive personal information
- Provider is not liable for breaches of confidentiality caused by the client/responsible party or any third party.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication using email and/or texts between associates of Trinity Counseling Center and me, and consent to the conditions as outlined, as well as any other instructions that may be imposed to communicate with me by email or text.

Client Name: _____ / SIGNATURE _____ (required)

Email: _____ / Mobile #: _____ / DATE: _____

I do NOT consent to the use of email or text message communications

I have read this document in full and agree to the terms and conditions. (required)

By default, all client balance notices are sent via text or email. To receive a paper statement you must contact our office. Thank you.

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NOTICE OF PRIVACY PRACTICES

January 1, 2024

This notice tells you how our associates or office make use of your health information, how either might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to all of us and we want to do everything possible to protect that privacy.

Each therapist and associate have a **legal responsibility** under the laws of the United States and the state of Oregon to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Trinity Counseling Center. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice if you request.

When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

We may use or disclose your health information verbally or in writing (including electronic communications)...

1. To your physician or other healthcare provider who is also treating you.
2. To any Trinity associate involved in your treatment program.

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3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services provided for you.
5. To our own associates in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our associates, supervising our associates, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.
8. To anyone to whom we are required to submit information in compliance with the laws and regulations of the State of Oregon.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission. As a client of Trinity Counseling Center's associates, **you have these important rights:**

- A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
- B. You can ask us for photocopies of the information in part "A" above.
- C. We will charge you \$30 first 10 pages, \$0.50 per page 11-50, \$0.25 51+ for making these photocopies. Actual costs of preparing an explanation or summary, and any postage will be at an additional fee. See Oregon 192.563 for additional information.
- D. You have a right to a copy of this notice at no charge.
- E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.
- F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to

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these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

- G. You can make a written request that we amend the information in part "A" above.
- H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
- I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
- J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.
- K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.
- L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice, you may complain to us in writing to the following person:

Gabriel McCoy, LMFT Clinical Director

Telephone: (541) 245-2787

Fax: (541) 201-8103

Address: Trinity Counseling Center
815 E. Jackson St., Medford, OR 97504

- M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

**please note: all associates with Trinity Counseling Center, LLC are independent contractors. All associates are governed by the appropriate state licensing board, and are covered by their own professional liability insurance, and are responsible for client's records. Requests for client files or records will need to be directed to client's therapist.*