Great Oaks Counseling Center
Phone: (406) 219-1778
Fax: (406) 219-1789
http://www.greatoakscounselingmt.org

141 Discovery Dr.
Bozeman, MT 59718

Fee_____ Diag. Code_____ Diag. Rec._____ Ins. Pay_____ Copay_____ 1LUC/ADL_____

Date: _____ Church Home

_____

Referred By: _____

Counselor/Therapist: Doug Samsel, MA, LCPC

BIOGRAPHICAL INFORMATION

Personal

Full Name: _____ Date of Birth: _____ Gender: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Address: _____ City _____ State_____ Zip_____

Soc. Sec. # _____ - _____ -_____

Education: High School College Other_____

Occupation: _____ Employer:_____ Phone # _____

Current Family

Marital Status: _____

Spouse's Name:_____ Date of Birth: _____

Spouse's Cell Phone #: _____ Spouse's Email Address_____

Spouse's Occupation: _____ Employer_____ Phone # _____

Children (please list names and ages): _____

_____

Previous Marriage(s): Name(s) _____ Duration _____

Family of Origin

What number child were you in your family? _____ of how many? _____
What number child was your current spouse? _____ of how many? _____

Do you or anyone in your family of origin or anyone in your immediate family misuse alcohol or drugs?

_____

_____

Is there anything else you'd like to write here about you or your family history?

_____

_____

_____

Health

Your current health Very good Good Average Declining

Approximate date of your last comprehensive exam: _____

Current medical problems: _____

Current medication(s) and dosage(s): _____

Please list any sleep disturbances. _____

Have you previously sought clinical or psychiatric help? ____Yes ____No

Therapist/Dr. _____ Profession _____ From _____ To _____

Therapist/Dr. _____ Profession _____ From _____ To _____

How satisfactory was your experience(s)?_____

CONSENT

Confidentiality & Treatment

Your rights to confidentiality are one of the most important policies in the provision of mental health services. Confidentiality means that the information that you discuss with your therapist/counselor will not, except as below, be shared with anyone without your specific permission. Confidentiality of personal information is vital for building a solid therapeutic relationship, and allows you to feel free to explore problems and work toward solutions. There are some very important exceptions to confidentiality that require the disclosure of personal information without your consent.

The following are exceptions to confidentiality: I am legally obliged to take action to protect others from harm, even if I have to reveal some information about your treatment/evaluation/consultation.

- If I believe that a child, elderly person, or person with a disability is being abused or neglected, I must file a report with the appropriate state agency.
- If I believe that a client is threatening serious bodily harm to another, or to himself/herself, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- Information subpoenaed in a legal proceeding might not be regarded by the Court as confidential.
- In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances a judge may require my testimony if s/he determines that resolution of the issues before him/her demands it.
- I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing identifying information about my clients. The person with whom I am consulting is also legally bound to keep the information confidential.
- When insurance coverage is utilized it is considered consent on the insured's part (client) that diagnosis and treatment plans and issues may be discussed by the therapist with your insurance company in order to facilitate insurance claim filing or case management with your insurance company.

Please note that breaking confidentiality because of issues of abuse/neglect, threat of serious bodily harm to oneself or others, subpoenas, Court order, and collection of outstanding payment are highly unusual in my clinical practice. If such a situation occurs, I will attempt to fully discuss it with you before taking any action. If it becomes necessary to release information, it will be made in such a way as to protect as much confidentiality as possible. I have a strong commitment to maintaining confidentiality and handling your personal information with the highest degree of confidentiality possible. If you have any questions or concerns about confidentiality it is important that we discuss them at our next meeting.

Understanding the above, I/we give permission for Doug Samsel, MA, LCPC to provide counseling to me/us.

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____ _____

Signature of Client Printed Name of Client Date

_____ _____

Signature of Counselor Date

Contact
In the event of any medical or life-threatening emergency, I grant permission for any employee of Great Oaks to contact the following person(s).

_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____
Client Signature

Please INITIAL <u>each</u> statement to which you consent.

____ I grant permission for information (billing, events, and other information) to be sent to my home address.

____ I grant permission for my therapist and the administrative staff to contact me at my home phone #.

____ I grant permission for my therapist and the administrative staff to contact me at my cell phone #.

____ I grant permission for my therapist and the administrative staff to contact me at my business phone #.

I grant permission for my therapist and the administrative staff to leave a message for me at my (**please initial**):

___home phone ___cell phone ___business phone

____ I grant permission for Great Oaks to thank the person who referred me.

I recognize that email and other forms of Internet communication are not a secure/confidential means to transmit data. By initialing any statement below pertaining to Internet communication, I voluntarily wave my rights provided by the HIPPA law, and any other federal or state laws regarding confidentiality and the transmission of information via the Internet. I voluntarily give my permission and will not hold Great Oaks and/or my therapist, Doug Samsel, MA, LCPC legally responsible for the transmission of this data.

Client Signature_____ Date_____

____ I grant permission to send and receive communication from my therapist at my email address.

____ I grant permission to send and receive communication from Great Oaks administrative staff at my email address.

Finances & Appointments

Please INITIAL <u>all</u> statements.

____ I understand that Great Oaks has a **48 hour cancellation policy**. I will be charged the full rate of my session if I do not call at least 48 hour in advance to cancel unless I have a serious physical illness. I understand that the administrative staff does not have the authority to change this policy. If there are extenuating circumstances that I believe should affect this policy, I will discuss those with my therapist.

____ I understand that Great Oaks normally **does not bill insurance companies**. Should I want to submit my counseling for insurance reimbursement, Great Oaks will issue a diagnostic receipt that I will submit to insurance and have the insurance company reimburse me.

____ I understand that Great Oaks accepts cash, checks, credit and debit cards.

____ I understand that counseling sessions last approximately 50 minutes including any time needed to schedule next appointments.

____ I agree to make payment at the beginning of each session. I understand that my counselor receives a percentage of the fee I pay to Great Oaks for our time together. I understand my counselor is not compensated for his/her time with me unless and until I make payment for a session.

____ I understand that Doug Samsel's current rate is $175 per session and agree to be personally responsible for this rate. Should this rate change in the future, Great Oaks will inform me a minimum of 30 days in advance.

____ I understand that if I become involved in legal proceedings that may require Doug Samsel's participation, I will be expected to pay for his professional time even if he is called to testify by another party. Because of the complexity of legal involvement, the charge for such services is $450 per hour for preparation, travel, and attendance at any legal proceeding, with a minimum three-hour charge.

Policies

Please INITIAL <u>all</u> statements.

____ I have received, read and understand the attached sheet "Great Oaks View of the Counseling Process."

____ I acknowledge that I have received Great Oaks attached, written explanation of their compliance with HIPPA entitled "Notice of Privacy Practices."

____ I understand that both the law and the standards of the clinical profession require that my therapist keep appropriate treatment records. I am entitled to receive a copy of the records upon written request, unless my therapist believes that seeing them would be emotionally damaging, in which case, my therapist will be happy to provide them to an appropriate mental health professional. Because these are professional records, they can be misinterpreted and/or can be upsetting, so Great Oaks strongly recommends that I review them with my therapist so that you can discuss what they contain. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.

Observation for Training

Please INITIAL if you consent

Great Oaks Counseling Center is a teaching institution committed to the ongoing training of interns and therapists. We would respectfully request that you consider allowing an intern, counselor-in-training or PLCPC to sit-in on your sessions with your counselor. This observer would quietly sit out of your line of vision and watch your therapist. Your session is always held in the strictest confidence and the trainee is bound by the same standards of confidentiality as your counselor.

____ I agree to allow a trainee to sit in my sessions with my therapist. I also understand that at any point, before, during or after a session I can ask for the trainee to leave.

Additional Information

How did you hear about Great Oaks Counseling Center?

_____

_____

What prompted you to choose Great Oaks Counseling Center?

_____

_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and as applicable law permits the terms of this Notice at any time, reflecting such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give use an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, within limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare as summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12-month period, we may charge you reasonable, cost-based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. You may complain to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information.

Contact Officer: Executive Director
Telephone: (406) 530-6234 Fax: (406) 219-1789
Address: 4769 W. Babcock – Bozeman, MT 59718

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View of the Counseling Process

The practice of counseling is based upon particular theoretical orientations as well as the personal style and experience of the counselor. Therefore, we believe it is in your best interest to briefly explain to you our background (as a group) as well as our views of the counseling process.

We view the counseling process as forming an alliance with you, to explore the nature of your problem. Although we will spend much of our time exploring the specific problem that brought you into counseling, we will also explore, in depth, the nature of your relationship with other significant people in your life. In our theoretical orientation, we believe that many of the forces and dynamics that have influenced the complexity and intensity of your problem are rooted in relational issues. In using a Biblical foundation in our counseling, we believe you are made to deeply relate—this is both a source of great joy and of deep pain. This is not to simplify your problem, but rather to highlight the complexity of the problem and how it interferes with the deep enjoyment for which you have been made. Aiming at the source of the problem is meant to give you hope.

Interpersonal relationships are the areas in which the result of the brokenness of humankind is most prevalent, and in which the need for change is most obvious. In working toward the goals of removing the initial problem and growing in relational maturity, the counseling process will require that firm effort is made to change, which may involve significant discomfort. Remembering and resolving unpleasant events can arouse intense fear, anger, depression, frustration, and other powerful emotions that may feel foreign, but are a normal part of the process of growth. Seeking to resolve issues between family members, marital partners and other persons can similarly lead to discomfort, as well as relationship changes that may not have been originally intended.

Many of the results of counseling will depend upon your determination to deal honestly with the issues that powerfully affect your life. We are human beings who have been profoundly affected by the effects of brokenness in the world. We are damaged people who do further damage through the way we handle our pain. We are tempted to transform our thirst for intimacy into things under our control that keep us feeling protected, yet, at the same time, in agony. This pain often appears in the form of symptoms such as depression, eating disorders, sexual dysfunction, workaholism, anxiety, rage, etc. Your symptoms are important. They point beyond themselves to the need for an inside look into your life. This “inside look” is intended to surface—and over time disrupt—old, unhealthy dependencies and to offer the enticing idea that dependency on God is an invitation we have both feared and longed for in the core of our souls. We believe that certain problems can also have (or develop) physical components. In such cases, medical consultation will be advised.

The course of therapy is determined mutually by your counselor and you, the client. You are encouraged to freely ask any questions you have regarding the educational and professional background or therapeutic approach of your counselor. You are also encouraged to freely ask questions pertaining to your specific therapy plan and progress. **People often ask how long they will be in counseling.** Some clients need fairly brief therapy to understand their conflicts and reach the goals they set for themselves. However, others may require many months or even years of work to achieve the growth they desire. We attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals, but we discourage clients from becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. Clients typically know when they are beginning to “feel finished” with therapy work. When this happens we encourage you to discuss this with your counselor so that we can close our relationship as carefully as it began. State certification requirements for professional counselors do not imply the effectiveness of treatment. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful.

It is always our intention to provide services in a professional manner that is consistent with all accepted ethical standards. If at any time in the course of your work with a counselor you feel that there may have been a misunderstanding or you have a question or complaint about your counselor’s services, please bring this up immediately so that your counselor can become aware of your concern and resolve the matter with you.