Suzanne Barnes, M.A., LMFT Counseling **541-301-6714**

SuzanneBarnesCounseling.com

Client Intake Information Form

Welcome to **Suzanne Barnes MA, LMFT Counseling**. The information asked for below is to help me understand you and your concerns. Please fill out this form as completely as you can. All information will be held in strict confidence.

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

□ Aging issues
□ Anger
□ Anxiety
□ Frequent crying
□ Eating/Food
□ Alcohol/Drugs
□ Loneliness
□ Self-doubt
□ Guilt
□ Suicidal feelings
□ Self-esteem
□ Hopelessness
□ Sexual concerns
□ Fear
□ Grief
□ Mid-life issues
□ Legal Issues
□ Finances
□ Vocation/Career
□ Physical health
□ Religious doubts
□ Poor appetite
□ Sleep disturbance

Relationship with:
□ Partner
□ Parents
□ Children
□ Others

Loss of:
□ Self respect
□ Meaning
□ Faith
□ Love

Abuse Issues:
□ Physical
□ Sexual
□ Emotional

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

Client's Name: _____ Client's Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Relationship to Client: _____

APPLICATION FOR SERVICE

Client ID:	
DATE:	

APPLICANT INFORMATION

Last Name	First Name	Middle Name	Last Name at Birth

Social Security Number	Date of Birth	Gender	Need an Interpreter? ☐Yes ☐No
		☐Male ☐Other ☐Female	☐Language Preferred: ☐Hearing Impaired

Oregon Health Plan	**OHP Prime #**	**Other Insurance**
☐ Jackson Care Connect ☐ All Care ☐ Other:		☐ Medicare ☐ VA/TRICARE ☐ Private Insurance:

Who referred you?	Who is your primary care doctor?	Who is your dentist?
	☐ None	☐ None

CONTACT INFORMATION

	Street Address	City	State	Zip
Residence Address				
Mailing Address (if different)	Street Address or PO Box	City	State	Zip

Primary Phone	☐ This is my phone	This phone belongs to:
		Message ok? ☐Yes ☐No
Secondary Phone	☐ This is my phone	This phone belongs to:
		Message ok? ☐Yes ☐No

Emergency Contact Phone	Name and Relationship to applicant	
		Message ok? ☐Yes ☐No

APPLICANT DEMOGRAPHIC INFORMATION

Highest grade completed	Currently in school?	Veteran	Tribal Affiliation
	☐Yes ☐No	☐Yes ☐No	☐ None

Marital Status	☐Never Married	☐Married	☐Separated	☐Divorced	☐Widowed
Race	☐Alaska Native	☐American Indian	☐White	☐Asian	☐Black/African American
	☐Native Hawaiian/Pacific Islander		☐Other Single Race	☐2 or More Unspecified Races	
Ethnicity	Hispanic ☐Yes ☐No	☐Mexican	☐Puerto Rican	☐Cuban	☐Other
Employment	☐Full Time	☐Part Time	☐Unemployed	☐Homemaker	☐Other
	☐Student	☐Retired	☐Disabled (Unable to work)		
Living Arrangement	☐Private Residence	☐Foster Home	☐Homeless	☐Residential Facility	
	☐Suppt Housing	☐Alcohol/Drug Free Housing		☐Other:	

Household Income/Source	Household Monthly Income $	☐Wages/Salary	☐Public Assistance	☐
		☐Disability/SSI	☐ Retirement/Pension/SSI	☐None

Household Dependents	How many people are dependent on this household income:	Of these, how many are children 0-17 yrs old?

SIGNATURE

Applicant/Legal Guardian*	Name (Please Print)	Date

****Legal guardians – please provide a copy of your legal guardianship documents.***

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Consent for In-Person and Telemental Health Services

Consent for Use and Disclosure of Protected Health Information

I, _____, agree to participate in In-person and/or Telemental Health services with provider Suzanne Barnes LMFT.

I authorize the release of information pertaining to me determined by my mental care providers or by my insurance company for the purpose of processing insurance claims.

I understand that under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.

I understand that this outpatient counseling service does not include crisis services. In the event of a mental health emergency, I will call the 24-Hour Crisis Hot Line at 541-774-8201 or go to the nearest hospital emergency room.

With Telemental health, I authorize information about my medical and mental health care to be transferred electronically through Doxy, a HIPAA protected interactive video connection. My therapist has explained how the teletherapy system works and how it will be used for my treatment. I understand that my therapist will not be physically present during my teletherapy session. Instead, we will see each other electronically. My therapist has explained how these services will differ from face-to-face sessions. I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized. Potential risks include at times, the video image may be unclear or inadequate or disruption of the connection may occur. I understand that adequate internet connectivity is dependent upon both the provider and client's separate internet connection. If connection is lost, both the client and provider will reach out via phone to complete the session or to arrange for another session time later that week. I understand that at any time, I may request to switch to in-person services which will be accommodated as the schedule allows.

I have had the full opportunity to read and consider the Notice of Privacy Practices, the Client Rights and Responsibilities, and the Professional Disclosure Statement of **Suzanne Barnes LMFT Counseling**.
I voluntarily consent to participate in in-person or telehealth mental health services with Suzanne Barnes LMFT. By signing this form, I give my consent to use and disclose my protected health information as stated in the Notice of Privacy Practices.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

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Client Rights and Responsibilities

The Civil Rights Act of 1964 requires that Suzanne Barnes MA, LMFT Counseling 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.
- Request a different therapist after discussing that request with your present therapist.
- Know that your records will be kept in locked storage not to be shared 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 be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
- 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.

As a client you have the responsibility to:

- Be on time and keep weekly appointments. Counseling sessions are one hour long and occur weekly.
- Reschedule within the week if session must be cancelled due to work or illness. Session times are reserved for you. I send text reminders of sessions the day before as missed appointments cause an interruption to the therapeutic momentum. I do my best to reschedule within the week to accommodate illness. Inconsistent attendance may result in the cancellation of services.
- If engaging in Telemental Health services, you will need a smart phone or electronic device with adequate audio/video internet capability.

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Notice of Privacy Practices

January 1, 2023

This notice tells you how I make use of your health information, how I 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 me and I want to do everything possible to protect that privacy.

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

I have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in my privacy practices will affect how I protect the privacy of your health information. This includes health information I will receive about you or that I create. These changes could also affect how I protect the privacy of any of your health information I had before the changes. When I make any of these changes, I will also change this notice and give you a copy of the new notice if you request.

When you are finished reading this notice or at any time in the future, you may request a copy of it at no charge to you. If you have any questions or concerns about the material in this document, please ask me for assistance which I will provide at no charge to you.

Here are some examples of how I use and disclose information about your health information:

I 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 anyone on our staff involved in your treatment program.

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 I provide for you.

5. To meet 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, I will give you an opportunity to object. If you object, or are not present, or are incapable of responding, I may use my 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, I will only use or disclose the aspects your health information that are necessary to respond to the emergency.

8. To anyone to whom I am required to submit information in compliance with the laws and regulations of the State of Oregon.

I will not use your health information in any of my marketing, development, public relations, or related activities without your written authorization.

I cannot use or disclose your health information in any ways other than those described in this notice unless you give me written permission.

As a client you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by me for my use.

B. You can ask me for photocopies of the information in part "A" above.

C. You have a right to a copy of this notice at no charge.

D. You can make a written request to have me 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, and I am treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

E. You can make a written request that I place other restrictions on the ways I use or disclose your health information. I may deny any or all of your requested restrictions. If I agree to these restrictions, I will abide by them in all situations except those which, in my professional judgment, constitute an emergency.

F. You can make a written request that I amend the information in part "A" above.

G. If I approve your written amendment, I will change our records accordingly. I will also notify anyone else who may have received this information, and anyone else of your choosing.

H. If I deny your amendment, you can place a written statement in our records disagreeing with my denial of your request.

I. You may make a written request that I provide you with a list of those occasions where I or my business associates disclosed your health information for purposes other than treatment, payment, or my Private Practice operations. This can go back as far as six years, but not before April 14, 2003.

J. If you request the accounting in "J" above more than once in a 12 month period I may charge you a fee based on actual costs of tabulating these disclosures.

K. If you believe I have violated any of your privacy rights, or you disagree with a decision I have made about any of your rights in this notice, you may complain to me in writing or Fax to: Suzanne Barnes, LMFT (541) 488-3339

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

Professional Disclosure Statement

Suzanne H. Barnes, MA, LMFT
Suzanne Barnes, LMFT Counseling
523 Strawberry Lane, Ashland, OR 97520
(541) 301-6714
SuzanneBarnesCounseling.com

Philosophy and Approach: I work with individuals, couples, and families utilizing many modalities of therapy. These include **Cognitive Behavioral Therapy** reducing negative and anxious thought patterns by addressing the relationship between thoughts, feelings, and behavior; **Dialectic Behavioral Therapy** supporting greater focus in the present and developing healthy ways to manage stress, improve communication, and regulate emotions; **Family Systems Theory** in which the family is understood as a complex social system such that change within the individual affects the system as a whole. A holistic approach is utilized in which physical, emotional, and spiritual aspects of well-being are addressed. Visualization and affirmation exercises are used to explore paths of growth and change with tools to assist with areas of challenge. All Services are provided through Telemental Health using a HIPAA compliant video conference platform.

Formal Education and Training: As a Licensed Marriage and Family Therapist, I hold a Master's Degree in Clinical Holistic Health Education from John F. Kennedy University. **Major coursework** included training in Dynamics of Personal Growth, Effective Clinical Communication, Physiology and Psychology of Stress, Theories of Family Dynamics, Psychosomatic Models of Marriage and Family counseling, Psychology of Dependency and Addiction, and Principals of Holistic Health.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics. To maintain my license, I am required to participate in continuing education, taking classes dealing with subjects relevant to this profession.

Fees: The standard fee is $425.00 per hour. I will accept the reimbursement rate of your private or public insurance carrier. Clients with private insurance coverage are expected to pay their copay to **Suzanne Barnes, LMFT Counseling** prior to each session. Oregon Health Plan services are covered without copay.

As a client of an Oregon Licensee, you have the following rights:
∗ To expect that a licensee has met the qualifications of training and experience required by state law:
∗ To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
∗ To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);
∗ To report complaints to the Board;
∗ To be informed of the cost of professional services before receiving the services;
∗ To be assured of privacy and confidentiality while receiving services as defined by rule and law, with the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to you or others; 3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me;
∗ To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

You may contact the Board of Licensed Professional Counselors and Therapists at
3218 Pringle Rd SE, Ste. 120, Salem, OR 97302. Telephone: (503) 378-5499.
Email: lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT
For additional information about this counselor or therapist, consult the Board's website.