Hello!

Thank you for taking the time to download these attachments. Contained within you’ll find directions to the office, a Professional Disclosure Statement, Consent to Treatment document, the HIPPA Confidentiality form, and a New Client Information form. In particular, please spend time thinking about your reasons for coming to see me, specific goals, and other background information requested in the New Client Information Form.

If you are using an insurance benefit to pay for services, please review your policy thoroughly with that company. If I am a contracted provider, my bookkeeper, Vickie Kupel, will automatically submit claims on your behalf. Co-payments can be made at each session by cash, check, or credit card (including small transaction fee). For those plans for whom I am an out-of-network provider, please speak with Vickie about billing options and co-payment amounts due at time of service. Vickie can be reached Monday-Thursdays at 360-735-7727 or VKupel@hotmail.com. Those clients seeing me privately and paying in full at each session may be eligible for a “bookkeeping” discount. Please speak to me directly for more information.

Thank you for bringing the signed or completed forms to your first appointment*. Please allow extra time to find the office and parking. Feel free to help yourself to tea, cocoa, or water in the waiting room. Should you need to cancel or re-schedule your appointment, 24 hours notice is kindly appreciated.

I look forward to meeting you soon.

Sincerely,

Mariel Pastor, M.A.

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* Providence Health Plan, United Behavioral Health, and Pacificare Behavioral Health members are required to also fill out the Brief Wellness Assessment included here. All others may skip this.
Please allow sufficient time to find the office and park for your first appointment so that we may start on time. You’ll find hot tea and water in the waiting room. Please silence your cell phone and limit its use for emergencies only.

THANK YOU!

I am located at 1130 SW Morrison in The Mayer Building which is a 6 story, yellow-brick 1930s building at the corner of SW Morrison and 12th. Saint Cupcake Bakery is on the ground floor.

**Directions to Office**

**From the North** - Take I-405 South to the Burnside/Couch Street Exit #2A which puts you on 15 Avenue. Stay on 15th about 5 blocks to Yamhill Street, turn Left. Take Yamhill to 12th Avenue and take another Left. The office is in the Mayer Building and will be on your right at the next corner which is 12th and Morrison.

**From the South** - Take I-5 North to downtown Portland and then transition onto 405-N (by staying in the middle lane of I-5 following signs to City Center/Beaverton). Take the Salmon Street exit #2A, and follow the signs that take your right onto Salmon Street and back over the freeway. Go 2 blocks to 12th Avenue and turn left. The office is two blocks down on the right.

**From the West** - Take Sunset Highway 26 to downtown Portland by staying in the middle lane through the tunnel. Doing so will then put you onto Market Street. Take Market to 12th Avenue and turn left. Go several blocks until Morrison Street. The office is on the corner of 12th & Morrison.

**From the East** - Take the Banfield Freeway I-84 West to downtown Portland and then take either I-5 North to I-405 South and follow the directions above for reaching the office from the north, OR get onto I-5 South from the Banfield and then transition onto I-405 North (get in far left lane of I-5 to make the correct transition), then follow directions above for reaching the office from the south.

**PARKING:** There is metered parking available all along 12th Avenue, underground parking on 12th at the Episcopal Church just north of Morrison, and a Smart Park garage on 10th Avenue between Morrison and Yamhill.

**PUBLIC TRANSPORTATION:** The Max trains stop about 2 blocks away from the office at the Galleria stop (westbound) and at the Public Library stop (eastbound). Tri-Met routes 15 and 51 stop right in front of the building.

***
1. Identifying Information

Client’s Name: _____________________________ First Appt. Date: __________
Gender: M ___ F ___ Age: ___ Birth Date: ______ Soc. Sec. # ______________ Drivers License: ______
Home Address: ___________________________ City/State: _______________ Zip: __________
Home Tele: _______________ Work Tele: _______________ OK to leave messages at both? ______

Will anyone else be attending counseling with you? If so, who? __________________________________________

Others living in the home:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>RELATIONSHIP TO CLIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

High School College Technical Graduate
Education: 1-2-3-4-5-6-7-8-9-10-11-12 13-14-15-16 Y/N Degree: ______
Emergency Contact:
Name ___________________________ Relationship ___________________________ Telephone ___________________________

Your Employer: ___________________________ Occupation: ___________________________
How long at current job: ___________________________ Military History if any: ___________________________

Marital Status: ___________________________ Spouse/Partner’s Name: ___________________________ Age: ___

Referred By: __________________________________________________________________________

Do you give me your permission to thank the person who referred you? No other information would be disclosed without a specific signed release. Yes ___ No ___
2. Insurance Information

Primary Insurance Co.: ____________________________ Telephone: ____________________________
Claims Address: ____________________________ City/State/Zip: ____________________________
Name of Insured Member: ____________________________ Relationship to Client: ____________________________
Insured Member’s Soc. Sec. #: ____________________________ Insured’s Date of Birth: ____________________________
Member ID # ____________________________ Group #: ____________________________
Employer Providing Insurance Benefit: _______________________________________________________________
Have you obtained pre-authorization for out-patient mental health services? ____________________________
Co-payment amount required by health plan: _______________________________________________________________

Secondary Insurance Co.: ____________________________ Telephone: ____________________________
Claims Address: ____________________________ City/State/Zip: ____________________________
Name of Insured Member: ____________________________ Relationship to Client: ____________________________
Insured Member’s Soc. Sec. #: ____________________________ Insured’s Date of Birth: ____________________________
Client’s Member ID# ____________________________ Group #: ____________________________
Employer Providing Insurance Benefit: _______________________________________________________________

Services provided by your counselor may not be covered by your insurance plan. Please verify coverage directly with your Plan Administrator. Payment for all services expected upon delivery unless counselor is under contract with your insurance carrier.
3. Presenting Problem

Please describe the problem(s) that brought you here and when it began to negatively affect you.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

How have the problems your dealing with affected you in the following areas (please check):

Work/study:  ____ No impact  ____ Moderate Impact  ____ Significant Impact
Physical health:  ____ No Impact  ____ Moderate Impact  ____ Significant Impact
Family:  ____ No impact  ____ Moderate Impact  ____ Significant Impact
Social:  ____ No impact  ____ Moderate Impact  ____ Significant Impact

What have you tried to resolve the problem?
_____________________________________________________________________________
_____________________________________________________________________________

How will you know if counseling has been successful?
_____________________________________________________________________________
_____________________________________________________________________________

Please list your top goals for counseling:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
4.

### Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank**, indicate **how long** these problems have affected you.

<table>
<thead>
<tr>
<th>Scale</th>
<th>1 = extremely big problem</th>
<th>6 = little or no concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOOD</td>
<td>1 2 3 4 5 6</td>
<td>IMPULSE Control 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Tiredness</td>
<td>1 2 3 4 5 6</td>
<td>Anger 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Inferiority Feelings</td>
<td>1 2 3 4 5 6</td>
<td>Temper 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Concentration</td>
<td>1 2 3 4 5 6</td>
<td>Hurting others 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Appetite</td>
<td>1 2 3 4 5 6</td>
<td>Hurting self 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Weight Gain/Loss</td>
<td>1 2 3 4 5 6</td>
<td>Dangerous behavior 1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SUBSTANCE USE 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Sleep</td>
<td>1 2 3 4 5 6</td>
<td>Alcohol 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Nightmares</td>
<td>1 2 3 4 5 6</td>
<td>Drinks/week</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1 2 3 4 5 6</td>
<td>Drugs 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Ambition</td>
<td>1 2 3 4 5 6</td>
<td>Caffeine 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Unhappiness</td>
<td>1 2 3 4 5 6</td>
<td>Drinks/week</td>
</tr>
<tr>
<td>Irritability</td>
<td>1 2 3 4 5 6</td>
<td>Tobacco 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Depression</td>
<td>1 2 3 4 5 6</td>
<td>Packs/week</td>
</tr>
<tr>
<td>Manic Behavior</td>
<td>1 2 3 4 5 6</td>
<td>RELATIONSHIPS 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td>1 2 3 4 5 6</td>
<td>Friends 1 2 3 4 5 6</td>
</tr>
<tr>
<td>ANXIETY</td>
<td>1 2 3 4 5 6</td>
<td>Marriage 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Nervousness</td>
<td>1 2 3 4 5 6</td>
<td>Separation/Divorce 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>1 2 3 4 5 6</td>
<td>Children 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Compulsive Behavior</td>
<td>1 2 3 4 5 6</td>
<td>Shyness 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Obsessive Thoughts</td>
<td>1 2 3 4 5 6</td>
<td>Loneliness 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Fears</td>
<td>1 2 3 4 5 6</td>
<td>Fear of being alone 1 2 3 4 5 6</td>
</tr>
<tr>
<td>HEALTH</td>
<td>1 2 3 4 5 6</td>
<td>Distancing others 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Bowel Troubles</td>
<td>1 2 3 4 5 6</td>
<td>SEXUAL Problems 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Headaches</td>
<td>1 2 3 4 5 6</td>
<td>SELF CARE 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Stomach Trouble</td>
<td>1 2 3 4 5 6</td>
<td>Work 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Binging/Purging</td>
<td>1 2 3 4 5 6</td>
<td>Career Choices 1 2 3 4 5 6</td>
</tr>
<tr>
<td>THOUGHTS</td>
<td>1 2 3 4 5 6</td>
<td>Education 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Making Decisions</td>
<td>1 2 3 4 5 6</td>
<td>Legal Matter 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Memory</td>
<td>1 2 3 4 5 6</td>
<td>Finances 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Confusion</td>
<td>1 2 3 4 5 6</td>
<td>Stress 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Communicating</td>
<td>1 2 3 4 5 6</td>
<td>Incest 1 2 3 4 5 6</td>
</tr>
</tbody>
</table>
5. COUNSELING HISTORY

Have you ever been in counseling before?  Yes ____  No ____
If Yes, how many times ________

Have you ever been hospitalized for psychological or emotional problems?  Yes ____  No ____
If Yes, how many times ________

If Yes to either question above, please describe your experience(s) below beginning with the most recent previous episode of treatment.

Treatment Episode:
When did you see the counselor (your age or dates): ____________________________________________
Who did you see: __________________________________________________________________________
Did you go alone or with others? ____________________________________________________________
What problems were addressed? ________________________________________________________________________________________________
What did you like or gain from the experience? _______________________________________________________________________________________
What did you not like about it? ________________________________________________________________________________________________

Treatment Episode:
When did you see the counselor (your age or dates): ____________________________________________
Who did you see: __________________________________________________________________________
Did you go alone or with others? ____________________________________________________________
What problems were addressed? ________________________________________________________________________________________________
What did you like or gain from the experience? _______________________________________________________________________________________
What did you not like about it? ________________________________________________________________________________________________

Treatment Episode:
When did you see the counselor (your age or dates): ____________________________________________
Who did you see: __________________________________________________________________________
Did you go alone or with others? ____________________________________________________________
What problems were addressed? ________________________________________________________________________________________________
What did you like or gain from the experience? _______________________________________________________________________________________
What did you not like about it? ________________________________________________________________________________________________
6. FAMILY BACKGROUND
Where did you grow up and who did you live with?
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
How would you describe your childhood?
___________________________________________________________________________________
___________________________________________________________________________________
What problems did your family have? What strengths?
___________________________________________________________________________________
___________________________________________________________________________________
Who are you closest to today?
___________________________________________________________________________________

Please describe any family history (past or present) of psychological or emotional problems.
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

7. MEDICAL INFORMATION
Have you seen a doctor in the last year? Yes ____  No ____
If Yes, for what problems? ______________________________________________________________
Who is your Primary Doctor? ___________________________ Doctor’s phone: ______________________
Please list any medications you are taking now including dosage and frequency:
___________________________________________________________________________________
___________________________________________________________________________________
Do you have any allergies? Yes ____  No ____
Have you ever been treated in a hospital?
   If Yes, for what problems? ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
Have you ever been in an accident or suffered any kind of physical/emotional/sexual trauma?
   Yes ____  No ____
   Please give brief description of kind of trauma and when it happened: ______________________
   ______________________________________________________________
   What kind of treatment did you receive, if any? __________________________________________
Have you ever had a head injury? Yes ____  No ____
Other serious medical conditions past or present:
___________________________________________________________________________________
___________________________________________________________________________________
8. SUBSTANCE USE HISTORY

Do you use/have you used alcohol? ○ Current ○ Past ○ No

**Alcohol Frequency:**
○ Never ○ Less than 1 time/month ○ 1-4 times/month ○ 2-3 times/week ○ Daily

**Usual Alcohol Consumption:**
○ None ○ 1-2 drinks per sitting ○ 3-4 drinks/sitting ○ 5 or more drinks per sitting

**Intoxication Frequency:**
○ Never ○ Less than 1 time/month ○ 1-4 times/month ○ 2-3 times/week ○ Daily

**Other Substance Use:** (Check all used in past 6 months)
○ None ○ Marijuana ○ Sedatives ○ Stimulants (speed, crank, etc)
○ Cocaine ○ Inhalents ○ Opiates ○ Hallucinogens (LSD, Ecstasy)
○ Prescription Drugs
○ Caffeine (number of cups/day) ______
○ Tobacco (number of cigarettes/day) ______

**Alcohol or other drug related problems:**
○ Binges ○ Job Problems ○ Sleep Disturbances ○ Physical Withdrawal
○ Hangover ○ Legal Problems ○ Blackouts/memory lapse ○ Medical Concerns
○ Seizures ○ Problems with Friends/Family ○ Assaulots ○ Changes in Tolerance
○ Inability to stop after first drink/use ○ Passing Out ○ Concern over use

**History of Substance Abuse Treatment:**
○ None ○ Stopped on own ○ Attended AA/other 12-step program
○ Attended In-patient ○ Attended Out-patient ○ Attended community based program

Please describe treatment received and outcome:
___________________________________________________________________________________
___________________________________________________________________________________

Please describe any family substance abuse history:
___________________________________________________________________________________
___________________________________________________________________________________

**Other impulsive/addictive concerns:**

_____ Problem gambling  _____ Impulsive spending/shopping  _____ Pornography

_____ Internet Surfing  _____ Excessive Television viewing  _____ Impulsive eating

9. COORDINATION WITH OTHER SERVICES:

Please indicate if there are other agencies/service providers you are currently working with:

Other Mental Health Provider: ________________ Attorney: _______________________

Physician: ________________________ Juvenile Dept.: _______________________

Corrections: ________________________ Child Protective Services: _______________

Career Counselor: ________________ Employee Assistance Program: ____________
PROFESSIONAL DISCLOSURE STATEMENT

Philosophy and Approach: As a Licensed Marriage and Family Therapist, I work collaboratively with individuals, couples, and families to facilitate change and to foster a better understanding of themselves and others in relationships. I consider multiple levels in which a client may be constrained from reaching his or her personal goals including family structure; interpersonal communication skills; cultural, gender, and developmental issues; and internal belief systems. I believe that every client, regardless of the presenting problem, has the potential to grow and to expand their alternatives in response to life's challenges.

Education and Training: I hold a Master of Arts degree in Marriage, Family, and Child Therapy from the Phillips Graduate Institute. Major coursework included marriage and family counseling, child therapy, cross-cultural issues, domestic violence, sexual abuse, divorce and blended family issues. I have obtained additional professional training in trauma resolution, grief counseling, substance abuse, and working with adolescents. I have extensive training in Internal Family Systems Therapy and facilitate trainings in this model of psychotherapy. To maintain my license, I fulfill my requirement to participate in annual continuing education. I may substitute professional supervision for part of this requirement. When external supervision or consultation is utilized to assist in planning services for clients, client confidentiality is maintained. I abide by the Code of Ethics of the Oregon State Board of Licensed Professional Counselors and Therapists.

Fees: Initial Intake Evaluations are charged at $150/hr. Follow-up sessions with individuals are $120 for 55-60 minutes ($110 for 45 minute sessions if restricted by insurance policy), $140 for couples and families. Extended length sessions can be prearranged at a prorated fee. All payments are due at time of service unless I have a contract with your insurance company, in which case only your copayment is due at time of service. Additional discounts may be available if bookkeeping services are not required.

Transfer Plan due to an Unforeseen Emergency: In the unlikely event of my inability to continue my counseling practice due to illness, injury, or death, my trusted colleague Debra Pearce-McCall, PhD, has agreed to contact my active clients to provide notification of my status and to coordinate ongoing treatment if necessary. This plan is required by license and includes provisions that allow for Debra to have access to my client files only in the case of serious emergencies. Additionally, in the event I will not be able to return to work, Debra is to store and subsequently dispose of my files according to all applicable state and federal laws.

Client Rights and Confidentiality: As a client of an Oregon Licensed Marriage and Family Therapist, you have the following rights:
* To expect that a licensee has met the minimal 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;
* To report complaints to the Board of Licensed Professional Counselors and Therapists at:  
* 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, including the following exceptions: 1) Reporting suspected child abuse 2) Reporting imminent danger to self or others; 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; 5) Defending claims brought by client against licensee; 6) When written permission to communicate to a third party is given. In the case of minors, this permission must be granted by the legal guardian.
* To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Contact in Public, Social Media and E-mail and Phone: I will preserve your right to confidentiality and our professional therapeutic relationship outside of counseling sessions. In particular, networking via social media, both personal and professional outlets could potentially compromise your confidentiality and therapeutic boundaries. Sometimes these networks may search your contact lists (and possibly mine) and inadvertently invite me to connect with you. For these and other ethical reasons, invitations to network outside of therapy will not be initiated or accepted.

Electronic Communication, Social Media, Other Contact: Electronic communication outside of sessions may be helpful and convenient for appointment reminders or updates. Unfortunately the security of these messages cannot be guaranteed nor should they be used for emergency or urgent matters. If you require frequent e-communication outside of treatment that requires more of my focused attention, it is likely that we will need to include this data in your file and consider additional fees for my time.

Should we run into each other in public I will respect your privacy by not approaching you nor will I expect any recognition from you. However, please feel free to say hello and connect briefly if you like. If other people are with us I will not disclose anything that might reveal the nature of our connection but will respect your right to do so. These boundaries will pertain even after your counseling with me has ended.

________________________________________________________________________
Client Signature                                              Date
________________________________________________________________________
Partner or Parent/Guardian of minor                           Date
The following is an explanation of clinical considerations and administrative details of this psychotherapy practice. I encourage you to discuss any questions or concerns you have with me before you sign this form.

**Confidentiality:** Privacy is essential to effective counseling, and the confidentiality of your therapy is protected by law. Information about you will not be disclosed to anyone without your written consent. Exceptions to confidentiality are limited to extreme circumstances regarding safety, your insurance company to facilitate payment, and my bookkeeping service provider. These exceptions and other information regarding your rights are detailed in my Professional Disclosure Statement.

**Appointments:** Your appointment is held exclusively for you. If you are unable to keep your appointment or need to reschedule, please call my office at least 24 hours in advance. Otherwise, you will be charged $65 for the session (insurance does not pay for missed appointments). Late fees in situations where you are unable to give 24 hours notice will be considered on a case by case basis.

**Emergencies:** In case of an urgent situation, please leave a message for me on my office voice mail. I check for messages several times during each work day, and will return your call as soon as possible. If you need immediate attention, call Multnomah County Crisis Line at 503 988 4888. In the event of a life threatening or extreme emergency, call 911 or go directly to the nearest emergency room.

**Fees:** The fee for my professional services is $150 for an Initial Evaluation with follow-up sessions billed at $120 for 50-60 minutes for individual clients ($110 for 45 minute sessions if restricted by insurance policy), and $140 for couples and families. Extended length sessions (greater than 60 minutes) may be prearranged at a prorated fee, although most insurance will not cover longer sessions. Payment is due at the time of service unless I have agreed to bill your insurance in which case only your copayment is needed at time of session.

If, at some point, you have difficulty with the payment arrangements that we agreed to at the beginning of treatment, please let me know so that we can design a payment plan or referral. Unpaid accounts may be turned over to an attorney or collection agency which, out of necessity, will compromise your confidentiality (only non-clinical information will be disclosed). Bookkeeping is outsourced to Vickie Kupel at MHP services and discounts may be available to clients who do not require her services (please inquire further with me). Vickie will happily answer questions about your account at 360-852-8739.

**Insurance:** My contract for professional services and payment is with you. Your counseling services may be partially covered by a behavioral health provision in your health insurance policy or some other third party payer (i.e. Victim's Assistance Fund). I will only bill directly those plans for whom I am a designated provider.

Mental health insurance coverage differs dramatically from one company to another, and change from year to year. It is often difficult to predict the services and fees different plans will cover. It is important that we discuss these issues in your early sessions, or when there is a change in policies, to avoid confusion and problems that could interfere with our work together. Please keep in mind any deductible that requires you to cover services, especially at the beginning of the year.

**Consent to Treatment/Termination:** Although counseling is often very useful to clients, it is not uncommon for individuals to become upset or to experience difficulties when things begin to change. Please talk to me about any concerns you may have and any significant negative effects of treatment on yourself or others attending sessions. During counseling we will discuss your goals and concerns, and although I might suggest actions you might take which could help, the responsibility for making decisions in your life ultimately resides with you. Most relationships have an ending, and at some point ours will too. It is important that we agree now, as we begin, that should either of us determine that our counseling contract is no longer necessary and/or workable, we will allow time to discuss this so that the ending be clear and honorable to your process and to the relationship.

____________________  ________________
Signature                        Date

____________________  ________________
Signature                        Date
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____________________, hereby authorize an disclosure of Protected Health Information by
(Name of Client)
Mariel Pastor, M.A., L.M.F.T., to representatives of _________________________________.
(Name of Health Insurance Company)

I also assign my benefits to be collected by my counselor for payment of eligible services.

Purpose for which information is to be released:

payment of claims;
authorization of services;
and coordination of treatment.

By signing below I hereby authorize the obtaining or release of Protected Health Information only. I understand that a separate authorization must be obtained to release more personal Psychotherapy Notes, and that such notes are, by federal HIPAA law, w not to be required by my insurance to authorize my treatment.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. Unless revoked earlier, this consent shall expire one (1) year from the date signed.

Signature of Client(s) Date

Signature of Parent/Guardian (if minor) Date
COMMUNICATIONS POLICY

CONTACTING ME:

When you need to contact me for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- By telephone (503) 227-8774. You may leave messages on the voicemail, which is confidential.
- By text (non-secure) for basic information only (i.e. regarding appointments)
- By email (non-secure), though this form of communication has risks to your confidentiality. Federal Laws require me to get your specific consent and authorization to communicate in this manner. PLEASE READ & SIGN THE CONSENT & AUTHORIZATION FORMS FOR NON-SECURE ELEC. COMMUNICATION.

I do not currently have an encrypted email or text service. If you choose to, you may send PDF or other digital documents to me on my regular email listed above.

Social media messaging systems such as Facebook Messenger, Twitter, or LinkedIn have very poor security and are not conducive to a confidential counseling relationship such as ours. And, though our professional relationship has a personal component to it, "friend" requests will be respectfully denied so as to protect your confidentiality. Please feel free to speak to me about any concerns you may have about my preferred communication methods.

RESPONSE TIME:

I may not be able to respond to your messages and calls immediately. Routine voicemails and texts will be returned within 1-2 business days. I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

EMERGENCY CONTACT:

If you have an urgent need or are in crisis, please leave me a VOICEMAIL to that effect and I will call you back when I am able, though generally between 8a-8p.

If you are experiencing an emergency, including a mental health crisis, please call the MULTNOMAH COUNTY CRISIS LINE: 503-988-4888

THANK YOU!
COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with me.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If there are people in your life that you don't want accessing these communications, please talk with me about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS:

I consent to allow Mariel Pastor to use unsecured email and mobile phone text messaging to transmit to me the following Protected Health Information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my Protected Health Information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

______________________________________________      _____________________
Signature of Client                          Date
CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION
BY NON-SECURE MEANS

I, ________________________________ authorize: Mariel Pastor, MA, LLC
(name of client) 1130 SW Morrison, #328
Portland, OREGON 97205
to transmit protected health information related to my health records and health
care treatment by the following non-secure media:

• Information related to the scheduling of meetings or other appointments
• Information related to billing and payment
• Completed forms, including forms that may contain sensitive, confidential
  information
• Information of a therapeutic or clinical nature, including discussion of
  personal material relevant to my treatment
• My health record, in part or in whole, or summaries of material from my
  health record
• Other information. Describe: ______________

By the following Non-secure media:
• Unsecured email
• SMS text message (i.e. traditional text messaging) or other type of texting.
• Other media. Describe: ___________________

TERMINATION:
_____ This authorization will terminate _______ days after the date listed below
OR
_____ This authorization will terminate when the following event occurs:
CURRENT COURSE OF TREATMENT ENDS.

I have been informed of the risks, including but not limited to, my confidentiality in
treatment, of transmitting my protected health information by unsecured means. I
understand that I am not required to sign this agreement in order to receive
treatment. I also understand that I may terminate this authorization at any time.

________________________________________  _____________________
Signature of Client                        Date
HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website which is located at WWW.MarielPastor.com.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office. I use MHP Billing Services for all bookkeeping records and that organization is HIPAA compliant.

4. Other disclosures. Examples: Your consent isn’t required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the patient or the patient’s representative pursuant to Oregon Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e adverse reaction to meds).

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the Oregon Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the Oregon Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research though I am not involved in any research projects.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tecum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

18. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which
you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: 1130 S.W. Morrison Street, Portland, OR 97219. Telephone: 503/227-8774.

VII. NOTIFICATIONS OF BREACHES
In the case of a breach, I, Mariel Pastor, am required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, I am ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. I, Mariel Pastor, bear the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VII. PHI AFTER DEATH
Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. I, Mariel Pastor, may disclose deceased individuals' PHI to non-family members, as well as family members who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. INDIVIDUAL' RIGHT TO RESTRICT DICLOSURES; RIGHT OF ACCESS
To implement the 2013 HITECH Act, the Privacy Rule is amended, Mariel Pastor is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring me, Mariel Pastor, to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that I, Mariel Pastor, must provide you only with an electronic copy of your PHI, not direct access to electronic health record systems. The 2013 Amendments also give you the right to direct me to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that I may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access from up to 90 days currently permitted to 30 days with a one-time extension of 30 days.

X. Notice of Privacy Policies
Most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you and you have the right to be notified in case of a breach of unsecured PHI.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on January 30, 2013

I acknowledge receipt of the HIPAA Privacy Notice

Patient Name: __________________ Date: ______ Signature: _______________

Patient Name: __________________ Date: ______ Signature: _______________