Nick DeMayo, LMFT
www.counselorforteens.com

CLIENT INFORMATION

Client Name: _____ Age: ____ Date of Birth: _____

Grade: _____ School: _____

Parents: _____

Address: _____

Phone Number: _____ Email Address: _____

Siblings: _____

Please list all family members in the household:

_____

How were you referred to me? _____

CLIENT HISTORY

Has your child received counseling before? If so, when and what were the goals of treatment?

_____

Does your child currently receive treatment from any other mental health providers?

_____

Has your child had any recent stressors in his life?

_____

Has your child ever engaged in self-harm, attempted suicide, or been hospitalized?

_____

Do you suspect your child is currently using any drugs or alcohol?

_____

Does your child have any current or prior health issues?

_____

Is your child currently taking any medication?

_____

Have any family members struggled with anxiety, depression, or other mental health challenges?

_____

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CLIENT QUESTIONNAIRE

What are your primary concerns about your child?

_____

How are these concerns impacting your child's life?

_____

How would you like your child to benefit from counseling?

_____

Are there any specific goals you would like your child to work toward in counseling?

_____

What effective coping skills is your child using currently?

_____

What are your child's strengths?

_____

What do you like most about your child?

_____

What are the most challenging behaviors that your child exhibits at school?

_____

What are the most challenging behaviors that your child exhibits at home?

_____

Is there any additional information that would help me in understanding your concerns and help me in working with your child?

_____

_____

_____

PRIVACY PRACTICES & INFORMED CONSENT

PRIVACY PRACTICES

Personal information, schedule of visits, and counseling notes are referred to as Protected Health Information (PHI). I am required by law to protect the privacy of your PHI. PHI is stored in a locked file cabinet in compliance with HIPAA (Health Insurance Portability and Accountability Act). More information on HIPAA and your rights to privacy can be found at: http://www.hhs.gov/hipaa/

I am required to obtain a signed release from you if I need to consult with a doctor, teacher, school counselor, or other mental health professional. I am required to grant you access to your PHI.

Insurance companies may request the following information: type of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

LIMITS OF CONFIDENTIALITY

The information disclosed during counseling sessions and the written records pertaining to those sessions are confidential and will not be disclosed without your written consent, with the following exceptions:

1. If there is reason to believe your child may be in danger of harming themselves or another person.
2. If there is reason to believe that the abuse or neglect of a child, elder, or someone with disabilities has occurred.
3. If a court order is received.
4. For insurance billing purposes.

THERAPEUTIC PROCESS & RISKS

The outcome of treatment depends largely on a client's (and client's family members) willingness to engage in the therapeutic process, which may, at times, result in discomfort. The therapeutic process can bring up uncomfortable feelings and reactions such as, anxiety, sadness and anger. These reactions and feelings are normal responses and will be addressed during the course of therapy.

It is important to ask questions about treatment if you are unclear about any aspect of treatment goals or plans. There is no guarantee that a client will meet their treatment goals.

I have read and understand this document and I agree to its terms.

_____	_____
Parent Signature	Date
_____	_____
Nick DeMayo, LMFT	Date

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PROFESSIONAL DISCLOSURE STATEMENT

Philosophy & Approach to Counseling: I believe that positive change begins with the relationship between client and therapist. I strive to be a present and open therapist, accepting the client where they are in life, while working to fully understand the challenges they may be struggling with. My goal is to help clients gain a better sense of self-awareness, as we examine their thoughts, feelings, and behavior, while working toward solutions, together.

Education, Training & Experience: I have a Masters of Arts degree in Counseling Psychology from The University of San Francisco. I specialize in working with adolescents, ages 11 to 17. My experience has come from working in hospitals, schools, group homes, and residential facilities over the past 7 years. I have also attended workshops in Mindfulness, Trauma-Focused Therapy, and Music Therapy.

Continuing Education: I am a Licensed Marriage and Family Therapist in the state of Oregon. It is my priority to abide by the Code of Ethics in this state. To maintain my license I am required to complete annual continuing education hours, taking classes relevant to this profession.

Payment for Services: My fee for a 50-minute session is $120. 24 hours notice of cancellation is required so that I may arrange my schedule accordingly. Payment is due at the start of each session and cash, check or card are accepted. I'm an independent contractor and not an employee of Portland Therapy Center.

Client Bill of 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;
- 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 client 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.
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Oregon Board of Licensed Professional Counselors and Therapists
3218 Pringle Rd. SE Suite 250, Salem, OR 97302-6312
Telephone: (503) 378-5499
Email: lpct.board@state.or.us Website: www.oregon.gov/OBLPCT

I have read and understand this document and I agree to its terms.

_____ _____
Parent Signature Date

_____ _____
Nick DeMayo, LMFT Date

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PRACTICE INFORMATION & POLICIES

SESSION LENGTH & FEE

My fee is $120 for a 50-minute session. If using insurance, your co-pay will be determined prior to the first session. Payment is required at the beginning of each session and I accept cash, check or credit/debit card.

CANCELLATION POLICY

I require at least 24-hour notice if you need to cancel a session. I allow clients to cancel one session at the last minute without being charged, but after that, I have to charge you my fee for one session. Please note that insurance companies do not reimburse me for missed sessions.

LITIGATION & LETTER WRITING

I do not participate in a client's legal proceedings and my policy is to not communicate with or write letters on behalf of the client to the court or lawyers for the purposes of a client's litigation. I also do not write letters pertaining to a client's mental health to schools, disability offices, employers, etc.

EMERGENCIES

I do not provide emergency or crisis response services. In the event of an emergency, please contact 911 or the Multnomah County Crisis Line at (503) 988-4888. If you contact me during a crisis I will do my best to respond to you within 24 hours.

I have read and understand this document and I agree to its terms.

_____ _____
Parent Signature Date

_____ _____
Nick DeMayo, LMFT Date