

CLIENT INFORMATION

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

Grade: _____ School: _____

Parents: _____

Address: _____

Phone Number: _____ Email Address: _____

Would you like to receive text message appointment reminders? _____

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 any self-harm?

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?

PARENT QUESTIONS

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 currently using?

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 home?

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

Is there any additional information that would help me better understand your concerns while 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 child's PHI. PHI is stored in a locked file cabinet in compliance with HIPAA (Health Insurance Portability and Accountability Act). I am required to grant you access to your child's PHI via written request.

I am required to obtain a signed release from you if I need to consult with your child's doctor, teacher, or other professional.

Insurance companies require that I assign a mental health diagnosis for your child. Through the claim submission process, they will have a record of the following information: diagnosis code, type of service, date/time of service. In the rare occurrence that I am audited by your insurance company, they may request more information, including a treatment plan, case notes or treatment summary.

LIMITS OF CONFIDENTIALITY

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

- 1) If I suspect your child may be in danger of harming themselves or someone else.
- 2) If I suspect any abuse or neglect of a child, elder, or person with disabilities has occurred.
- 3) If using insurance, your insurance company will have a basic record of our sessions.
- 4) If a court order is received.

THERAPEUTIC PROCESS/RISKS & GOALS

The outcome of counseling largely depends on your child's willingness to engage in the therapeutic process, which may result in discomfort at times. The therapeutic process can reveal uncomfortable feelings of anxiety, sadness and anger. These responses are normal and will be addressed during the course of therapy.

I will help your child identify three counseling goals to work toward in our sessions. There is no guarantee that your child will reach their counseling goals but we will track their progress and identify new goals as needed. Counseling goals will be shared with parents and parents are encouraged to have a discussion with their child around how they can best support them.

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

Parent Signature

Date

Nick DeMayo, LMFT

Date

PROFESSIONAL DISCLOSURE STATEMENT

Philosophy & Approach to Counseling: I'm a relational therapist, I believe that change comes from the relationship that we build in our sessions. I strive to create a safe and trusting environment, providing a space for clients to allow themselves to feel comfortable and open to the therapeutic process. I'm flexible and adaptive with my approach to counseling, drawing from Cognitive Behavioral Therapy (CBT), Person-Centered Therapy, Humanistic Therapy, Solution-Focused Brief Therapy, and Mindfulness. I take a collaborative approach with clients, working together to make the most of our time.

Education, Training & Experience: I have a Masters degree in Counseling Psychology from The University of San Francisco. I specialize in working with adolescent boys and my experience comes from working in a psychiatric hospital, outpatient clinics, schools, and residential facilities.

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 is \$175 per 50 minute session. Payment is due at the start of each session via Ivy Pay, a HIPAA compliant payment service for therapists. 24-hour notice is requested for the cancellation or rescheduling of an appointment. If less than 24-hour notice is given, clients will be charged a \$125 cancellation fee.

Client Bill of Rights:

As a client of an Oregon licensee, you have the following rights and responsibilities:

- 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 Road SE, Ste. 120 Salem, OR 97302
(503) 378-5499

lpct.board@mhra.oregon.gov

Additional information about this therapist is available on the Board's 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

PRACTICE INFORMATION & POLICIES

SESSION LENGTH, FEE & PAYMENT INFO

My fee is \$175 per 50 minute session (subject to change with at least 30 days notice). I accept payment via Ivy Pay, a HIPAA compliant payment service for therapists. You will receive a text message after our first session prompting you to put a credit, debit or HSA/FSA card on file. Your card will be charged after each session and you will receive a receipt via text message.

CANCELLATION POLICY & FEE

Please provide at least 24-hours notice if you need to cancel or reschedule a session. My cancellation fee is \$125 for last minute cancellations. Please note that insurance companies do not reimburse me for canceled sessions.

INSURANCE: IN NETWORK BENEFITS

I will call your insurance company prior to our first session to confirm your benefits and copay/coinsurance. If your deductible needs to be met, I will charge you the "reimbursement rate" (the amount your insurance company pays me per session) until your deductible is met.

INSURANCE: OUT OF NETWORK BENEFITS

You may be eligible for full or partial reimbursement for our sessions, but this is not guaranteed. I can provide you with a receipt called a "superbill" which you can submit for possible reimbursement. If additional information is requested by your insurance company for payment, I will not provide any additional information beyond what is listed on the superbill.

PARENT INVOLVEMENT, COMMUNICATION & RESOURCES

I am an individual therapist and my goal is to provide a safe and confidential space for your child. While I don't collaborate with parents or provide parent coaching or family therapy, I have some excellent resources and referrals listed on my website if you or your family may need additional support. I don't provide updates to parents but will let you know if I have ever a specific concern or recommendation. I welcome the occasional update from parents, especially if an event occurs that your child may not mention in session, on their own. Updates via text/email are preferred but we can also meet individually at the start of your child's session if needed.

LITIGATION & LETTER WRITING

I do not write letters to courts or lawyers for the purposes of a client's litigation. I do not write letters pertaining to a client's mental health to schools, disability offices, employers, etc.

EMERGENCIES & CONTACT INFO

I do not provide emergency or crisis response services. In the event of an emergency, please contact your local crisis line or 911. Email is the best way to reach me during holidays and outside of regular office hours.

TERMINATION OF THERAPY

The therapeutic relationship will conclude and client files will be closed 60 days after our final session, unless we have made prior arrangements for a longer break in services.

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

Parent Signature

Date

Nick DeMayo, LMFT

Date