Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Your Contact Information and History

Please fill this information out and bring with you to our first session. If you're doing couples counseling, each person would do their own. Thank you for helping us serve you

Today's date _____ How'd you hear about us?

- ❑ Facebook
- ❑ Google Search
- ❑ Psychology Today
- ❑ Yelp
- ❑ Mobile search
- ❑ Craig's List
- ❑ Your Insurance
- ❑ Family/friend
- ❑ Other _____

Name _____

Address _____

City _____ State _____ Zip _____

Home phone_____ Work phone _____

Cell number _____ Email _____

For confidential messages (email, addr, phone) _____

Date of birth _____ Age _____ Place of Birth _____

Insurance Provider _____ Phone _____

Policy # _____ Group # _____

Secondary Insurance info _____
Name ID # Group # Phone

Spouse or partner _____ Phone _____

Emergency contact _____ Phone _____

Emergency contact _____ Phone _____

Employer _____ Allergies _____

Current prescription drugs _____

_____

Homeopathic or herbal treatment _____

What brought you here? _____

_____

_____

What would you want to have accomplished or want to be different upon completing our work together?

1. _____
2. _____
3. _____
4. _____
5. _____

Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Our Office Policies & Your Informed Consent

Welcome to Counseling. **Your investment in counseling can lead to a more rich and rewarding life.** Here are the guidelines to our work together. If you have any questions regarding any aspect of your counseling experience, please feel free to ask. The information below covers a number of areas that protect you and let you know how we operate.

Confidentiality: Limits on Confidentiality. The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows: 1. Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless they feel that it is important to your work together. All consultations will be noted in your Clinical Record (which is called "PHI" in the attached Notice of Privacy Practices used to protect the privacy of your health information).

As a group, we practice with other mental health professionals and employ administrative staff. In some cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with a software billing company. As required by HIPAA, we have a formal business associate contract with this business in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

When Disclosure Is Required By Law**: In some circumstances the law requires that we report**. These situations include: a reasonable suspicion of child, dependent or elder abuse or neglect; where you might be in danger of harming yourself, others, property, or are gravely disabled, or when your family members or other person(s) communicate to CSP **(Counseling Services of Portland)** staff or clinicians that the you present a danger to self or others.

When Disclosure May Be Required: We may also have to disclose if there is a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony by your CSP counselor. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your CSP counselor will use his or her clinical judgment when revealing such information. Your CSP counselor will not release records to any outside party unless she or he is authorized to do so by all family members age 15 or over who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination where your CSP counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he or she will do whatever possible, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, he or she may also contact the person whose name you have listed as your emergency contact.

Health Insurance & Confidentiality of Records: If you use your health insurance, we may need to disclose confidential information to your health insurance company HMO, PPO, MCO or EAP in order to process the claims. If you instruct your CSP counselor to bill your insurance, only the minimum necessary information will be communicated to them. **Your CSP counselor has no control or knowledge over what insurance companies do with the information he or she submits or who has access to this information. Submitting a mental health invoice for reimbursement carries some risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job.** Mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

Consultation: Your CSP counselor consults regularly with other professionals regarding his or her clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

Litigation Limitation**:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings such as, but not limited, to divorce and custody disputes, injuries, lawsuits, etc., neither you nor your attorney, nor anyone else acting on your behalf will call on your CSP counselor to testify in court or at any other proceeding, nor will a disclosure of your counseling records be requested unless otherwise agreed upon.

Emails, Cell phones, Computers and Faxes: Computers, e-mail and cell phone communication can be accessed by unauthorized people and can compromise confidentiality. E-mails, in particular, are vulnerable because servers have unlimited, direct access to all e-mails that go through them. **Your CSP counselor's e-mails are not encrypted**. Faxes can be sent to the wrong address. Some texts are never received. Your CSP counselor's computers are equipped with firewall, virus protection and password. All backups are stored securely. Please notify Your CSP counselor if you decide to avoid or limit the use of any or all communication devises. **If you communicate confidential information via e-mail or text, your CSP counselor will assume that you have made an informed decision that such communication may be intercepted**, and he or she will assume you desire to correspond on such matters via e-mail. Please notify us if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell-phone or faxes. Please, be aware that emails are part of your medical record. **Please do not use e-mail, text or faxes for emergencies.**

Email and Phone Consulting: Occasionally, a client will request counseling via phone or e-mail rather than in person in the therapist's office. This has some complexities and disadvantages to the therapeutic process. We always recommend that you find a local therapist and meet face to face. If your CSP counselor is not aware of a local referral, call the local Psychological Association chapter, local NASW chapter or local LPC chapter for a referral. Treating clients exclusively via phone consultations or e-mails may put therapists at a disadvantage because we cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally and may not be able to intervene as effectively as necessary in emergency situations. So far there is no extensive or conclusive research on phone or online therapy. As was noted in the Termination section, if your CSP counselor assesses that he or she is not effective in helping you reach the therapeutic goals via the telephone sessions, he or she is obligated to discuss it with you and, if appropriate, to terminate treatment. For more information on the topic you can go to: http://psychcentral.com/best.

***Records and Your Right to Review Them*:** Both the law and the standards of Your CSP counselor's profession require that **we keep appropriate treatment records for at least seven years**. Unless otherwise agreed to be necessary, your CSP counselor retains clinical records only as long as is mandated by Oregon law. If you have concerns regarding the treatment records please discuss them with your CSP counselor. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Your CSP counselor assesses that releasing such information might be harmful in any way. In such a case your CSP counselor will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, your CSP counselor will release information to any agency/person you specify unless your CSP counselor assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, your CSP counselor will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Telephone & Emergency Procedures: If you need to contact your CSP counselor between sessions, please leave a message and your call will be returned as soon as possible. If an emergency situation arises, indicate it clearly in your message. If you need to talk to someone immediately, call the **Multnomah County Crisis Line at 503-988-4888**. You can also go to your nearest emergency room. **If you are under the influence of a substance or otherwise unable to drive, have someone else take you or call a taxi.** Depending on his or her individual procedures, your CSP counselor may also give you an emergency contact number where he or she can be reached more immediately. **Please do not use e-mail, texts or faxes for emergencies.**

***Payments & Insurance Reimbursement*: Please prepare your payment in advance each week** so we can devote every minute to you and your concerns. Unless otherwise arranged**, payment or co-payment is due at each session.** You can pay by check, credit card or cash. **Checks can be made out to Counseling Services of Portland**. Please have your payment ready before the session to save time. Standard rates **are $180 per 55 minute session. Initial intake session is $199**. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify your CSP counselor if any problems arise regarding your ability to make timely payments. **As a courtesy to you, CSP will bill your insurance company for you**. However, our services are provided and charged to you and not the insurance company, and you are ultimately responsible for payment. As was indicated in the section *Health Insurance & Confidentiality of Records,* please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. **Not all issues, condition and problems which are dealt with in psychotherapy are reimbursed by insurance companies**. It is your responsibility to verify the specifics of your coverage.

Mediation & Arbitration: If a dispute arises we will seek mediation before, and as a pre-condition of, the initiation of arbitration. The mediator will be a neutral third party mutually agreed up by you and your CSP counselor. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Washington County, Oregon in accordance with the rules of the American Arbitration Association in effect at the time the demand for arbitration is filed.

The Process of Therapy and Scope of Practice: We see **counseling as a cooperative effort geared to resolving problems or issues that you present. Your active participation with your thoughts, feelings and actions help to create success.** Therapy is simply a means to an end and most beneficial when guided by your goals. We will regularly review your goals as well as your thoughts and feelings expressed regarding the therapy process. We like to begin by getting to know you and hearing about your concerns, what you have tried so far, what has not helped and what has improved your situation. Then we usually discuss what successful completion of therapy would look like for you. We then set a course to achieve your goals. **Using this plan, we will know what you are achieving, and when you are done**. Sometimes

difficult emotions arise, and we have found that open and honest feedback from you can be a turning point in getting you the results you desire. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for you may at times be challenging for others in your life.

We use a number of approaches to help you achieve your goals. These include: behavioral, cognitive-behavioral, cognitive, psychodynamic, transpersonal, Jungian, existential, system/family, developmental (adult, child, family), humanistic, SoulCollage®, Somatic Experiencing®, psycho-educational, guided imagery, hypnosis, EMDR, Gottman-method couples therapy and others. Your CSP counselor **does not provide custody evaluation recommendations, medication or prescription recommendation or legal advice**, as these activities do not fall within his or her scope of practice. Any communications regarding the above should in no way be construed as advice.

Therapy can be as short as one session, or as long as a few years, depending upon the breadth and depth of your goals, and your own personal change process. **Research shows that 50% of patients make noticeable improvement after 8 sessions. And 75% of individuals in therapy improved by the end of 6 months.** There are many people for whom therapy is a deeper, longer-term process that may require a longer course of treatment to achieve their goals. Additionally, many clients come for a course of treatment, finish up, and then return later to achieve other goals or for "tune-ups." This is a perfectly normal part of the therapy process and the therapeutic relationship.

Discussion of Treatment Plan: Once you've started, your CSP counselor will discuss with you the problem(s) that brought you to treatment, and **together you will create a plan to reach your goals**. The more active role you take in describing the problem and the goals you want to achieve, the better. **We are the experts in the change process. You are the expert in "you".** If at any time you are uncomfortable with the way things are going, please let us know and together we can make a course correction.

Gottman Method Couples Therapy: If you are receiving couples therapy from a CSP Gottman-trained therapist, your therapist is completely independent in providing you with clinical services, and is solely and fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

Termination: After the first couple of meetings, we will assess if the therapy process can benefit you. **We don't accept clients who we are unable to help.** When this happens we will give you a number of referrals. **If at any point during therapy your CSP counselor assesses that he or she is not effective in helping you reach your goals, he or she is obligated to discuss it with you and, if appropriate, to terminate treatment.** If this happens we will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your CSP counselor will talk to the counselor of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your CSP counselor will assist you with referrals, and if he or she has your written consent, he or she will provide the essential information needed. **You also have the right to terminate therapy at any time.**

***Dual Relationships*:** A dual relationship happens when you have contact with your therapist outside the counseling office. Not all of these relationships are unethical or avoidable. However, therapy never involves a sexual or romantic relationship with a client. Your CSP counselor will assess carefully before entering into non-sexual and non-exploitative dual relationships with you. You may bump into someone you know in the waiting room or into your CSP counselor out in the community. **Your CSP counselor will never acknowledge working with anyone without your written permission**. Many clients choose their therapist because they know of him or her before they enter into therapy or are personally aware of his or her professional work and achievements. Nevertheless, your CSP counselor will discuss with you the complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. Please let your CSP counselor know if the dual or multiple relationship becomes uncomfortable for you in any way. Your CSP counselor will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if he or she finds it interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours notice is required for re-scheduling or canceling an appointment**. Unless we reach a different agreement, **the full fee of $180, not just your copay**, will be charged for sessions missed without 24 hours notice**. Insurance companies do not reimburse for missed sessions.**

Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Agreements for Working Together in Psychotherapy

Please Initial ↓

1. **Billing:** I authorize Counseling Services of Portland to furnish my insurance company with any/all information requested or necessary concerning my present claim. I authorize payment of benefits from my insurance provider Counseling Services of Portland or my contracted provider at Counseling Services of Portland.

2. **Fee:** I agree to pay Counseling Services of Portland **$180 per 55 minute session** unless otherwise noted. I agree to pay at time of service for my payment or copayment. **Initial intake session is $199**.*

3. **Emergency calls:** I understand that I will be **charged for emergency telephone consultations** at the hourly office visit rate.*

4. **Extended Sessions:** I understand that I will be **charged at the prorated hourly rate for extended sessions**.*

5. **Overpayment:** I agree to return any money owed to Counseling Services of Portland received from my insurance company. I understand that any money in excess of my bill will be returned to me from insurance reimbursement.*

6. **Late Cancelation:** I understand that **I am responsible for paying fees** incurred from **late cancellations without 24 hour notice**. My insurance will not cover missed appointments. I understand that I am responsible **for the full fee of $180** which is not covered by insurance. Benefits quoted are no guarantee of payment. Exceptions to this policy are cases where sudden illness and legitimate emergencies occur. **I authorize my credit card to be charged at the time of the canceled session using credit or debit card number below**.*

7. **Payment Plan (initial one)**
   I agree to pay the session fee or insurance copayment in full at the time of service by **cash, check or credit**.*

   I request that my **credit or debit card be charged** for each session fee or insurance copayment at the time of service. Note if you use a HSA, this will not pay for a late cancel session fee and we would need an additional card data**. I understand that my credit/debit information will be kept secure and confidential by CSP.***

* Does not apply to Oregon Health Plan clients

Credit Card Information (required): Type of Card: ❑ Visa ❑ MasterCard ❑ Discover ❑ HSA ❑ Debit

Account #:

Expiration Date: Security Code: Billing Zip Code:

Address (if different than page 1):

Signature: _____ Card Holder Name: _____

❑ We send out a more-or-less monthly email newsletter **UnCommon Sense** with practical tools for everyday life. **Check the box if you do not** want to receive this free service.

_____
Client name (print) Date Signature

_____ _____
Client name (print) Date Signature

Counseling Services of Portland Counselor Date Signature

Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Authorization to Release and Exchange Information

I, _____, _____ give permission to
Client Name Birth date

Counseling Services of Portland and its staff to disclose and obtain mental health treatment information and records obtained in the course of my psychotherapy treatment, including, but not limited to, my therapist's diagnosis to:

_____ _____
Your physician or psychiatrists name Phone number

Information to be Disclosed: _____ Entire mental health and/or substance abuse record,
Initial

or such disclosure shall be **limited to the following specific types of information**: (client must initial each item to be released):

Initial		Initial	
___	Substance abuse evaluation	___	Treatment recommendations
___	Expected length of treatment	___	Attendance records only
___	Diagnosis/assessment	___	Treatment plan
___	Name of new treatment provider	___	Treatment progress report
___	Medication information	___	Other (specify) _____

Purpose for Disclosure (client must initial):

Initial
___ Continuity of care
___ Care management and processing of benefit claims
___ Education coordination
___ Coordination and collaboration of care
___ Other (specify) _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the **right to revoke** this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such **revocation must be in writing and received by Provider at 7100 SW Hampton Street, Suite 128, Tigard, OR 97223** to be effective. Therapist shall **not condition treatment upon Client signing this authorization.** I have the **right to refuse to sign** this form. I understand that information used or disclosed in this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Oregon law may protect such information.

This authorization shall remain valid until one year after termination of treatment or _____

_____ _____
Client signature Date

_____ _____
Signature of parent, guardian, conservator or authorized rep. Date

_____ _____
Therapist Date

Notice to Recipient of Information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFE Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member.

Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Notice of Privacy Practices

This notice describes how clinical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. CSP refers to Counseling Services of Portland. This notice is for you to keep if you wish.

Who Will Follow This Notice. This notice describes the information privacy practices followed by **Counseling Services of Portland**

Your Health Information This notice applies to the information and records CSP has about your health, health status and the health care and services you receive at the CSP office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

How May CSP Use & Disclose Health Information About You CSP may use and disclose health information for the following purposes:

- **For treatment:** CSP may use health information about you to provide you with critical treatment or services. CSP may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Different personnel in CSP office may share information about you and disclose information to people who do not work in CSP office in order to coordinate your care. Family members and other health care providers may be part of your clinical care outside this office and may require information that CSP has.
- **For substance abuse:** Federal and state law require your written consent each time CSP releases health information. The consent will specify who is to receive the information, the purpose of the release of information and the time period after which the consent will terminate. You may modify or revoke a consent at any time.

Special Situations CSP may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations.

- **To avert a serious threat to health or safety: CSP** may use and disclose health information about you when necessary to prevent a serious thereat to your health and safety or the health and safety of another person.
- **Required by law: CSP** will disclose health information about you when required to do so by federal, state or local law.
- **Military, veterans, national security and intelligence:** If you are or were a member of the armed forces, or part of the national security or intelligence communities, CSP may be required by military command or other government authorities to release health information about you. CSP may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation: CSP** may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public health risks:** CSP may disclose health information about your of public health reasons in order to prevent or control diseases, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medicines or problems with products.
- **Health oversight activities: CSP** may disclose health information to a health oversight agency of audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws**.**
- **Lawsuits and disputes:** If you are involved in a lawsuit or dispute, CSP may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, CSP may also disclose health information about you in response to a subpoena.
- **Information not personally identifiable: CSP** may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and friends: CSP** may disclose health information about you to your family members of friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such disclosures and you do not raise an objection. CSP may also disclose health information to your family or friends if we can infer from the circumstances (based on our professional judgment) that you would not object. In situations where you are not capable of giving consent (because you are not present, or due to your incapacity, or medical emergency), CSP may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, CSP will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information CSP will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written authorization. If you give CSP authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If your revoke your authorization, CSP will no longer use or disclose information about you for the reasons covered by your written authorization, but CSP cannot take back any uses or disclosures already made with your permission. In some instances, CSP may need specific written authorization from you in order to disclose certain types of specially protected information such as HIV, substance and mental health information.

Your Rights Regarding Health Information About You. You have the following rights regarding health information CSP maintains about you:

- **Right to inspect and copy:** You have the right to inspect and copy your health information. You must submit a written request to CSP in order to inspect and/or copy records of your health information. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing, or other associated supplies.
- **Right to amend:** If you believe the health information that CSP has about you is incorrect or incomplete, you may ask CSP to amend the information. You have the right to request an amendment as long as the information is kept by CSP office. To request an amendment, complete and submit a *Clinical Record Amendment and Correction Form.* CSP may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, CSP may deny your request if we are asked to amend information that: 1. CSP did not create, unless the person or entity that created the information is no longer available to make the amendment. 2. Is not part of the health information the CSP keeps. 3. You would not be permitted to inspect and copy. 4. Is accurate and complete.
- **Right to an accounting of disclosures:** You have the right to request and "accounting of disclosures." This is a list of the disclosures made of clinical information about you for purposes other than treatment, payment, health care operations and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures based on you written authorization. To obtain this list you must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before May 1, 2003. Your request should indicate in what form you wan the list (on paper, electronically, etc.)
- **Right to request restrictions:** You have the right to request a restriction or limitation on the health information used or disclosed about you for treatment, payment or health care operations. You also have the right to request a limit on the health information disclosed about you to someone (such as a family member or friend) who is involved in your care or the payment for it. CSP is not required to agree to your request. If CSP does agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the Request for Restrictions on Use/Disclosure of Clinical Information Form to CSP.
- **Right to request confidential communications:** You have the right to request that CSP communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that CSP only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Clinical Information and/or Confidential Communication Form to CSP. CSP will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes To This Notice CSP reserves the right to change this notice and to make the revised or changed notice effective for clinical information we already have about you – as well as any information we receive in the future. CSP will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

Complaints If you believe your privacy rights have been violated, you may file a complaint with CSP or with the Secretary of the Department of Health and Human Services. To file a complaint with CSP, call 503-945-5944 You will not be penalized for filing a complaint.

CONTACT OFFICER: Suzie Wolfer LCSW or Jonelle Richards LCSW, 7100 SW Hampton Street, Suite 128; Tigard, OR 97223 503-639-2390. This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510
10424 SE Cherry Blossom Dr. Portland OR 97216
www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I *(your name)* _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (please specify) _____