Professional Disclosure Statement & Informed Consent to Treatment

Michala Senarsky, LPC
Attentive Counseling, LLC

110 E. Historic Columbia River Hwy, Troutdale, OR 97060
(503) 888-0697
www.AttentiveCounseling.com

Philosophy and Approach:
I thrive on interacting with people of varied backgrounds. I see my relationship with you as an attempt to truly understand your emotional needs and life motivations.
My goal is to act as an avenue through which you may enable and empower yourself to uncover your individual needs and desires, and to help you to realize your own life answers and your potential for happiness.
I am a firm believer in 'Brief Solution Focused Therapy' — a way to assist you with your immediate needs, with a goal of 8-10 weeks to help bring about a resolution.
I focus on individual, child, family, and couple counseling. I have an extensive background in multicultural, domestic violence, and career/vocational counseling.

"Each person is an island unto himself, in a very real sense; and he can only build bridges to other islands if he is first of all willing to be himself and permitted to be himself."
Carl R. Rogers

About Psychotherapy:
Psychotherapy requires you to actively and fully engage with the process, including working on the things and/or issues we talk about; both, in our sessions and outside of our sessions. Like most health care treatments, psychotherapy may have benefits as well as risks. As our work together may likely involve discussing unpleasant aspects of your past and present life, you may experience unpleasant emotions, such as; loneliness, sadness, guilt, regret, anger, frustration, etc. However, research has demonstrated that engaging in therapy is usually more effective than doing nothing and that most people benefit from therapy. Please keep in mind that there are no guarantees as to what you will experience, because each person's therapy experience and outcome is unique.

Confidentiality:
By law I am required to honor the privacy of our conversations, and information that you share in our sessions, is held in the strictest confidence possible; however, according to the state of Oregon there are a few exceptions to this rule, as discussed in the following *Client Bill of Rights*.
Additionally, please be aware that if you choose to communicate with me via telephone and/or email, these means of communication are not entirely confidential.

Formal Education and Training:
Bachelor degree in Psychology – California State University, Los Angeles
Master degree in Counseling with emphasis on Marriage and Family Therapy – California State University, Fullerton
Nationally Certified Workforce Professional 1

Ethical Practice:
As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I will abide by its *Code of Ethics*. To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession. I may substitute professional supervision for part of this requirement.

Fees Schedule:
My fee schedule is as follows: Individual counseling -- $205.00 (45 min.) and $225 (60 min.); Employment counseling -- $115.00. Sessions are made by appointment only, and typically last 45-55 minutes.
For clients who are receiving services on a self-pay basis, we will discuss and agree to a fee prior to the start of services for you and/or your family. On a limited basis, we may agree on a reduced fee if your financial status warrants it. For counseling services, payment-in-full is due by the end of each session unless other arrangements have been made with me. For clients using insurance coverage to pay for a portion of the fee, it is your responsibility to learn about the nature and extent of your coverage. I will bill the insurance provider my standard and customary fee, but you are responsible for paying the difference between my standard or our negotiated fee and what the insurance company pays. If the insurance company does not pay for my services, you will be responsible for paying the full fee. A 24-hour notice must be given for cancellation of any appointments, otherwise the client will be responsible for payment of a full session.

Client Bill of Rights:
As a client of an Oregon licensee 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
- 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; and 5) Defending claims brought by client against licensee;
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

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

Emergencies:
If you believe that you may be a risk to the safety of yourself and/or others, please **call 911** or go to the nearest emergency room or hospital. If your call is of an urgent mental health nature and not an emergency, you may call the Multnomah County Crisis Line at (503) 988-4888, Clackamas County Crisis Line at (503) 655-8585, Washington County Crisis Line at (503) 291-9111

Consent to Treatment:
Your signature below indicates that you have read and understood this document, that you have received and reviewed a copy of the Notice of Privacy Practices (HIPAA), and that any questions you may have were answered to your satisfaction. Further, your signature indicates your agreement with the terms of this document and your desire to enter into counseling/psychotherapy with Michala Senarsky, LPC and/or Attentive Counseling, LLC. You authorize the release of your healthcare information and/or PHI (Protected Health Information) necessary to process any and all claims and for any purpose necessary to provide counseling/psychotherapy services to you. You hereby authorize payment directly to Attentive Counseling, LLC of any benefits due for counseling/psychotherapy services.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(required if client under 18)

Client Name (Please Print Legal Name): _____

Date of Birth: _____ DL# _____

Health Insurance Member ID#, Group#, Carrier Name _____

Address: _____ City: _____ State: ____ ZIP: _____

Telephone: (H) _____ (W) _____ (M) _____
May we leave a message? ☐ Yes ☐ No

Email address: _____
May we email you? ☐ Yes ☐ No (*Please note: Email correspondence is not considered to be a confidential medium of communication.)

Emergency Contact Name: _____ Relationship to client: _____

Address: _____ City: _____ State: ____ ZIP: _____

Telephone: (H) _____ (W) _____ (M) _____

Email address: _____

Telehealth Informed Consent

Michala Senarsky, LPC
Attentive Counseling

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I hereby consent to engage in Telehealth counseling/psychotherapy with Michala Senarsky, LPC (Therapist) of Attentive Counseling, LLC.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Professional Disclosure Statement & Informed Consent to Treatment form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Professional Disclosure Statement & Informed Consent to Treatment form.
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information regarding Telehealth as provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Client Signature: _____ Date: _____

Client Name (Please Print Full Legal Name): _____

Parent/Guardian Signature: _____ Date: _____
(required if client under 18)

Confidential Patient Information

DRIVER'S LICENSE # _____

HEALTH INSURANCE – POLICY #, GROUP #, ID #, CARRIER NAME

_____

(Important: Please list all Health Insurance companies you may have for coverage)

Name (Legal Name): _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Please list any children/age: _____

Address: _____/_____/_____/_____
(Street and Number) (City) (State) (Zip)

Home Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

Mobile/Other Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Name & Phone): _____

Referred by (if any): _____

Medicaid (OHP) only – Annual Household Income: $_____ Other Insurance: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No
☐ Yes If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
☐ No
☐ Yes If yes, please list: _____

Have you ever been prescribed psychiatric medication?
☐ No
☐ Yes If yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____

What types of exercise/activities do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating patterns _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
☐ No
☐ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ No
☐ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
☐ No
☐ Yes If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship?
☐ No
☐ Yes If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

☐ Alcohol/Substance Abuse		☐ Eating Disorders	
☐ Anxiety		☐ Obesity	
☐ Depression		☐ Obsessive Compulsive Behavior	
☐ Domestic Violence		☐ Suicide Attempts	
☐ Schizophrenia		☐ Other:	

ADDITIONAL INFORMATION:

1. Are you currently employed?
☐ No
☐ Yes If yes, what is your current employment situation: _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious?
☐ No
☐ Yes If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

4. What do you consider to be some of your weaknesses?
_____

_____

_____

5. What would you like to accomplish with your time in therapy? _____

_____

_____

I hereby authorize the use of my signature below on all insurance submissions, and also certify that all information given to this office and/or provider is correct and complete. I hereby authorize this office and/or provider to release all information and/or PHI (Protected Health Information) necessary to process any and all claims and for any purpose necessary to provide counseling/psychotherapy services to me. I hereby authorize payment directly to Attentive Counseling, LLC of any benefits due for counseling/psychotherapy services. I understand that services not covered by insurance are my financial responsibility to Attentive Counseling, LLC. Further, my signature indicates consent and my desire to enter into counseling/psychotherapy with Attentive Counseling, LLC.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Authorization for Use and/or Disclosure of Confidential and/or Protected Health Information

I, _____, (Name of client or legal guardian) hereby authorize Attentive Counseling, LLC and/or Michala Senarsky, LPC to release or exchange confidential information and/or PHI obtained prior to and during the course of my psychotherapy/counseling sessions to recipient(s) named below:

Client/Patient Information

Name: _____ DOB: ____/_____/_____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Recipient Information

Recipient/Company/Other Name: _____

Title: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

This Authorization permits the release or exchange of the following information:

☐ All health information pertaining to my medical history, mental or physical condition; OR only the following types of health information (limitations on use): _____

_____

☐ I specifically authorize the release of the following information: Behavioral Health Assessment including Mental Health (Diagnosis, Treatment Plan, Prognosis, Treatment Progress, Dates of Treatment, Client/Patient Records, Summary of Treatment, Clinical Test Results, Medication, Compliance, etc.)

I authorize the release/exchange of the information described above for the following purpose(s):

☐ Patient's request ☐ Coordination of Care ☐ Other: _____

_____

I understand that I have a right to receive a copy of this Authorization. I also understand that any cancellation or modification of this Authorization must be in writing. This Authorization shall remain valid for one year from the date of signature or until: _____/_____/_____ (date).

Signature: _____ Date: ___/____/_____

If signed by other than Patient, please indicate your relationship to patient: _____