

Guy D. Burstein, LCSW

COUNSELING AND PSYCHOTHERAPY for INDIVIDUALS AND COUPLES

833 SW 11th Avenue, Suite 214

Portland, OR 97205

Telephone: 503-701-1050

Email: guyburstein@msn.com

CONTACT INFORMATION

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____ Okay to leave message? (circle) **Yes** **No**

Mobile Phone: _____ Okay to leave message? (circle) **Yes** **No**

Work Phone: _____ Okay to leave message? (circle) **Yes** **No**

Home Phone: _____ Okay to leave message? (circle) **Yes** **No**

Preferred Method of Contact: _____

Date of birth: _____

Occupation: _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Telephone: _____

How did you hear about me:

Friend/Co-worker: _____

Internet Website Name: _____

Family Member: _____

Health Care Provider: _____

Insurance Company: _____ **Identification Number:** _____

Guy D. Burstein, LCSW

COUNSELING AND PSYCHOTHERAPY
INDIVIDUALS AND COUPLES
833 SW 11th Avenue, Suite 214
Portland, OR 97205

OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome and thank you for choosing me for your psychological care. I assure you that I will work with you in a caring and professional manner. Please take a few minutes to read my policies, and do not hesitate to ask any questions you may have.

OFFICE HOURS: My office hours fluctuate with my appointments but I generally work from 10 am to 6 pm Monday through Friday.

SESSIONS: A standard session is 50-55 minutes.

FEE SCHEDULE:

- **Psychotherapy Session for Individual:** 50-55 minutes -- \$140 (standard session)
- **Psychotherapy Session for Couples:** 50-55 minutes -- \$150
- **Group Psychotherapy Session:** \$50 (90 minutes)
- **I accept checks, credit cards (Visa and MasterCard) and cash.** A fee of \$25 will be charged for all returned checks.
- **Payment is due at each session** unless other arrangements have been made, although with longer term clients I typically collect co-pays and/or fees once a month on the last session of the month. Telephone conversation or emails lasting more than ten minutes, consultation with other professionals, longer sessions, and so forth, will be prorated at the standard session rate.

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law.

Disclosure required by law: Some circumstances requiring disclosure exist when there is reasonable suspicion of child, dependent, or elder abuse or neglect; when a client presents a danger to self, others, property, or is gravely disabled or suffering a mental health crisis.

Please feel free to ask me about any privacy or confidentiality concerns.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. I have no control or knowledge over what insurance companies do with the information or who has access to it. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact accessibility to computers or databases is always in question, as computers are inherently vulnerable to break-ins and unauthorized access.

Telephone and Emergency Procedures

If you need to contact me between sessions, leave a message on my voicemail at (503) 701-1050 and your call will be returned as soon as possible. I check my messages a few times a day, but less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away and I'm not available, you can call the 24-hour *Multnomah County Crisis Line* at (503) 988-4888, the Police (911), or go in person to the mental health emergency walk-in clinic at 2415 SE 43rd Avenue (SE 43rd and Division Streets) in Portland.

Insured Clients

You are responsible for obtaining prior authorization from your insurance company. With your agreement, I will bill your insurance company directly, however you are responsible for your deductible, co-payment and/or co-insurance. You should remember that ultimately, my professional services are rendered and charged to you and not to your insurance company. Co-payment amounts are set by your benefit plan, and are due and payable at each appointment.

Cancellations and Missed Appointments

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24-hours (one full working day's) notice, you are responsible for the full fee of the missed or cancelled appointment. Insured clients should know that your insurance company cannot be billed for fees associated with missed or cancelled appointments. Unless other arrangements have been made, the only exception to this policy is if you or a dependent are medically ill.

Diagnosis and Treatment Plan

If an insurance company is paying for all or part of your bill, I am normally required to provide them with a diagnosis and/or a treatment plan in order to be paid. Diagnoses are technical terms that describe the nature of your issues and whether they are short or long-term problems. All diagnoses come from a book titled the DSM-IV, a copy which is in my office and which is available for us to review and discuss. Developing a treatment plan is a collaborative effort that requires that you and I identify the issue and/or problem you have and anticipate the therapeutic steps and techniques we'll use to resolve the issue.

My Approach to Therapy.

Most people with whom I've worked find that therapy is helpful and produces significant growth. However, therapy also has potential emotional risks: remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing discomfort or feelings of anger, sadness, worry, fear and other strong emotions. Making changes in your beliefs or behaviors can be disruptive to existing relationships, employment, schooling, housing, and other life circumstances. In addition, our conversations may challenge some of your assumptions or perceptions, or cause different ways of looking at, thinking about, or handling situations that can create unanticipated changes. There is no guarantee that therapy will yield positive or intended results.

My approach to therapy is broad-based. I draw upon theories and techniques from many well-researched traditions and psychological approaches according to the problem we're addressing and what we determine will best benefit you. These approaches include psychodynamic/psychoanalytic, cognitive-behavioral, family systems, developmental/attachment, and existential. If another health care provider is working with you, I will request that you sign a release of information so that I can communicate freely with that person about your care. You have the right to refuse anything I suggest.

Termination

After the first couple of meetings, we'll assess if I can be of benefit to you. I don't accept clients who, in my opinion, I can't help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, it's determined by either of us that I'm not effective in helping you reach your therapeutic goals, we'll discuss it and, if appropriate and with your agreement, we'll terminate treatment. In such a case, I'll provide you with a number of referrals and, if I have your written consent, I'll provide her or him with the essential information needed to help with the transition. You have the right at any time to seek another professional's opinion, consult with another therapist, or terminate therapy.

Complaints

If you're unhappy with what's happening in therapy, I hope you'll talk with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to: **State Board of Clinical Social Workers**, 3218 Pringle Road SE, Suite 240, Salem, OR 97302-6310, or call (866)-355-7050. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want to keep confidential.

Client Consent to Psychotherapy

I have read this policy and information agreement, and have had sufficient time to be sure that I understand both my rights and responsibilities as a client, and Mr. Burstein’s responsibilities to me. I agree to undertake therapy with Guy Burstein, LCSW, and know that I can end therapy at any time I wish.

Couples Therapy

- For couples/conjoint therapy, I will meet with one partner if an individual session is planned in advance. If both partners are not present for a conjoint session, the session will be cancelled and you will be charged for the appointment.
- Both parties involved in couples/conjoint psychotherapy understand that I will not agree to keep any secrets from his or her partner. Any information provided to me when the partner is not present may be either withheld or disclosed to the other party at my discretion.
- You always retain the right to request changes in treatment or to end treatment. I reserve the right to end treatment if I determine that treatment is no longer effective, for irregular attendance, or if payment on your account is past due.
- If you use insurance for couples/conjoint, your partner understands that he or she is not the patient, is not receiving treatment and may not be protected under confidentiality laws.
- Any release of information when both participants are patients in couples therapy requires the signature of both clients.
- Psychotherapy is for the improvement of your emotional functioning and is different from evaluation for legal issues. I do not do evaluations or provide any evaluative statements for psychotherapy clients because the role of an evaluator would be a dual relationship which is not ethically compatible with the role of a psychotherapist.

Client:

(Print Name)

Signature

Date Signed

Spouse, Partner, or Family Member (if applicable):

(Print Name)

Signature

Date Signed

Client History Questionnaire

STRESSORS OR SIGNIFICANT CHANGES IN THE PAST YEAR

- | | | |
|--|---|---|
| <input type="checkbox"/> Separation | <input type="checkbox"/> problems with children | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> divorce | <input type="checkbox"/> loss of close friend | <input type="checkbox"/> assaulted |
| <input type="checkbox"/> ending of close relationship | <input type="checkbox"/> friend died | <input type="checkbox"/> working too much |
| <input type="checkbox"/> marriage | <input type="checkbox"/> no friends | <input type="checkbox"/> little time for relationship |
| <input type="checkbox"/> birth of a child | <input type="checkbox"/> lost/changed job | <input type="checkbox"/> little time for self |
| <input type="checkbox"/> serious illness or injury | <input type="checkbox"/> partner lost/changed job | <input type="checkbox"/> few leisure/hobby activities |
| <input type="checkbox"/> medical problems | <input type="checkbox"/> unemployed | <input type="checkbox"/> none |
| <input type="checkbox"/> partner, child, parent or pet seriously ill | <input type="checkbox"/> career/work problems | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> partner, child parent or pet died | <input type="checkbox"/> started school | |
| | <input type="checkbox"/> moved | |
| | <input type="checkbox"/> financial problems | |

CURRENT PROBLEMS

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> anger | <input type="checkbox"/> painful memories/PTSD |
| <input type="checkbox"/> low energy | <input type="checkbox"/> crying spells | <input type="checkbox"/> dissociation |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> withdrawal | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> loss of pleasure in activities | <input type="checkbox"/> elevated mood | <input type="checkbox"/> no close friends |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> racing thoughts | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> restlessness/agitation | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> shy/social anxiety |
| <input type="checkbox"/> significant weight change | <input type="checkbox"/> anxiety/worrying | <input type="checkbox"/> little support from friends/relatives |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> self-criticism | <input type="checkbox"/> distrust |
| <input type="checkbox"/> memory | <input type="checkbox"/> compulsive behaviors | <input type="checkbox"/> none |
| <input type="checkbox"/> obsessive thoughts | <input type="checkbox"/> addictions | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> suicidal thoughts/plans | <input type="checkbox"/> avoidance/procrastination | |
| <input type="checkbox"/> irritable mood | <input type="checkbox"/> avoidance of social situations | |

CURRENT RELATIONSHIP PROBLEMS

- | | | |
|--|--|---|
| <input type="checkbox"/> Does not apply | <input type="checkbox"/> Financial issues | <input type="checkbox"/> Partner's anxiety/worrying |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Work issues | <input type="checkbox"/> My emotional withdrawal |
| <input type="checkbox"/> Emotional intimacy | <input type="checkbox"/> Chores | <input type="checkbox"/> Partner's emotional withdrawal |
| <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Time for myself | <input type="checkbox"/> My affair |
| <input type="checkbox"/> Lack of affection | <input type="checkbox"/> Leisure time together | <input type="checkbox"/> Partner's affair |
| <input type="checkbox"/> Separations | <input type="checkbox"/> Parenting | <input type="checkbox"/> My alcohol/drug use |
| <input type="checkbox"/> Anger/temper | <input type="checkbox"/> Stepchildren | <input type="checkbox"/> Partner's alcohol/drug use |
| <input type="checkbox"/> Commitment | <input type="checkbox"/> Adult children | <input type="checkbox"/> My blaming or criticism |
| <input type="checkbox"/> Handling differences | <input type="checkbox"/> Relatives | <input type="checkbox"/> Partner's blaming or criticism |
| <input type="checkbox"/> Resolving major decisions | <input type="checkbox"/> Friends | <input type="checkbox"/> My anger/temper |
| <input type="checkbox"/> Different interests | <input type="checkbox"/> Ex-partner | <input type="checkbox"/> Partner's anger/temper |
| <input type="checkbox"/> Different backgrounds | <input type="checkbox"/> My depression | <input type="checkbox"/> None |
| <input type="checkbox"/> Religious values | <input type="checkbox"/> Partner's depression | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> Sexual issues | <input type="checkbox"/> My anxiety/worrying | |

CHILDHOOD

- Parents divorced
- Parent died
- Separations from parents
- Parents argued
- Moved frequently
- Financial stress
- Conflicts with mother
- Conflicts with father
- Conflicts with stepparent(s)
- Conflicts with sibling(s)
- Emotionally abused
- Emotional neglect
- Physically abused
- Sexually abused
- Few friends
- Conflicts with peers
- Loneliness
- Social anxieties
- Weight
- Excessive fears or anxiety
- Fear of failure
- Fear of abandonment
- Obsessive thoughts
- Compulsive behaviors
- Depression eating disorder
- Parents' alcohol/drug abuse
- Your alcohol/drug use
- Academic
- Hyperactive
- Attention/concentration
- Anger/temper
- Discipline
- Legal
- Medical
- Head injury
- None
- Other

MEDICAL

Current medical problems: _____

 Current medications: _____
 Current physician: _____

MENTAL HEALTH CURRENT AND PAST

Are you (and/or your partner) currently in psychotherapy, and if so, with whom: _____
 Are you taking psychiatric medications and if so, please provide names and amount:

Who is your current medication prescriber: _____

Have you ever been hospitalized for a psychiatric reason, and if so, when and where:

Have you taken psychiatric medications in the past, and if so please list:

CURRENT ALCOHOL AND SUBSTANCE USE

- Caffeine amount/daily or weekly/type: _____
- Tobacco amount/daily or weekly/type: _____
- Alcohol amount/daily or weekly/type: _____
- Marijuana amount/daily or weekly/type: _____
- Cocaine amount/daily or weekly/type: _____
- Narcotics amount/daily or weekly/type: _____
- Amphetamines amount/daily or weekly/type: _____
- None
- Other _____

PROBLEMS WITH COMPULSIVITY OR ADDICTIVE BEHAVIOR PATTERNS

- Gambling
- Sexual
- Pornography
- Shopping
- Eating
- Exercising
- Sports
- Working
- Internet
- Computer games
- Smart-phone/tablet
- Social media
- Television/movies
- None
- other _____

PROBLEMS ASSOCIATED WITH ALCOHOL/SUBSTANCE USE

- Conflicts with partner, friends, relatives
- Work issues
- Legal issues
- Treatment programs

WHAT BRINGS YOU TO THERAPY

Guy Burstein, LCSW
Psychotherapy for Individuals, Couples and Families
833 SW 11th Ave Suite 214
Portland, OR 97205

HIPAA NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of

the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
- **Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process or with your authorization.
- **Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
- **Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
- **With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The

following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to me at my business address listed above.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on November 1, 2016

Client: _____

Date: _____