COUNSELING INTAKE

Are you here on a ☐ voluntary basis or by ☐ court order? **Pronouns:** ____________________

Date:__________________ **Case #:**______________________

Your Name: ____ **Age:** ________

Address: ______________________________ **City:** ____________ **State:** ______ **Zip Code:** _________

County: ________________ **Cell #:** ______________________ **☐Home/ ☐ Other #:** __________________

Email: ______________________________________ **Is it ok to leave a message?** ☐ Yes ☐ No

Occupation: __________________________________ **Years of education completed:** ___________

Name of the other parent: ____________________________________

Children:

Name	Age	Name	Age	Name	Age

Length of time the other parent and I have been living separately: ______________________________

How long married/living together? ____________________ Number of prior marriages: _________

Legal Custody and Parenting Time:

Do you have ☐ joint or ☐ sole legal custody of the children?

If sole custody, which parent is designated? ☐ Dad ☐ Mom ☐ Other:_______________

What is your parenting time schedule? ____

____

Name of your current spouse/significant other: ____

Do you have other children? ☐ Yes ☐ No

Name	Age	Name	Age	Name	Age

Please list all others living in your home:

Name	Name	Name

Emergency Contact(s): Name: ____________________________ Telephone: ____________________

Name: ____________________________ Telephone: ____________________

Health Information:

Do you or the children have any health problems? ☐Yes ☐ No *(If yes, please describe)* ____________________

____

____

Your primary physician/health provider: ____

Are you on prescribed psychiatric medication? ☐Yes ☐No *(If yes, please provide names of prescriber & medication and for what purpose)* ____

____

Mental Health Counseling (Past/Present):

Are you currently in mental health counseling? ☐Yes ☐No *(If yes, please give name and telephone number of counselor/organization)*____

Have you been in mental health counseling in the past ☐Yes ☐No *(If yes, please give name and telephone number of counselor/organization)*____

What are your present concern(s) or problem(s) that brings you here today?

Abuse and Domestic Violence:

The other parent has caused me or threatened to cause me, physical harm: ☐ Yes ☐ No

- ☐ Domestic Violence - If you check this box, please check below:
  - ☐ Emotional and verbal: includes a range from put-downs and insults, to threats of life or property
  - ☐ Physical: includes a range from pushing or shoving, to attacking, hitting or choking
  - ☐ Sexual: includes unwanted touch, treated like a sexual object, rape, violence before or after sex

Please describe any concerns with Alcohol and/or other drugs: ________________________

CIRCLE the number that best describes the following:

1. What is the level of conflict between you and the other parent?
   (Low) 1 2 3 4 5 6 *(High)*
2. How much are you in agreement about rules and expectations for the children?
   (Low) 1 2 3 4 5 6 *(High)*
3. How hopeful are you of successfully resolving your differences?
   (Low) 1 2 3 4 5 6 *(High)*

What are your goals for counseling?

Who referred you to our program? ________________________________

CONCILIATION SERVICES CONSENT FOR COUNSELING

Washington County Conciliation Services asks that clients provide their informed consent prior to receiving counseling services with us. Please read the following information carefully, review it with your conciliation counselor if necessary, and provide your signature below to indicate your wish to begin conciliation counseling services with our agency.

Washington County residents with children who are seeking to resolve issues about their relationship, to discuss issues of separation or divorce adjustment, or to discuss co-parenting concerns can access counseling through Conciliation Services. There is no fee for your first four counseling sessions. This service is offered to the couples, is intended to be short term in nature, and is *not* intended to provide mental health treatment for concerns beyond the scope of the separation or conciliation matter. In the event that you or your counselor identifies additional mental health issues that need to be addressed, your counselor will make appropriate referrals to available services within the Washington County area to address your concern. All eligible clients will be served without regard to race, color, national origin, religion, age, sex, sexual orientation or disability.

The counseling services we offer are designed to help you solve problems and cope more effectively with difficult decisions and/or transitions in your relationship with your co parent. To help make counseling work you will be expected to take part in activities that support positive change during sessions and between sessions, and you'll be expected to attend all scheduled meetings, letting your counselor know ahead of time if you cannot come. If you need to cancel or reschedule a mediation appointment**, it is your responsibility to notify the other participant(s) and contact Conciliation Services; *failure to contact Conciliation Services at least 24 hours prior to your scheduled appointment may result in the loss of one of your no fee sessions.***

You have the right to stop counseling at any time. If counseling has been court-ordered, your counselor will inform the Court that you are no longer attending counseling. However, it will be your responsibility to arrange for alternative services to comply with the court order.

Your counselor works collaboratively with a team of qualified professionals, and may consult with other team members about your case in order to make sure that you and your counseling partner get the best possible service. All information about you and your family will be treated as strictly confidential in keeping with the laws of the State of Oregon, and HIPAA Privacy Practices. *However, there are specific exceptions to confidentiality which include:*

- Child or Elder Abuse
- Harm to Self or Others
- Subpoena or Court Order

Your Counselor will further explain these exceptions to confidentiality during your first session. **By signing this form, you are saying that you have been informed of these confidentiality policies and exceptions to confidentiality.**

I have read this consent form and have been able to ask questions. I fully understand its contents and agree to its terms. I give my permission for conciliation counseling to commence.

Printed Name: ______________________________________

Signature:____ Date:_____________________

FEE POLICY

Court Connected Mediation Package- $200 per person

- Includes: Mediation Orientation and Parent Education* in one group session, plus 1 mediation session (available until the final court judgement).
- Each Additional Mediation session $125 per person.
- Fee waived if court fees are waived, must submit proof of court approval.

* Parent Education *is replacing the Kids' Turn Program offered through Youth Contact.*

Voluntary Mediation- $125 per person per session

- Session scheduled for 2 hours.

New Ways for Families- $250 per person

- Includes: 4 group skill building sessions plus 4 co-parent counseling sessions.
- Fee reduced to $150 if court fees are waived, must submit proof of court approval.

Co-Parent Counseling- $93.75 per person per session

- Session scheduled for 90 minutes.
- Fee does not apply to the 4 sessions included with New Ways for Families

Expert Witness Testimony- $100 nonrefundable fee

- Must accompany a properly served subpoena.
- $25 per 15-minute segments testifying or waiting to testify.
- Does not apply to mediations, as mediators are not available to testify.

No Shows

- Missed appointments with less than 24-hour notice may be counted as a session.

My signature below indicates that I have been given an opportunity to ask questions regarding Conciliation fees and understand how they relate to service delivery and court testimony.

Printed Name: ____

Signature: _____________________________________ Date: _______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Read Carefully Before Signing

The County's Notice of Privacy Practices outlines how the County may receive, use or share health information about you.

I have been given a copy of the Notice of Privacy Practices and had a chance to ask questions about how my health information will be handled.

____

Client or Legal Representative Signature   Date

____

Relationship of Legal Representative (if applicable)

Staff Only

If the person has been provided the NPP, but refuses to sign, mark here, date and initial: _____________.

Additional staff comments (if any): ____

____

____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (SHARED) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The law requires Washington County to protect the privacy of your health information. This Notice informs you of the way we may use and share health information about you with others. It describes your right regarding the use and share of your health information. The law requires us to give you the Notice effective April 14, 2003.

This Notice is printed in other languages. It is available in other formats for persons with disabilities.

THE JUVENILE DEPARTMENT MAY USE OR SHARE "PROTECTED HEALTH INFORMATION" (PHI) ABOUT YOU IN THE FOLLOWING WAYS WITHOUT YOUR AUTHORIZATION.

(In all other situations, the Juvenile Department will ask you for written authorization before disclosing information.)

For Treatment. For example, we may share your health information with doctors, dentists, mental health care providers, nurse, office staff or other persons who are involved in your care or treatment.

For Payment. For example, we may use and share health information about you to collect payment for your health plan.

For Health Care Operations. We may use and share health information with other government offices such as the Oregon Youth Authority.

Appointments. The Juvenile Department may contact you by telephone or mail to remind you of an upcoming appointment for services. For example, we may call you at home to remind you of an appointment.

Treatment Choices/Health-Related Benefits and Services. The Juvenile Department may tell you about or recommend possible treatment choices or health-related services. For example, we might send your information on low cost services in the community.

As You Permit. We may use and share health information about you if you sign a form giving us permission.

To You or Your Personal Representative, Family and Friends. Unless you object, we may release health information about you to your personal representative, a family member or friend who assists with your medical care.

To Business Associates. These are contractors that help us provide services or perform our business activities.

Public Health. We may use or share health information with public health agencies to help prevent a threat to the health or safety of you or the public. This includes reporting certain diseases. We will use and report vital statistics such as births and deaths.

Organ/Tissue Donation Groups that obtain organ, eye, or tissue for transplants.

Coroners, Medical Examiners, and Funeral Directors so we may identify you when you die, find the cause of death or provide other services.

To report abuse, neglect, or domestic violence as required by law.

Legal Proceedings. We will use and share health information if we are ordered by a court or an administrative agency or required by law to do so. This may include a subpoena or other discovery process.

Law Enforcement as required by law or if we suspect or missing person or provide information about a crime victim.

Workers' Compensation. The Juvenile Department may use and share PHI about you to perform studies and develop reports. These reports do not identify you by name.

Research. The Juvenile Department may use and share PHI about you to perform studies and develop reports. These reports do not identify you by name.

For Public Benefits. We may share health information with other government agencies, such as the State, that also provide public benefits so that we may coordinate and improve services. State law (ORS 179.505) in some cases may limit this sharing to obtaining payment or to only certain cooperating health care providers.

Incidental Disclosures such as to our attorneys, computer staff and others who help us do our work.

Right to Cancel Your Authorization. If you have given us the right to use your health information in some way, you may order us to stop by asking us in writing. You may ask us to stop at any time. This will only stop future uses and sharing with others. We cannot take back information that has already been used or shared.

Right to Inspect and Copy. You have the right to see and get a copy of your health information. You must ask in writing. You have to pay a copy and mailing fee unless you cannot afford it. We have 5 days to respond regarding treatment records and up to 30 days for other health records. If we deny you access, you may challenge our decision by filing a challenge in writing. Our decision will be reviewed by an independent health care professional.

Right to Change or Add Information. If you think that health information about you is not correct or is not complete, you may ask that we change it or add it our file. This must be in writing and you must tell us why you want to make the change. We will try to respond in 30 days. If we say no, and your response to our denial in your medical file.

Right to Request Restrictions. You may ask that we not use or share health information in a certain way. For example, you may ask us not to share some information with a family member. You must ask in writing. *We are not required to grant your request.* Even if we agree, we may decide not to follow your request in certain cases, such as an emergency.

Right to Request Restrictions. You may ask that we not use or share health information in a certain way. For example, you may ask us not to share some information with a family member. You must ask in writing. *We are not required to grant your request.* Even if we agree, we may decide not to follow your request in certain cases, such as an emergency.

Right to Request Private Communication. You have the right to tell us how we may or may not contact you. For example, you may tell us to contact you only at home and only by telephone. You must ask in writing. WE will honor reasonable requests.

Right to Record of Disclosures. We must keep a record of some of the times we use or share your health information after April 14, 2003. You may get one copy of this list for free every 12 months. We may charge you a fee if you ask for more than one copy every 12 months.

Right to a Paper Copy of this Notice. You have the right to get a free copy of this Notice at any time. A copy of the current Notice will also be posted.

Right to File a Complaint. If you think your privacy rights have been violated, you may file a complaint. *You will not be retaliated against for filing a complaint.*

CHANGES TO THIS NOTIICE

By law we must comply with this Notice. But, we may change it and make the changes apply to health information that we already have about you. You have the right to get a free copy of the changed Notice.

COMPLAINTS

1. To file a complaint with us or get any additional information, contact the Washington County Privacy Manager at:

   Washington County
   Juvenile Department Privacy Mana
   222 N. First Avenue MS 47
   Hillsboro, OR 971234
   Phone: (503) 846-3485

2. If you are not satisfied with the response from the Privacy Manage, you may contact County Privacy Officer at:

   Don Bohn
   115 N. First Ave MS 21
   Hillsboro, OR 97124
   Phone: (503) 846-8685

3. Instead of filing a complaint with use, you have the right to file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services at:
   Office of Civil Rights

   Medical Privacy, Complaints Division
   US Department of Health & Human Services
   200 Independence Avenue SW HHH Building Room 509H
   Washington, DC 20201

   Phone: (866) 627-7748
   TTY: (866) 788-4989
   Email: www.hhs.gov/ocr