



2325 E. Burnside Portland, OR 97214

971.235.5939 fax 971.275.1439

JILL HAUBEN LCSW

jillhauben@gmail.com

Individual Psychotherapy Client Intake Form for Couple Therapy

(Please fill out using Adobe Acrobat or print and write clearly. *Do not send this form by email. It is not secure.*)

Name: _____

Date: _____

Address: _____

Date of Birth: _____

City: _____

Social Security #: _____

State: _____

Zip: _____

Client Authorized Confidential Communications

(Please tell us which means of communication you authorize:)

Phone calls with voice mail if needed to the following number: _____

Is there an alternate phone number or email to use if there are questions regarding this request?

E-mail to the following address: _____

Text messaging to the following phone: _____

I authorize the office and staff of Jill Hauben, LCSW, LLC to place phone calls, leave voice mail and text message, send emails, and postal mail to the numbers and addresses defined within this section of the intake form. This authorization will remain in place until a written notice is provided.

If we aren't able to reach you through any of the above routes of communication, or if you only want information delivered by U.S. Mail, provide the address here: _____

X Communications authorized by my signature here

Emergency Contact

Name: _____

Authorized Phone #'s:

Relationship: _____

Home: _____

Work: _____

Cell: _____

Your Employer: _____

Your Occupation: _____



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PRIVACY POLICY AND CLIENT CONSENT

IMPORTANT INFORMATION: Please print, read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

AVAILABLE SERVICES: Jill Hauben, LCSW, LLC, offers a wide array of counseling services, including individual, family and couples.

Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. The intent is to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues that may bring to the surface uncomfortable emotions such as anger, shame, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process.

However, some of the possible benefits of counseling are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals, for counseling and/or psychotherapy.

COUNSELING: I provide counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session; in which we will determine your concerns. If we both agree that I can meet your therapeutic needs, then we will develop a plan of treatment together. Should you choose not to follow the plan of treatment, services to you may be terminated.

The goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss the matter with me to determine if transferring to a more suitable Therapist is right for you. If we decide that other services would be more appropriate, then I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optional well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. The services are designed to provide my clients an integrated solution for their mind; body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on an as-needed basis and are approximately 120 minutes long. If you must cancel or rescheduled your appointment, we ask that you call the office at 971.235.5939 at least 24 hours in advance.

The time we have negotiated for an appointment is reserved for you only; unless we make arrangements otherwise. You will be expected to pay in full for any missed appointments or cancellations without 24 hour notice. Most insurance companies will not pay for missed appointments.

PAYMENT/INSURANCE FILING: Payment of fees, including any required deductibles and/or co-pays, are expected at the time of each appointment. If you are using insurance benefits, Jill Hauben, LCSW, LLC, employs a business associate to file claims for you, and will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, Jill Hauben, LCSW, LLC, expects full payment at the time of service, and she will provide you with a statement for services rendered and payments collected.

EMERGENCIES: You may encounter a personal emergency that will require prompt attention. In this event, please contact Jill Hauben LCSW, LLC, regarding the nature and urgency of the circumstances. She will make every attempt to schedule you as soon as possible, or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately.

Insurance

Insurance Company: _____

Member #: _____

Group #: _____

Primary Insurance Member Employer: _____

Primary Insurance Member: _____

Primary Insurance Member Occupation: _____

Primary Insurance Member's Date of Birth: _____

Primary Provider/Specialist: _____

Missed Appointment and Financial Agreement

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Jill Hauben, LCSW, Llc., will honor contractual agreements made with those managed health care companies; which stipulate specific reimbursement restrictions. Missed Appointment Fee: I agree to provide a 24 hour notification to reschedule or cancel my appointments. If notification is not provided by me a fee of \$125.00 will be applied to full patient responsibility.

X Client Signature

Date

I hereby consent to treatment by Jill Hauben, LCSW, Llc. Although the chances for obtaining my goals with therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X Client Signature

Date

Release of Medical Records for Normal Course of Business

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X Client Signature

Date

Assignment of Benefits

I authorize the payment of medical benefits to the provider of services.

X Client Signature

Date



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Notice of Privacy Practices

Patient Name: _____

Date Of Birth: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPAA (Health Information Protection Portability Act), Privacy Practices for the office of Jill Hauben, LCSW, LLC.

Signature

Date

Patient Refusal to Acknowledge Receipt:

Descriptive for refusal: _____

Signature of Staff Member

Date

Insurance

Insurance Company: _____

Member #: _____

Group #: _____

Primary Insurance Member Employer: _____

Primary Insurance Member: _____

Primary Insurance Member Occupation: _____

Primary Insurance Member's Date of Birth: _____

Primary Provider/Specialist: _____

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