Client Intake Form

Guy Burstein, LCSW
833 SW 11th Ave Suite 710, Portland, OR 97205

Name:_____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____
(city) (state) (zip)

Cell/other: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email:_____ May we email you?* Yes No

*NOTE: Emails may not be confidential
Who may we contact in case of an emergency: _____

Phone: _____

Who were you referred to me by:_____

Primary insurance co & identification number: _____

Insurance subscriber name and date of birth: _____

Secondary insurance identification number: _____

Insurance subscriber name and date of birth:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Clinician:_____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

_____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:_____

Have you been psychiatrically hospitalized in the past? Yes No

If yes, please list dates and locations:_____

General Health Information

Please provide the name and telephone number for your primary care physician: _____

_____

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): _____

_____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:_____

_____

Do you consume alcohol regularly? Yes No
In one week, how many drinks in a week do you consume

_____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

What kinds of recreational drugs do you use: _____

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship?_____

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

Check the issues below that apply to you.

Depressed mood	Panic Attacks	Memory Lapse	Relationship Problems
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating difficulties
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No

If yes, for how long?_____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago?_____

How often did you have these thoughts? Frequently Sometimes Rarely

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? _____

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer?_____

What is your position? _____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors? _____

Other Information

List your strengths and what you like most about yourself: _____

_____

_____

List areas you feel you need to develop _____

_____

_____

What are some ways you cope with life obstacles and stress?_____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from Guy Burstein. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Signature Date

Guy D. Burstein, LCSW
833 SW 11th Avenue, Suite 710
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'll work with you in a caring and professional manner. Please take a few minutes to read my policies, and don't hesitate to ask any questions you may have.

OFFICE HOURS: I generally work from 9 am to 6 pm Monday through Thursday.

FEE SCHEDULE:

- **Psychotherapy Session for Individuals** 50-55 minutes -- $175 (standard session)
- **Psychotherapy Session for Couples and/or family** 50-55 minutes -- $175
- **Group Psychotherapy Session:** 90 minutes -- $75
- **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.

HEALTH INSURANCE:

- **If you are using health insurance**, 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.
- **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 that nature of your issues and whether they are short or long-term problems. All diagnoses come from a book titled the DSM-5, 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.

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. Exceptions to Confidentiality Include:

- **Signed Consent**: If a client signs a consent to release information;
- **Medical or Mental Health Emergencies**: To avoid harm to a client or if a client is a danger to him or herself;
- **Duty to Warn**: If a client discloses intentions or a plan to harm another person or persons;
- **Abuse**: If a client or third party states or suggests that client is abusing a child or vulnerable adult (such as an elder) or has recently abused a child or vulnerable adult. Abuse includes physical and/or sexual abuse, domestic violence, neglect and exploitation.
- **Judicial or Administrative Proceedings**: If a court order or subpoena has been placed;
- **Defending Claims**: If a client makes a claim against a mental health practitioner;

- **Other Cases**: as required by public health and/or government health oversight activities, law enforcement, and other legal proceedings.
- **Health Insurance and Confidentiality of Records**
  Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Although only the minimum necessary information will be communicated to the carrier, 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 and privacy due to the fact that:
    - accessibility to computers or databases is always in question;
    - computers are inherently vulnerable to break-ins and unauthorized access;
    - information may be used to determine future eligibility and/or deny health or life insurance.

AVAILABILITY/EMERGENCIES: If you need to contact me between sessions, electronic communications can be received at any time via telephone, telephone voice mail, and/or email at (503) 701-1050. It is important to note that when electronic communications are received, they are picked up regularly and will be returned as soon as possible (generally no later than 24 hours or the next business day) but less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. However, if you are experiencing a life-threatening emergency or if you need to talk to someone right away and I'm not available, you can:

- call the 24-hour *Multnomah Country Crisis Line* at (503) 988-4888
- the Police (911)
- go in person to the urgent mental health emergency walk-in clinic at 4212 SE Division St in Portland
- go in person to your nearest hospital emergency department.

CANCELLATIONS AND MISSED APPOINTMENTS: Attending scheduled appointments is critical to the success of psychotherapy. It is understood that you will occasionally need to cancel or reschedule your appointment time because of an emergency or other obligation (i.e., illness, car accident/trouble, family emergency, etc). However, please understand that by scheduling an appointment you have reserved an hour of my clinical time. If you do not show up for your appointment, and you have not notified me at least 48 hours in advance that you cancelling it, you – not your insurance company – will be required to pay the full cost of the session. Emergency cancellations will be discussed on a case-by-case basis.

LATE ARRIVAL POLICY: In order to ensure that your time is respected and waiting time does not interrupt your schedule or mine, I make every effort to start and stop on time. Please understand that if you're using insurance and you arrive more than 15 minutes late after your scheduled time, insurance carriers will not cover that expense, and you will be responsible for the full cost of the session. I will assume that you do not plan to keep your appointment if you have not arrived by 15 minutes after your scheduled time unless I hear from you otherwise.

TEXT MESSAGING AND EMAIL COMMUNICATION POLICY: Because I can't ensure your confidentiality via cellular service, as well as to remain HIPPA compliant, I require that the use of text messaging be reserved for the sole purpose of communicating logistical information (i.e., scheduling/rescheduling and/or running late for your appointment, etc). If you wish to send me an e-mail message between appointments about issues related to your therapy, please feel free to do so with the understanding that I will use your session time to address them and will not respond to them via e-mail, with the exception being to address logistical information solely related to appointment scheduling.

It is very important to be aware that e-mail and cell phone/text communication can be relatively easily accessed by unauthorized parties and therefore the privacy and confidentiality of such communication can be easily compromised. E-mails in particular are vulnerable to unauthorized access to non-secure electronic servers.

Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mention electronic communications.

NOTICE OF PRIVACY PROCEDURES: I am required to: (i) maintain the privacy of your health information, (ii) provide you with a notice as to my legal duties and privacy practices with respect to information I collect and maintain about you, (iii) abide by the terms of this notice, (iv) notify you if I am unable to agree to a requested restriction, and (v) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

YOUR RIGHT TO REVIEW RECORDS: You have the right to review or receive a summary of your records, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful to you in any way. In such case, I will provide the records to an appropriate mental health professional of your choice.

THE PROCESS OF 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. With couples and families, the changes that occur in one client may result in discomfort for another, and generally couples and families do better if all are involved in psychotherapy. There is no guarantee that therapy will yield positive or intended results.

MY APPROACH TO THERAPY: My approach to therapy is broad-based. I draw upon theories and evidence-based 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.

COUPLES THERAPY POLICIES:

- For couples therapy, I will only meet with one partner separately if an individual session is planned in advance with the agreement of both partners. If both partners are not present for a session, the session will be cancelled and you will be charged for the appointment.
- Both parties involved in couples 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 therapy, your partner understands that he or she is not the patient, is not receiving treatment and may not be protected under confidentiality laws.
- With the exception of information required by health insurance companies, any release of information when both participants are patients in couples therapy requires the agreement and 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.

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.

MEDIATION AND ARBITRATION: Disputes arising out of or in relation to the agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by mutual agreement between me and the client. The cost shall be divided equally unless otherwise agreed. In the event the mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Multnomah County, Oregon in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue/unpaid and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or a collection proceeding shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, that sum will be determined by the arbitrator.

LITIGATION LIMITATIONS: Due to the sensitive nature of the disclosures required in the therapeutic process, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither the client nor his/her attorney, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

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 discus 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.

Client:

_____	_____	_____
(Print Name)	Signature	Date Signed

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

_____	_____	_____
(Print Name)	Signature	Date Signed

Guy Burstein, LCSW
Psychotherapy for Individuals, Couples and Families
833 SW 11th Ave Suite 710
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 February 1, 2024

Client: _____ Date: _____

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____Clinician: _____

- I understand I have the following rights under this agreement:
- I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.
- There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
- I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services. I have read and understand the information provided above.
- I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.
- I understand that I can withdraw my consent to Telehealth communications by providing written notification to Prepare to Change. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Authorized Signature for Client Date

Guy Burstein LCSW
833 SW 11th Ave #710 Portland OR 97205
email: guy@guyburstein.com
web: www.guyburstein.com