Kelly Murray MA, LPC
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Portland, OR 97205
Ph# 971-258-1712
kellymurraylpc@gmail.com
www.kellymurraytherapy.com

INTAKE PACKET

Please fill out this intake paperwork to provide me with basic contact information, and information related to the issues you want to work on in counseling.

Name_____ Age _____

DOB:_____ Referred By_____ Date_____

Address _____City_____State_____ Zip_____

Phone _____ Email _____

Emergency ContactName/#_____ OK to contact you by phone? _____ OK to leave a message? _____

OK to contact you by email? _____ (If yes, read and sign the Professional Disclosure Statement/Informed Consent)

Why have you decided to seek counseling at this time?

What would be helpful to you right now?

Have you ever worked with a counselor before? When, and what were you working on at the time? What went well or poorly about your counseling experience?

Have you ever been given a diagnosis by counselor, psychiatrist in the past?

What style of counselor do you imagine working best with? Interactive? Mostly listening? Gives suggestion and opinions? (Anything you want to add or share.)

What is your social support like right now?

Are you in a relationship? Do you have concerns about your current relationship, relationship history, or relationship patterns?

What do you do for work? Are you in school? How do you feel about your job/career?

What is your current living situation?

Is there anything about your family of origin or childhood that impacts you in the present?

Do you consider yourself having experienced any trauma in the past?

Are you currently taking any medications for anxiety, depression, etc? If so, please list. Do you see a primary physician, psychiatrist, psychiatric mental health nurse practitioner?

Any relevant legal history?

Are you having any suicidal thoughts? Have you in the past? Have you ever made a suicide attempt? Any history of self-harm?

Any issues with drugs or alcohol? Gambling, pornography, or any other addictive behaviors?

Anything else you'd like to share?

Eating Disorder Clients: **(If you have not identified yourself as struggling with an eating disorder, please skip this section**)

Do you have any difficulties around food and weight you would like to work on?

Do you use any purge, use laxatives, dieuretics, edemas, chew/spit, overexercise or do any other things to compensate for eating, etc?

Do you have a history of dieting? If so, when did you first start?

Do you weigh yourself? If so, how regularly?

Do you exercise? What kind of exercise, how often?

Are there things you don't allow yourself to do that you would like yourself to do because of an eating disorder?

I certify that the above information is accurate. I understand that this information will be included in my clinical record and will be used and disclosed only as allowed by Oregon law and HIPPA—as described in the Professional Disclosure/Informed Consent..

_____

Name Signature Date

FINANCIAL AGREEMENT

A. In-Network Insurance Authorization:

Kelly Murray MA, LPC and the billing service contracted with Kelly Murray MA, LPC have my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for service are due at the time of the service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (less than **48** hours notice) will be charged to me at full fee and cannot be charged to my insurance company. I also understand that there is a returned check processing fee of $25.00.

_____Signature Date

B. Out-of-Network Insurance Benefits or Out-of-Pocket Payment Agreement:

I, _____, am choosing to make out-of-pocket payments for the clinical services I receive with Kelly Murray MA, LPC. I am doing this for the following reason(s):

I do not presently have insurance that covers mental health benefits.

I have mental health benefits with _____ (Insurance Company), however:

- I have exhausted my current outpatient mental health benefits.
- I am choosing not to use my insurance benefits at this time.
- I wish to be treated by Kelly Murray MA, LPC who is not a paneled member of my insurance network. However, I authorize Kelly Murray MA, LPC or any billing service she works with to submit claims to my insurance if I have out-of-network benefits available. If claims to out-ofnetwork benefits are submitted, I understand that some plans will direct me to pay the entire billed amounts in full, and I will be reimbursed directly by my insurance company for approved claims.
- My concerns are not covered by my insurance benefits and are not deemed medically necessary by my insurer. Fees for Service: $160 Assessment $120 Individual Therapy C. Agreement to Begin Treatment:

This agreement pertains to services beginning _____ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is

obtained and I consent for Kelly Murray MA LPC to bill my insurance, or I leave treatment. I agree to make out-of-pocket payments at the time that services are rendered. These payments can be made by cash, check, or debit/credit cards (Visa, MasterCard, Discover, or American Express). **Complete Section (A) if using “In-Network” insurance benefits. For all others, complete Section (B).

_____ Client Signature

_____ If minor, Signature of Legal Guardian

_____ _____ Printed Name of Client Date

_____ _____ Printed Name Date

Client Insurance Information Sheet

PRIMARY INSURANCE

Subscriber's name _____ Date of Birth _____

Address _____City _____ State _____

Zip _____ Phone _____

Client's relation to insured _____ Insured's employer _____

Primary insurance company _____

Address _____

Phone_____

Identification #_____

Group #_____

Deductible met? __ Yes __ No __

Deductible amount $_____

If no, how much left? $_____

Effective Date _____

Name of contact for preauthorization _____Phone _____ Limits of mental health benefit? __ Yes __ No # _____

sessions per year $_____ per year Mental health benefit currently available ____ **Kelly Murray MA,** LPC, has my permission to bill my insurance company. I authorize the program to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to the program.

_____

Name Signature Date _____

Kelly Murray MA, LPC

PROFESSIONAL DISCLOSURE STATEMENT & PRIVACY PRACTICES

General Information and Policies:

This document is designed to inform you of my policies and your rights as a client, be informed of my credentials and licensure, as well as to familiarize you with my treatment approach. Please ask questions if there is any confusion regarding this information.

Philosophy and Approach:

The purpose of my work is to help you improve in overall functioning, quality of life and relationships. I utilize a highly collaborative, warm, and direct approach in my practice. I use an integrated approach in therapy; pulling from Gestalt therapy, Sensorimotor Psychotherapy and Cognitive-Behavior treatments. I believe in a collaborative process and bring a holistic perspective to the work that I do. I abide bye the Code of Ethics of Counselors and Therapists adopted by the Oregon State Board of Licensed Professional Counselors and Therapists.

Formal Training and Education:

I have a Masters in Counseling Psychology (M.A.) from Lewis & Clark College (2008) and have successfully passed the National Board of Certified Counselor examination and have completed the required number of clinical hours to obtain licensure as a Licensed Professional Counselor (LPC). I hold a Bachelors of Arts (B.A.) in Psychology from Portland State University.

Typical session:

Sessions are 50 minutes in length, typically occurring on a weekly or bi-weekly basis (Other needs may be accommodated). During the first session, we will discuss the concerns that brought you into my office, and outline goals you wish to achieve. We will go over office policies, discuss confidentiality and the limits to confidentiality

Risks and Benefits of Treatment

The benefits of counseling include but are not limited to a greater sense of personal and relational well-being, the resolution of mental health issues and the recovery from trauma or losses. The risks of

counseling are the presenting symptoms, concerns or issues do not improve/can worsen and/or new symptoms, concerns, issues can arise. Other options exist including not seeking treatment, working with another therapist or treatment agency and/or medication to treat your counseling goals or concerns.

Initial Assessment Period and Closure

The initial period of counseling work is an assessment period whereby I may deem it unethical to continue to provide treatment due to 1) additional needs arising that are outside my scope of practice, 2) concern over the “fit” between myself and my client, 30 a limit to my availability that would impact the effectiveness of treatment.

If it has been 3 months or more since we have actively met, I will consider your case closed. Many clients return to my practice after time away. Your are more than welcome to resume counseling if mutually agreed upon by the both of us.

Fees:

My rate is $120 for a 50 minute session and $160 for Insurance Intakes (First session). I offer a set number of reduced fee slots for those with limited financial resources. Please inquire about this option if you are unable to pay my standard fee. I am on a number of insurance panels and you are responsible for checking your insurance benefits to see if I am on your plan and to understand the risks and benefits of using insurance for therapy. Copays and self-pay fees are due at each session and can be paid via check, cash or card.

Cancellations:

Therapy is most helpful when you come to sessions on a regular basis. Please email or call at least **48** hours in advance to avoid being charged in full for missed sessions unless other arrangements are made on an individual basis. Insurance companies do not reimburse for missed sessions.

Emergencies:

I check voice mail Monday thru Saturday and return messages promptly. If an emergency arises, please indicate it clearly in your message. If you are in need of immediate support, prior to my returning your call, please call 911, the emergency room of the hospital nearest you, or the Multnomah County Crisis Line at 503-988-4888.

Consultations:

I consult regularly with other mental health/addiction professionals in the field, but a client's identity will remain anonymous so as to not breach confidentiality.

Health Insurance & Confidentiality of Records:

Confidential information may be requested by your health insurance/HMO/PPO/MCO/EAP to pay for services. If you ask Kelly Murray MA, LPC, CADCI to release the minimum information necessary, Kelly Murray MA, LPC, CADCI has no control or awareness of how insurance companies will process these submittals; as well as who has access to this information.

Emails, Cell Phones, Computers, and Faxes:

It is important to be aware that email/computer communications cannot be absolutely guaranteed to be confidential; due to the nature of internet servers, unauthorized users, etc. Kelly Murray, MA, LPC, CADCI does not encrypt her emails. Kelly Murray MA, LPC, CADCI's computer's are protected with firewall, a virus protection, and a password. Please let me know if you prefer to not communicate via cell phone/email, etc. Please do not leave reviews for my practice on social media sites.

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 free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving 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;
5. Defending claims brought by client against licensee.

If you have any questions or concerns about services provided to you by any Licensed Professional Counselor, direct them to:

Oregon Board of Licensed Professional Counselors and Therapists
3218 Pringle Road SE #250,
Salem, OR 97302-6312
Telephone: (503) 378-5499

Please ask before signing this form if you have any questions about these policies. Your signature indicates that you agree to enter counseling under these conditions. Your signature indicates an understanding that either party may terminate counseling if it determined that you are not benefiting from my services. If this should occur, I would be glad to provide possible sources of referral.

All records shall be held as confidential as provided by law. You may review your file at any time during our counseling relationship.

I have read, understand, and agree to the above. I have received a copy of this document:

Client Signature_____ Date_____

Partner Signature_____Date_____

Therapist Signature_____Date_____

Credit Card Authorization Form

Kelly Murray MA, LPC requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged for copays (or agreed upon fees) after each session on the day the session occurs. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

□ I do not authorize Kelly Murray MA, LPC to charge my credit card after each session but only for additional fees I and/or my minor child/ren incur as set forth in the businesses disclosure statement and policies. I will be notified of the type of additional fees I and/or my minor child/ren incur.

□ I authorize Kelly Murray MA, LPC to charge my credit card copays after each session and for any and all additional fees I and/or my minor child/ren incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for thirty (30) days, your account may be sent to collections. Kelly Murray MA, LPC reserves the right to send your account to collections, in accordance with Kelly Murray MA, LPC policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify your therapist Kelly Murray MA, LPC of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

PLEASE CHECK ONE:
□ Card Holder is the client (or parent/legal guardian) receiving services from Kelly Murray MA, LPC
□ Card Holder is a third-party payer for the client receiving services from Kelly Murray MA, LPC

Kelly Murray MA, LPC Accepts the Following Credit Cards:
□ VISA □ DISCOVER □ AMERICAN EXPRESS □ MASTERCARD

_____

Name on Credit Card

_____ _____ _____

Credit Card Number CCV Code Expiration Date

Card Holder's Full Address, including zip code (the mailing address for your credit card statements):

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