



CLIENT INTAKE FORM

PORTLAND MENTAL WELLNESS

RYAN GRASSMANN, .MA., LPC | LICENSED PROFESSIONAL COUNSELOR

1235 SE DIVISION STREET, SUITE 207 | PORTLAND, OREGON 97202

|503| 505.9672 | HELLO@PORTLANDMENTALWELLNESS.COM

PLEASE COMPLETE THIS FORM BY ENTERING THE FOLLOWING INFORMATION BELOW AND BRING IT TO YOUR FIRST SESSION.

PLEASE NOTE: INFORMATION PROVIDED HERE IS PROTECTED HEALTH INFORMATION.

GENERAL INFORMATION

TODAY'S DATE: _____ NAME: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____ RELATIONSHIP STATUS: _____

PLEASE LIST ANY CHILDREN & THEIR AGE(S): _____

ADDRESS: _____

PHONE | HOME : _____ MAY WE LEAVE A MESSAGE? Y N

PHONE | CELL/OTHER: _____ MAY WE LEAVE A MESSAGE? Y N

EMAIL: _____ MAY WE EMAIL YOU? Y N

*PLEASE NOTE: EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL FORM OF COMMUNICATION.

DO YOU WANT TO SUBSCRIBE TO OUR E-NEWSLETTER? Y N

BRIEFLY DESCRIBE WHAT IS TROUBLING YOU (YOUR PRIMARY REASON FOR SEEKING COUNSELING SERVICES).

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES (PSYCHOTHERAPY, PSYCHIATRIC SERVICES, ETC.)?

NO: YES | PREVIOUS THERAPIST/PRACTITIONER: _____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION?

NO: YES | PLEASE LIST:

HAVE YOU EVER BEEN PRESCRIBED PSYCHIATRIC MEDICATION?

NO: YES | PLEASE LIST AND PROVIDE DATES:

DO YOU SUFFER FROM ANY CHRONIC ILLNESS?

NO: YES | PLEASE DESCRIBE:



GENERAL HEALTH AND MENTAL HEALTH INFORMATION

HOW WOULD YOU RATE YOUR CURRENT PHYSICAL HEALTH?

POOR: UNSATISFACTORY: SATISFACTORY: GOOD: VERY GOOD:

PLEASE LIST ANY SPECIFIC HEALTH PROBLEMS YOU ARE CURRENTLY EXPERIENCING:

HOW WOULD YOU RATE YOUR CURRENT SLEEPING HABITS?

POOR: UNSATISFACTORY: SATISFACTORY: GOOD: VERY GOOD:

HOW MANY TIMES PER WEEK DO YOU GENERALLY EXERCISE?

IN WHAT TYPES OF EXERCISE DO YOU PARTICIPATE?

PLEASE LIST ANY DIFFICULTIES YOU EXPERIENCE WITH YOUR APPETITE OR EATING PATTERNS:

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING SADNESS, GRIEF, OR DEPRESSION?

NO: YES | FOR APPROXIMATELY HOW LONG? _____

ARE YOU CURRENTLY EXPERIENCING ANXIETY, PANIC ATTACKS, OR HAVE ANY PHOBIAS?

NO: YES | PLEASE DESCRIBE:

HAVE YOU HAD THOUGHTS OF ENDING YOUR LIFE?

NO: YES | PLEASE DESCRIBE:

ARE YOU CURRENTLY EXPERIENCING ANY CHRONIC PAIN?

NO: YES | PLEASE DESCRIBE: _____

DO YOU DRINK ALCOHOL MORE THAN ONCE PER WEEK?

NO: YES | HOW MANY TIMES? _____

HOW OFTEN DO YOU ENGAGE IN RECREATIONAL DRUG USE?

DAILY: WEEKLY: MONTHLY: INFREQUENTLY: NEVER:

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP?

NO: YES | FOR HOW LONG? _____

ON A SCALE OF 1-10, HOW WOULD YOU RATE YOUR RELATIONSHIP? _____

WHAT SIGNIFICANT LIFE CHANGES OR STRESSFUL EVENTS HAVE YOU EXPERIENCED RECENTLY?

FAMILY MENTAL HEALTH HISTORY

IN THE SECTION BELOW IDENTIFY IF THERE IS A FAMILY HISTORY OF ANY OF THE FOLLOWING. IF YES, PLEASE INDICATE THE FAMILY MEMBER'S RELATIONSHIP TO YOU IN THE SPACE PROVIDED.

	YES NO	LIST FAMILY MEMBER
ALCOHOL/SUBSTANCE ABUSE	<input type="checkbox"/> Y <input type="checkbox"/> N	
ANXIETY	<input type="checkbox"/> Y <input type="checkbox"/> N	
BI-POLAR DISORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	
DEPRESSION	<input type="checkbox"/> Y <input type="checkbox"/> N	
DOMESTIC VIOLENCE	<input type="checkbox"/> Y <input type="checkbox"/> N	
EATING DISORDERS	<input type="checkbox"/> Y <input type="checkbox"/> N	
OBESITY	<input type="checkbox"/> Y <input type="checkbox"/> N	
OBSESSIVE COMPULSIVE BEHAVIOR	<input type="checkbox"/> Y <input type="checkbox"/> N	
PERSONALITY DISORDER	<input type="checkbox"/> Y <input type="checkbox"/> N	
SCHIZOPHRENIA	<input type="checkbox"/> Y <input type="checkbox"/> N	
SUICIDE ATTEMPTS	<input type="checkbox"/> Y <input type="checkbox"/> N	

ADDITIONAL INFORMATION

ARE YOU CURRENTLY EMPLOYED?

NO: YES | WHAT IS YOUR CURRENT EMPLOYMENT? _____

DO YOU ENJOY YOUR WORK? _____

IS THERE ANYTHING STRESSFUL ABOUT YOUR CURRENT WORK?

DO YOU CONSIDER YOURSELF SPIRITUAL OR RELIGIOUS?

NO: YES | DESCRIBE YOUR BELIEF/FAITH: _____

*PLEASE NOTE: BY COMPLETING THIS SECTION YOU AUTHORIZE ME TO CONTACT THE INDIVIDUAL IN SITUATIONS INVOLVING AN EMERGENCY.

PLEASE LIST AN EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT PORTLAND MENTAL WELLNESS / RYAN GRASSMANN, M.A., LPC?

BY SIGNING THIS I CERTIFY THAT THE ABOVE IS TRUE TO MY KNOWLEDGE.

SIGNATURE

DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE



CONSENT TO TREATMENT

PORTLAND MENTAL WELLNESS

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SCHEDULING APPOINTMENTS

To schedule an appointment, call [503] 505.9672.

Leave a confidential voicemail message including instructions on when and how to reach you. Make sure to state whether a voicemail may be left at your return phone number. You may also email hello@portlandmentalwellness.com to request an appointment. Messages are returned periodically throughout the day. Please understand that if you need to cancel an appointment for any reason, a 24 hour notice is required. The full rate for your scheduled service will be assessed when 24 hour notice is not provided. If late cancel/no shows become an issue, your session will require prepayment.

PHONE CALLS

Voice messages are typically returned within 24 hours. If you need to speak with someone immediately due to a mental health crisis, please call Multnomah County Crisis Line at [503] 988.4888. If you are experiencing a serious mental health or medical crisis please go to the nearest emergency department or call 911. NOTE: Please state to the dispatcher that you are having a mental health crisis. Additional crises resources can be found at portlandmentalwellness.com/additional-resources.

FEES

The fee for an initial intake session is \$190. The fee for individual therapy services is \$175 per 60 minute session. The fee for couple's sessions is \$190 per 60 minute session or \$210 per 90 minute session. Fees for group sessions will be determined based upon session duration and frequency. Information regarding current and future group sessions will be published on portlandmentalwellness.com. Sliding scale fees for those experiencing financial hardship will be determined on a case-by-case basis.

PAYMENTS/REIMBURSEMENT FOR SERVICES

I accept all major forms of payment including cash, check, credit card, and health savings account cards. I do participate in-network with various health plans including Pacific Source, Moda, Regence BCBS, Cigna, and Health Net (MHN). Further, if your insurance plan includes out-of-network benefits, I can offer two options: electronically file a "courtesy claim" to your health plan following a benefits and eligibility inquiry, or collect the fee directly from you and provide you with the documents you'll need to submit your claim for reimbursement. As a reminder, it is always best to contact your health plan's member services center prior to receiving services.

NOTE: As of January 1st, 2022, The Public Health Service Act requires all licensed healthcare providers to make publicly available a single page notice describing the various protections from receiving "Surprise Billings" from out of network providers. This notice can be found at portlandmentalwellness.com or at the offices of Portland Mental Wellness. You will also receive a copy within your intake documents.

ELIGIBILITY FOR TREATMENT

Portland Mental Wellness will not deny services on the basis of race, color, creed, gender, sexual orientation, disability, national origin or status of residence. Note: Portland Mental Wellness does not provide counseling services to minors. I would be glad to assist in a referral. Please ask.

RECORD KEEPING

Portland Mental Wellness utilizes professional charting software that remains fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that your Private Health Information (PHI) is encrypted and stored remotely while remaining available to share with another provider of your choice. Clients that become inactive in treatment services for 90 days will have their PHI archived. You retain the right to request access to your PHI at any time. After your PHI is entered into the encrypted database all paper copies are destroyed. Additionally, all portable devices operated by Portland Mental Wellness are capable of access to remote databases, are password protected and/or bio encrypted, and remain free of all PHI on local storage.

CONFIDENTIALITY

Portland Mental Wellness considers your right to privacy and confidentiality to be an essential component of successful treatment. Anything discussed between therapist and client will not be disclosed without your prior knowledge and written approval. For limitations and additional information regarding confidentiality please see the document titled "Notice of Privacy Practices" provided with this form.

TREATMENT PROCESS

Participating in psychotherapy will involve discussing personal topics that may evoke strong emotions and, at times, forms of distress. In general, most clients experience some form of relief or improvement in the frequency and intensity of their symptoms after participating in treatment. However, the risk remains that symptoms of distress may intensify during the process of treatment. You are strongly encouraged to discuss any concerns regarding your treatment process with your therapist. Your therapist is obligated to direct your treatment in a manner that is sensitive and responsive.

It is important to note that, if while engaged in treatment, a client fails to attend a scheduled session and no contact with the client can be made for a period of 45 days, it should be understood that the client is no longer considered "in-treatment" or "under my care." If at any point in the course of treatment, the therapist determines that the therapeutic relationship or the therapeutic services may not be the most appropriate form of clinical care (for any reason) then the therapist reserves the right to take appropriate action on the behalf of the well-being of the client by terminating services and making referrals to the appropriate level of care.

THERAPY DOGS

At all times, the client possesses the right to request or refuse the presence of the therapy dog while in session. Alice is a 14 year-old, 42 pound female Golden Retriever/Poodle mix who is a semi-retired therapy dog. She has received professional behavioral training and obtained her Canine Good Citizen certification issued by the American Kennel Club. Alice carries current vaccinations required by Multnomah County Animal Services. See Alice's bio at portlandmentalwellness.com/alice for additional information. Frances is a two year-old, 52 pound female Golden Retriever/Poodle mix who is currently training to become a therapy dog. As of January 1, 2022 we will begin introducing Frances to sessions.

GRIEVANCES

In the case that you wish to submit a complaint or grievance related to therapy services, you are first encouraged to present your concern directly to your therapist. Additionally, you may contact the Oregon State Board of Licensed Professional Counselors and Therapists by phone |503| 378.5499 or by mail at 3218 Pringle Rd. SE Suite 120 Salem, OR 97302-6312.

INHERENT RISKS INVOLVED WITH TEXT MESSAGES & EMAIL COMMUNICATION

At times, text messages are received and transmitted to and from |503| 505.9672. Texting to this number presents risks to clients' confidentiality and privacy. Additionally, sending and receiving email cannot guarantee your privacy and confidentiality, therefore it is highly recommended that you consider these risks prior to sending any text or email to Portland Mental Wellness. If you decide to proceed with texting or emailing you are encouraged to limit the content to issues of scheduling or for requesting a return call.

SOCIAL MEDIA & INTERNET PRESENCE

In addition to portlandmentalwellness.com, Portland Mental Wellness maintains a presence on both Facebook and Instagram for the sole purpose of providing the general public with information related to mental health research findings, national mental health policies, and support for the reduction of stigma associated with mental health challenges. All clients of Portland Mental Wellness are highly encouraged to refrain from any acts that compromise your privacy including "liking," "commenting," "posting," "sharing," "pinning," and or any other activity that reveals your identity as a client of Portland Mental Wellness. Additionally, please consider that the posting of reviews of mental health services compromises your privacy and confidentiality though it is your right to do so.

OFF-SITE SERVICES

With the exception of telehealth and telephone counseling, services that are not rendered at 1235 SE Division Street, Suite 207, Portland, Or 97202 are considered off-site services. Off-site services are provided solely at the discretion of the therapist. Prior to receiving off-site services, the therapist will require the client's verbal and written consent via an addendum to this consent form. The addendum addresses matters of logistics, additional fees, risks to confidentiality, and limitations to services. Examples of off-site services may include therapy while walking, therapy related to extinguishing phobias, telehealth, and travel to any treatment center for the delivery of therapy services to an existing client. In order to obtain these services, completion of the Consent to Telemental Health is required.

EXPERT WITNESS TESTIMONY

At times, clients involved in civil and criminal proceedings will seek verbal or written testimony from their therapist to support or defend a legal argument. When this occurs the therapist is asked to provide private and confidential protected health information (PHI). Some mental health providers and examiners have received training in providing expert witness testimony. If you believe you may require such testimony you will gladly be directed to an attorney who can assist. Ryan Grassmann, M.A., LPC has not received training and possesses no experience in providing such service. Any subpoena or summons by a court of law and consistent with State or Federal Statutory Law will be honored, however Portland Mental Wellness and Ryan Grassmann, M.A., LPC, reserve the right to assess fees for written and verbal testimony per hour. Fees begin at \$250 per hour for written testimony and \$395 for verbal testimony.

I have read and understand the above statements. I have been given the opportunity to review this document with my provider. By signing this document I consent to treatment and agree to the terms and conditions of treatment. I may revoke this agreement in writing at any time.

PRINTED NAME

SIGNATURE

DATE



NOTICE OF PRIVACY PRACTICES

PORTLAND MENTAL WELLNESS
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NOTICE OF PRIVACY PRACTICES

This notice provides information regarding disclosures of your Protected Health Information (PHI). Portland Mental Wellness is required to notify clients of legal obligations, duties, and practices involving the protection of and the risks to your PHI. Portland Mental Wellness reserves the right to change these privacy practices and will notify you should changes be made. Portland Mental Wellness will not use or disclose your PHI for any purposes other than the exception of the circumstances listed below.

MANDATED REPORTING

- If there is reason to believe that there is serious and imminent risk to yourself or another person Licensed Professional Counselors are mandated by law to intervene by reporting the circumstances to the authorities.
- If there is reason to believe that the abuse of a child has occurred, Licensed Professional Counselors are mandated by law to intervene by reporting the circumstances to the appropriate authorities.
- If there is reason to believe that the abuse of an senior citizen, a mentally ill citizen, or a developmentally disabled citizen has occurred, Licensed Professional Counselors are mandated by law to report the circumstances to the appropriate authorities.
- Licensed Professional Counselors are obligated to provide your PHI upon request to organizations responsible for overseeing compliance with governmental rules and standards for providing healthcare.
- Should the receipt of a court order, subpoena, warrant, summons or similar process occur, Licensed Professional Counselors are obligated by law to provide the requested material.
- Licensed Professional Counselors may disclose your PHI if there is reason to believe that there is risk to public health and safety.
- Licensed Professional Counselors may disclose your PHI to a coroner or medical examiner in the case of your death.
- Licensed Professional Counselors may disclose your PHI in the case of a request from the Workers Compensation Administration.
- In the case of a medical emergency Licensed Professional Counselors may disclose your PHI to the extent required to deliver appropriate medical care.

YOUR PRIVACY RIGHTS

- You have the right to request restrictions to your PHI. Requests need to be written. Your therapist will consider such requests however please note that Licensed Professional Counselors are not obligated to agree to such requests.
- You have the right to receive confidential communications from Portland Mental Wellness. Please discuss your concerns with your therapist either verbally or in writing.
- You have the right to inspect and copy your PHI from Portland Mental Wellness at any time. There are limited circumstances where Portland Mental Wellness may deny such requests.
- You have the right to request that I amend your PHI for as long as your PHI is maintained on record. There are limited circumstances where Portland Mental Wellness may deny such requests.
- You have the right to receive an accounting of disclosures made within the past six years.
- You have the right to obtain a paper copy of this notice upon request.

I have read and understand this privacy notice. I have been provided the opportunity to review this document with my therapist. By signing below I agree to proceed with therapy having considered the risks and limitations to my privacy and confidentiality.

PRINTED NAME

SIGNATURE

DATE



PROFESSIONAL DISCLOSURE STATEMENT

PORTLAND MENTAL WELLNESS

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PHILOSOPHY AND APPROACH

I assist adults experiencing problems in living. I do this by employing various therapeutic approaches although my therapeutic framework and clinical training is grounded in the cognitive behavioral therapies. Because I believe no single theory fully explains the complex nature of the human experience, I rely upon the practice of utilizing effective interventions that have evolved from the field of applied psychotherapy. My particular therapeutic orientation often calls upon the use of the Existential Humanistic approach. I offer a relatable, reliable, and relevant style that allows the therapeutic process to proceed organically through an alliance with my clients. This relationship is the primary element that facilitates positive and beneficial changes in client's lives.

FORMAL EDUCATION AND TRAINING

I hold a master's degree in counseling psychology from Pacific University School of Professional Psychology. Major course work included human development, group dynamics, addictions, and the integrated use of evidenced based practices. My post graduate training includes animal assisted therapy, chronic pain management, couples therapy, somatic therapies, and existential humanistic psychotherapy.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I abide by its Code of Ethics. To maintain my license I am required to participate in continuing my education, taking classes dealing with subjects relevant to this profession.

FEES

My fee for a 60 minute initial intake session is \$190. My fee for one clock hour of individual counseling is \$175. My fee for a 60 minute clock hour couple's session is \$190. My fee for a 90 minute clock hour couple's session is \$210.

AS A CLIENT OF AN OREGON LPC REGISTERED INTERN, YOU HAVE THE FOLLOWING RIGHTS:

- To expect that a licensee has met the 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 (Oregon Administrative Rules 833-100);
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to yourself or others; 3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me;
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

You may contact the Board of Licensed Professional Counselors and Therapists at:

3218 Pringle Rd SE, #120, Salem, OR 97302-6312

Telephone: |503| 378.5499

Email: lpct.board@mhra.oregon.gov

Additional information about this counselor or therapist is available on the Board's website: www.oregon.gov/oblpc

Please sign and date below indicating that you have read the counselor's professional disclosure statement and have been provided a copy for your records.

PRINTED NAME

SIGNATURE

DATE