

Elsbeth Martindale, Psy.D.

5525 E. Burnside

Portland, OR 97215

Phone (503)236-0855 FAX (503)233-4449

Scheduling Your First Appointment

The wait time to schedule your first appointment is dependent on your availability and Dr. Martindale's open slots. We do not schedule new clients until there is a consistent open time slot in which to see them. Many clients prefer to schedule after work or school and, as a result, these are the least available times. If you have flexibility in your schedule this will increase your odds of getting an appointment sooner.

Currently, Dr. Martindale is only seeing clients three days each week. Please let us know your preferred times for scheduling, using the form below. Send your scheduling information in to our office along with the intake forms. We will call you when our appointment times match your availability.

If you prefer not to wait to begin your therapy, we can suggest several excellent therapists who may have current openings. Please feel free to call to get referral names.

Please return the following:

- Client Information Questionnaire
- Current Symptoms
- Informed Consent for Treatment
- Insurance Information
- Schedule with your preferred times marked

Our office is in an old Victorian Home on East Burnside. This is a busy street. We suggest that you park on a side street and walk, although you may park in front of the house except between 7:00 and 9:00 AM. The QFC parking lot is reserved for their patrons.

If you need wheelchair access, please let us know this in advance. We have a ramp, in the back of the office, for those who may have difficulties with stairs. Dr. Martindale's office is on the second floor but arrangements can be made to meet in a ground floor office. Please tell us about your needs so we can make necessary accommodations.

We look forward to seeing you soon.

Schedule Information

Please return this page so we can know your schedule.

Name _____ Date _____

The times I am available to schedule an appointment are below.

Preferred times for appointments mark with \checkmark
Available times mark with X

<u>Monday</u>	<u>Wednesday</u>	<u>Friday</u>
<input type="checkbox"/> 9:30-12:00 AM	<input type="checkbox"/> 9:00-12:00 AM	<input type="checkbox"/> 9:30-12:00 AM
<input type="checkbox"/> 12:00-2:00 PM	<input type="checkbox"/> 12:00-2:00 PM	<input type="checkbox"/> 12:00-2:00 PM
<input type="checkbox"/> 2:00-4:00 PM	<input type="checkbox"/> 2:00-4:00 PM	<input type="checkbox"/> 2:00-5:00 PM
	<input type="checkbox"/> 4:00-6:00 PM	

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INFORMED CONSENT FOR TREATMENT/ CONFIDENTIALITY

As a client, you have rights and responsibilities when you seek my consultation, including:

1. **THE RIGHT OF CLIENTS TO REFUSE TREATMENT.** You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are unhappy with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another practitioner.

2. **THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HER/HIS NEEDS.** I will make an assessment and suggest possible treatment modes that may be helpful to you. However, the choice of treatment mode remains with you. If at any time you feel dissatisfied with the therapy, your questions and concerns must be addressed before we can continue.

3. **THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW.** Under Oregon state law psychologists have an obligation to honor client confidentiality. Nothing you tell me can be told to anyone else without your permission. **HOWEVER, THERE ARE EXCEPTIONS, SOME OF WHICH ARE:**

- **CHILD ABUSE** - I am required to report any known or suspected child abuse to the Department of Human Services.
- **HARM TO ANOTHER** - If I believe a client is about to harm another person, I have a duty to warn and, insofar as possible, to protect the intended victim.
- **SUICIDE** - If I believe someone is immediately likely to harm her/him self, I will try to protect the person by notifying a family member, the police, or the Mental Health Department.
- **EVALUATIONS** - If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, or physician), I will routinely send a written report of my findings to that professional. I will obtain a written consent from you in advance authorizing me to make such a disclosure.
- **COLLECTION PROBLEMS** - If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with other information that may help make collection possible.
- **FAX** - Our office occasionally uses a FAX machine to transmit information. If personal and confidential information is sent, we make it a priority to insist on the confidentiality of the material to the person receiving the FAX. Our fax number is 503-233-4449.

Client's Initials _____

**FEES/ ADDITIONAL CHARGES/ BILLINGS/ OFFICE POLICIES
PROFESSIONAL FEES**

My fees are based on the amount of professional time spent or reserved. The initial diagnostic interview evaluation fee is \$225. This is charged for your first appointment or upon returning to therapy after a two year absence. The basic fee for subsequent 45 minutes of psychotherapy is \$150 for individual and \$175 for family. Group psychotherapy (1 and 1/2 hours) is \$75 a session. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at \$150/hour. Psychological assessments, testing, and/or questionnaires are priced individually. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

ADDITIONAL CHARGES - You will also be charged for the following. Each charge is payable immediately upon demand.

- \$15 for any check submitted to us to pay any sums for which you are obligated and which check is dishonored.
- A delinquency fee of \$25 in the event you fail to timely pay us any sum you owe and we elect to institute or turn your debt over to a collection agency for collection. If we initiate a collection action and prevail, we will also seek such reasonable attorney fees as the court allows.
- \$95 should you fail to keep an appointment and fail to give us 24 hours advance notice that you will not keep such appointment.
- Phone sessions are available but insurance can not be billed for this service.

BILLINGS - We request that you pay for your portion of services at the time of your session unless you:

- request that we will bill your insurance carrier (both primary and secondary, if applicable), which we will do, at the end of your session if you provide us with complete and accurate information (including address of carrier) as we may request on our forms as we deem necessary; or
- request we bill you monthly, in which case the bill is due and is payable immediately upon demand. There is a \$5 monthly service fee for billing.

MISSED APPOINTMENTS - The time scheduled for you is reserved exclusively for you. If you do not keep the appointment, no one else will be able to use the time. Therefore, we ask that you please give us 24 hours notice if you need to cancel an appointment. In all events, please call as soon as you know that you will not be able to keep a scheduled appointment. Our voice mail is accessible at all hours.

EMERGENCIES- Should you find yourself in need of emergency assistance during hours when our office is closed, call **my home office at 503-234-6577**. If I am not available, you may call the **Crisis Line at 503-988-4888** 24 hours a day or your local emergency room.

Client's Initials _____

MY TRAINING, BACKGROUND AND ORIENTATION-

I earned my B.A. in Psychology from Westmont College and a Master's degree in Marriage, Family, Child Therapy from Pepperdine University. In 1987, I graduated from Rosemead Graduate School in Southern California with a doctorate in Clinical Psychology. I am currently licensed by the State of Oregon as a Psychologist. To continue my growth and education, I complete a minimum of 25 hours a year of continuing education credit, as required by the Oregon Licensing Board. I operate from an existential theoretical orientation, which essentially means I am concerned with issues of personal meaning, life experience, and self responsibility. Please do not hesitate to ask me about any of my policies, beliefs, or my psychological orientation.

I, _____, HAVE READ AND UNDERSTOOD ALL THE FOREGOING AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.

Signature of client or legal guardian

Date .

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Client name _____ Date of birth _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Self Spouse Parent Other

Employer _____

Insurance Company _____ Phone # _____

Insurance Address _____

Group # _____ Identification # _____

Effective date _____ D.O.B. of insured (if not client) _____



Mental health benefits often differ from medical benefits in terms of preauthorization, copay, and billing address. Please call your insurance carrier to obtain answers to the following questions.

Mental Health Insurance Carrier _____

Insurance Address _____

Insurance Phone # _____

Deductible Amount _____ Met? Yes No Copay per Visit _____

Preauthorization required? No Yes If yes, # of sessions authorized? _____

Maximum # sessions/year? _____ Maximum \$ amount/year? _____

Mental health benefit available: All Part \$ _____

Do you have secondary insurance coverage? Yes No

If "yes" please provide the above information for secondary carrier using the back of this form.

Please read and sign

We bill insurance as a service to you. We are not responsible for assuring that you have initial or ongoing coverage. If your coverage or authorization expires, for any reason, we will hold you responsible for payment. Please keep abreast of your coverage maximum.

I understand the insurance policy of Mt. Tabor Psychological Services, and I authorize Dr. Martindale to provide requested information regarding my treatment to my insurance carrier(s). I also authorize my insurance carrier to assign benefits directly to Dr. Martindale. I have called my mental health insurance carrier to verify coverage and obtain needed authorization.

Signature

Date

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CHILD INFORMATION QUESTIONNAIRE

Welcome to our office. Please complete the following questionnaire which will be helpful in planning our services for you. If you need clarification or assistance please do not hesitate to ask.

CLIENT INFORMATION

Full Name _____ Today's Date _____

Address _____

City _____ Zip _____

Phone: Home _____ Work _____ Cell _____

(Please indicate your preferred contact number with a √)

Age _____ Birth Date _____ Email _____

School _____ Education Level _____

Religious Preference: _____ Active Inactive

PARENT OR GUARDIAN INFORMATION

Mo. Name _____ Fa. Name _____

Address _____ Address _____

City _____ Zip _____ City _____ Zip _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

Cell _____ Fax _____ Cell _____ Fax _____

Employer _____ Employer _____

SS# _____ SS# _____

DOB _____ Drivers Lic.# _____ DOB _____ Drivers Lic.# _____

Occupation/Job Title _____ Occupation/Job Title _____

Email _____ Email _____

List members of your family and all others living in your home:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Occupation</u>

Who suggested you contact us? _____

Name of person to contact in case of emergency _____

Address _____ Phone _____

Has your child ever received psychiatric or psychological help of any kind before? yes no

<u>Therapist</u>	<u>Dates</u>	<u>Purpose</u>	<u>Was it helpful?</u>
_____			<input type="checkbox"/> yes <input type="checkbox"/> no
_____			<input type="checkbox"/> yes <input type="checkbox"/> no
_____			<input type="checkbox"/> yes <input type="checkbox"/> no
_____			<input type="checkbox"/> yes <input type="checkbox"/> no

Who is the child's primary care physician? _____

Address _____ Phone _____

Date of child's last physical: _____

It is our policy to inform your physician that your child is receiving psychological care. This is for the purpose of coordinating treatment. May I notify your physician about the issues for which your child is seeking psychotherapy? yes no Please initial _____

List major health concerns for which your child is currently receiving treatment:

Allergies or adverse reactions to medication or treatment: _____

List any medications your child is currently taking:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed by</u>	<u>Start Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Unusual prenatal or perinatal events: _____

Developmental delays or concerns: _____

Explain any abnormalities or concerns regarding; physical, psychological, social, intellectual, or academic development: _____

Briefly describe their reason for seeking help: _____

Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your child's life. Also, **in the blank**, indicate **how long** these problems have been present.

Scale	1=extremely big problem		6= little or no concern
MOOD	1 2 3 4 5 6 _____		IMPULSE Control 1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____		Anger 1 2 3 4 5 6 _____
Inferiority Feelings	1 2 3 4 5 6 _____		Temper 1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____		Hurting Others 1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____		Hurting Self 1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____		Food Management 1 2 3 4 5 6 _____
	amount in last month _____		Dangerous Behavior 1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____		Attention Deficit 1 2 3 4 5 6 _____
Nightmares	1 2 3 4 5 6 _____		
Insomnia	1 2 3 4 5 6 _____		SUBSTANCE USE 1 2 3 4 5 6 _____
Ambition	1 2 3 4 5 6 _____		Alcohol 1 2 3 4 5 6 _____
Unhappiness	1 2 3 4 5 6 _____		Drinks/week _____
Irritability	1 2 3 4 5 6 _____		Drugs 1 2 3 4 5 6 _____
Depression	1 2 3 4 5 6 _____		Caffeine 1 2 3 4 5 6 _____
Manic Behavior	1 2 3 4 5 6 _____		Drinks/week _____
Suicidal Thoughts	1 2 3 4 5 6 _____		Tobacco 1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____		RELATIONSHIPS 1 2 3 4 5 6 _____
Nervousness	1 2 3 4 5 6 _____		Friends 1 2 3 4 5 6 _____
Panic Attacks	1 2 3 4 5 6 _____		Conflicts with Parents 1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____		Parent _____
Obsessive Thoughts	1 2 3 4 5 6 _____		Separation/Divorce 1 2 3 4 5 6 _____
Fears	1 2 3 4 5 6 _____		Shyness 1 2 3 4 5 6 _____
			Loneliness 1 2 3 4 5 6 _____
HEALTH	1 2 3 4 5 6 _____		Fear of Being Alone 1 2 3 4 5 6 _____
Bowel Troubles	1 2 3 4 5 6 _____		Distancing Others 1 2 3 4 5 6 _____
Headaches	1 2 3 4 5 6 _____		Sexual Problems 1 2 3 4 5 6 _____
Stomach Trouble	1 2 3 4 5 6 _____		
Binging/Purging	1 2 3 4 5 6 _____		SELF CARE 1 2 3 4 5 6 _____
			School behavior 1 2 3 4 5 6 _____
THOUGHTS	1 2 3 4 5 6 _____		Career Choices 1 2 3 4 5 6 _____
Making Decisions	1 2 3 4 5 6 _____		Grades 1 2 3 4 5 6 _____
Memory	1 2 3 4 5 6 _____		Legal Matter 1 2 3 4 5 6 _____
Confusion	1 2 3 4 5 6 _____		Stress 1 2 3 4 5 6 _____
Communicating	1 2 3 4 5 6 _____		Incest 1 2 3 4 5 6 _____

LIST ANY OTHER CONCERNS YOU MAY HAVE _____

OPTIONAL QUESTIONS

Rate your child's level of activity on a scale of 1 - 10, where 1 is low and 10 is high: _____

What activities does your child engage in for fun and play? _____

How much attention do you pay to your child's physical health? Please explain. _____

How socially involved is your child on a scale of 1 - 10, where 1 is low and 10 is high? _____

With whom does your child have the most conflict? Over what issues? _____

Who are the people that are important in your child's life? _____

What losses has your child experienced in his/her life? _____

How many hours each week is the television on in your home? _____

Does your child have a television in his/her bedroom? yes / no

Is television/video/internet viewing monitored in your home? Please explain. _____

If "everything were better" in your child's life, what would that look like? _____

