# *Elsbeth Martindale, Psy.D.*

5525 E. Burnside
Portland, OR 97215
Phone (503)236-0855  FAX (503)233-4449


COUPLES FORMS

**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, and once a month on Fridays. 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 by mail, fax (503-233-4449), or by dropping them off. Email is not a confidential means for submitting these forms:

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

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 accommodates.

We look forward to seeing you soon.

## Schedule Information

**Please return this page so we can know your availability.**

Name _____Date _____

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

Preferred times for appointments mark with √
Available times mark with X

| Monday | Tuesday | Wednesday | Friday (monthly only) |
|---|---|---|---|
| ❑ 9:00-12:00 AM | ❑ 2:00-4:00 PM | ❑ 9:00-12:00 AM | ❑ 9:00-12:00 AM |
| ❑ 12:00-2:00 PM | ❑ 4:00-6:00 PM | ❑ 12:00-2:00 PM | ❑ 12:00-2:00 PM |
| ❑ 2:00-4:00 PM | | ❑ 2:00-5:00 PM | ❑ 2:00-4:00 PM |
| ❑ 4:00-6:00 PM | | ❑ 4:00-6:00 PM | |

In couples therapy, one person is generally identified as the "primary client." This is usually the person who has insurance coverage for treatment. Please decide which person will be considered the primary client. The “secondary client” will be the spouse. Fill out the following forms for both primary and secondary clients.

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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.

Primary client's Initials _____
Secondary 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 $245. 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 couples therapy is $180. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at $180/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.
- $100 should you fail to keep an appointment and fail to give us 24 hours advance notice that you will not keep such appointment.

**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.

Primary client's Initials _____

Secondary 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 primary client Date

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 secondary client Date

# *Elsbeth Martindale, Psy.D.*

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**Primary Client** Name _____ Date of birth _____
Mailing Address _____ Phone # _____
**PRIMARY INSURANCE INFORMATION**
Name of Insured _____ ❑ Self ❑Spouse ❑Parent ❑Other
Mailing Address _____ Phone # _____
Employer _____
Insurance Company _____ Phone # _____
Insurance Address _____
Group # _____ Identification # _____
Effective date _____ D.O.B. of insured (if not client) _____
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. We do not provide any EAP services. Please keep abreast of your coverage maximum.

We processes insurance claims electronically through a MindEase Billing. We will share information with MindEase sufficient to file insurance claims on your behalf.

I understand the insurance policy of Mt. Tabor Psychological Services, and I authorize Dr. Martindale to release information to insurance carrier(s) and billing service necessary to process insurance claims for services provided. 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 of Responsible Party Date

# *Elsbeth Martindale, Psy.D.*

5525 E. Burnside
Portland, OR 97215
Phone (503)236-0855  FAX (503)233-4449


Please complete the following questionnaire which will be helpful in planning our work together. If you need clarification on any question please do not hesitate to call our office.
For **couples**, one person is generally identified as the "primary client." This is usually the person who has insurance coverage for treatment. Please decide which person will be considered the primary client. The "secondary client" will be the spouse.
PRIMARY CLIENT INFORMATION

Full Name_____ Today's Date_____

Address _____

City _____ Zip _____

Phone:Home_____ Work _____ Cell _____
(Please indicate your preferred contact number with a √)

Fax _____ Age _____ Birth Date _____

Email _____@_____

Social Security # _____ Driver's License # _____

Occupation/Job Title _____

Employer/School _____

Your Education: _____

Religious Preference:_____ ❑ Active ❑ Inactive

Relationship Status (circle one) Single Married/Partnered Separated/Divorced Widowed

Relationship status satisfactory? ❑ yes ❑ no Length of current relationship _____

List members of your family and all others <u>living in your home</u>:

| <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 _____

Have you ever received psychiatric or psychological help of any kind before? ❑ yes ❑ no

| Therapist | Dates | Purpose | Was it helpful? |
|---|---|---|---|
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |

Who is your primary care physician?_____

Address _____

Phone _____ Fax _____

Date of your last physical:_____

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

List major health concerns for which you are currently receiving treatment:

_____

_____

Allergies or adverse reactions to medication or treatment: _____

_____

List any medications you are currently taking:

| Name of medication | Dosage | Frequency | Prescribed by | Start Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Briefly describe your reason for seeking help: _____

_____

_____

_____

_____

# Primary Client's Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you.
**Scale** **1-extremely big problem** **6-little or no concern**

| | | |
|---|---|---|
| MOOD | 1 2 3 4 5 6 | _____ |
| Tiredness | 1 2 3 4 5 6 | _____ |
| Inferiority Feelings | 1 2 3 4 5 6 | _____ |
| Concentration | 1 2 3 4 5 6 | _____ |
| Appetite | 1 2 3 4 5 6 | _____ |
| Weight Gain/Loss | 1 2 3 4 5 6 | _____ |
| amount in last month | | _____ |
| Sleep | 1 2 3 4 5 6 | _____ |
| Nightmares | 1 2 3 4 5 6 | _____ |
| Insomnia | 1 2 3 4 5 6 | _____ |
| Ambition | 1 2 3 4 5 6 | _____ |
| Unhappiness | 1 2 3 4 5 6 | _____ |
| Irritability | 1 2 3 4 5 6 | _____ |
| Depression | 1 2 3 4 5 6 | _____ |
| Manic Behavior | 1 2 3 4 5 6 | _____ |
| Suicidal Thoughts | 1 2 3 4 5 6 | _____ |
| | | |
| ANXIETY | 1 2 3 4 5 6 | _____ |
| Nervousness | 1 2 3 4 5 6 | _____ |
| Panic Attacks | 1 2 3 4 5 6 | _____ |
| Compulsive Behavior | 1 2 3 4 5 6 | _____ |
| Obsessive Thoughts | 1 2 3 4 5 6 | _____ |
| Fears | 1 2 3 4 5 6 | _____ |
| | | |
| HEALTH | 1 2 3 4 5 6 | _____ |
| Bowel Troubles | 1 2 3 4 5 6 | _____ |
| Headaches | 1 2 3 4 5 6 | _____ |
| Stomach Trouble | 1 2 3 4 5 6 | _____ |
| Binging/Purging | 1 2 3 4 5 6 | _____ |
| | | |
| THOUGHTS | 1 2 3 4 5 6 | _____ |
| Making Decisions | 1 2 3 4 5 6 | _____ |
| Memory | 1 2 3 4 5 6 | _____ |
| Confusion | 1 2 3 4 5 6 | _____ |
| Communicating | 1 2 3 4 5 6 | _____ |

| | | |
|---|---|---|
| IMPULSE Control | 1 2 3 4 5 6 | _____ |
| Anger | 1 2 3 4 5 6 | _____ |
| Temper | 1 2 3 4 5 6 | _____ |
| Hurting Others | 1 2 3 4 5 6 | _____ |
| Hurting Self | 1 2 3 4 5 6 | _____ |
| Food Management | 1 2 3 4 5 6 | _____ |
| Dangerous Behavior | 1 2 3 4 5 6 | _____ |
| Attention Deficit | 1 2 3 4 5 6 | _____ |
| | | |
| SUBSTANCE USE | 1 2 3 4 5 6 | _____ |
| Alcohol | 1 2 3 4 5 6 | _____ |
| | Drinks/week | _____ |
| Drugs | 1 2 3 4 5 6 | _____ |
| Caffeine | 1 2 3 4 5 6 | _____ |
| | Drinks/week | _____ |
| Tobacco | 1 2 3 4 5 6 | _____ |
| | Packs/week | _____ |
| | | |
| RELATIONSHIPS | 1 2 3 4 5 6 | _____ |
| Friends | 1 2 3 4 5 6 | _____ |
| Marriage | 1 2 3 4 5 6 | _____ |
| Separation/Divorce | 1 2 3 4 5 6 | _____ |
| Children | 1 2 3 4 5 6 | _____ |
| Shyness | 1 2 3 4 5 6 | _____ |
| Loneliness | 1 2 3 4 5 6 | _____ |
| Fear of Being Alone | 1 2 3 4 5 6 | _____ |
| Distancing Others | 1 2 3 4 5 6 | _____ |
| Sexual Problems | 1 2 3 4 5 6 | _____ |
| | | |
| SELF CARE | 1 2 3 4 5 6 | _____ |
| Work | 1 2 3 4 5 6 | _____ |
| Career Choices | 1 2 3 4 5 6 | _____ |
| Education | 1 2 3 4 5 6 | _____ |
| Legal Matter | 1 2 3 4 5 6 | _____ |
| Finances | 1 2 3 4 5 6 | _____ |
| Stress | 1 2 3 4 5 6 | _____ |
| Incest | 1 2 3 4 5 6 | _____ |

List any other concerns you may have at this time: _____

_____

_____

_____

_____

**OPTIONAL QUESTIONS**

What do you do for relaxation and enjoyment? _____

_____

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

_____

How does spirituality inform or assist you in managing your life? _____

_____

What do you value most in life? _____

_____

How important is honesty in your life? Please explain. _____

_____

How many hours each week is the television, video, or a big screen on in your home? _____

On average, how often do you check devices for email, texts, calls, or social media contacts?

❑ every several minutes ❑ hourly ❑ several times each day ❑ daily or less

How many hours each day do you spend in face to face contact with another person outside of work? _____ With whom? _____

How is it? ❑ satisfying ❑ joyous ❑ obligatory ❑ stressful ❑ conflictual ❑ uncomfortable

Do you make time for reflection, quiet, meditation, etc? ❑ yes ❑ no If yes, how often? _____

Explain, if desired _____

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

_____

_____

_____

_____

**SECONDARY CLIENT INFORMATION**

Full Name_____ Today's Date_____

Address _____

City _____ Zip _____

Phone:Home_____ Work _____ Cell _____
(Please indicate your preferred contact number with a √)

Fax _____ Age _____ Birth Date _____

Email _____@_____

Occupation/Job Title _____

Employer/School _____

Your Education: _____

Religious Preference:_____ ❑ Active ❑ Inactive

Relationship Status (circle one) Single Married/Partnered Separated/Divorced Widowed

Relationship status satisfactory? ❑ yes ❑ no Length of current relationship _____

Name of person to contact in case of emergency _____

Address _____ Phone _____

Have you ever received psychiatric or psychological help of any kind before? ❑ yes ❑ no

| Therapist | Dates | Purpose | Was it helpful? |
|---|---|---|---|
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |
| | | | ❑ yes ❑ no |

Who is your primary care physician?_____

Address _____

Phone _____ Fax _____

Date of your last physical:_____

List major health concerns for which you are currently receiving treatment:

_____

_____

Allergies or adverse reactions to medication or treatment: _____

_____

List any medications you are currently taking:

| Name of medication | Dosage | Frequency | Prescribed by | Start Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Briefly describe your reason for seeking help: _____

_____

_____

_____

# Secondary Client's Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you.
**Scale 1-extremely big problem 6-little or no concern**

| | | |
|---|---|---|
| MOOD | 1 2 3 4 5 6 | _____ |
| Tiredness | 1 2 3 4 5 6 | _____ |
| Inferiority Feelings | 1 2 3 4 5 6 | _____ |
| Concentration | 1 2 3 4 5 6 | _____ |
| Appetite | 1 2 3 4 5 6 | _____ |
| Weight Gain/Loss | 1 2 3 4 5 6 | _____ |
| amount in last month | | _____ |
| Sleep | 1 2 3 4 5 6 | _____ |
| Nightmares | 1 2 3 4 5 6 | _____ |
| Insomnia | 1 2 3 4 5 6 | _____ |
| Ambition | 1 2 3 4 5 6 | _____ |
| Unhappiness | 1 2 3 4 5 6 | _____ |
| Irritability | 1 2 3 4 5 6 | _____ |
| Depression | 1 2 3 4 5 6 | _____ |
| Manic Behavior | 1 2 3 4 5 6 | _____ |
| Suicidal Thoughts | 1 2 3 4 5 6 | _____ |
| | | |
| ANXIETY | 1 2 3 4 5 6 | _____ |
| Nervousness | 1 2 3 4 5 6 | _____ |
| Panic Attacks | 1 2 3 4 5 6 | _____ |
| Compulsive Behavior | 1 2 3 4 5 6 | _____ |
| Obsessive Thoughts | 1 2 3 4 5 6 | _____ |
| Fears | 1 2 3 4 5 6 | _____ |
| | | |
| HEALTH | 1 2 3 4 5 6 | _____ |
| Bowel Troubles | 1 2 3 4 5 6 | _____ |
| Headaches | 1 2 3 4 5 6 | _____ |
| Stomach Trouble | 1 2 3 4 5 6 | _____ |
| Binging/Purging | 1 2 3 4 5 6 | _____ |
| | | |
| THOUGHTS | 1 2 3 4 5 6 | _____ |
| Making Decisions | 1 2 3 4 5 6 | _____ |
| Memory | 1 2 3 4 5 6 | _____ |
| Confusion | 1 2 3 4 5 6 | _____ |
| Communicating | 1 2 3 4 5 6 | _____ |

| | | |
|---|---|---|
| IMPULSE Control | 1 2 3 4 5 6 | _____ |
| Anger | 1 2 3 4 5 6 | _____ |
| Temper | 1 2 3 4 5 6 | _____ |
| Hurting Others | 1 2 3 4 5 6 | _____ |
| Hurting Self | 1 2 3 4 5 6 | _____ |
| Food Management | 1 2 3 4 5 6 | _____ |
| Dangerous Behavior | 1 2 3 4 5 6 | _____ |
| Attention Deficit | 1 2 3 4 5 6 | _____ |
| | | |
| SUBSTANCE USE | 1 2 3 4 5 6 | _____ |
| Alcohol | 1 2 3 4 5 6 | _____ |
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| | Drinks/week | _____ |
| Tobacco | 1 2 3 4 5 6 | _____ |
| | Packs/week | _____ |
| | | |
| RELATIONSHIPS | 1 2 3 4 5 6 | _____ |
| Friends | 1 2 3 4 5 6 | _____ |
| Marriage | 1 2 3 4 5 6 | _____ |
| Separation/Divorce | 1 2 3 4 5 6 | _____ |
| Children | 1 2 3 4 5 6 | _____ |
| Shyness | 1 2 3 4 5 6 | _____ |
| Loneliness | 1 2 3 4 5 6 | _____ |
| Fear of Being Alone | 1 2 3 4 5 6 | _____ |
| Distancing Others | 1 2 3 4 5 6 | _____ |
| Sexual Problems | 1 2 3 4 5 6 | _____ |
| | | |
| SELF CARE | 1 2 3 4 5 6 | _____ |
| Work | 1 2 3 4 5 6 | _____ |
| Career Choices | 1 2 3 4 5 6 | _____ |
| Education | 1 2 3 4 5 6 | _____ |
| Legal Matter | 1 2 3 4 5 6 | _____ |
| Finances | 1 2 3 4 5 6 | _____ |
| Stress | 1 2 3 4 5 6 | _____ |
| Incest | 1 2 3 4 5 6 | _____ |

List any other concerns you may have at this time: _____

_____

_____

_____

_____

**OPTIONAL QUESTIONS**

What do you do for relaxation and enjoyment? _____

_____

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

_____

How does spirituality inform or assist you in managing your life? _____

_____

What do you value most in life? _____

_____

How important is honesty in your life? Please explain. _____

_____

How many hours each week is the television, video, or a big screen on in your home? _____

On average, how often do you check devices for email, texts, calls, or social media contacts?

❑ every several minutes ❑ hourly ❑ several times each day ❑ daily or less

How many hours each day do you spend in face to face contact with another person outside of work? _____ With whom? _____

How is it? ❑ satisfying ❑ joyous ❑ obligatory ❑ stressful ❑ conflictual ❑ uncomfortable

Do you make time for reflection, quiet, meditation, etc? ❑ yes ❑ no If yes, how often? _____

Explain, if desired _____

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

_____

_____

_____

_____